Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. D 2022
Cloverhill Prison
4 February 2022
Aged 41

To the Minister: 19 December 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
CCTV	Closed Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
FASU	Falls and Syncope Unit
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
PICLS	Prison in Reach and Court Liaison Service
TIA	Transient Ischaemic Attack

INTRODUCTION

1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Chief Inspector of Prisons has been obliged to investigate all deaths in prison custody. This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carries out regular inspections of prisons. The Office is independent of the Irish Prison Service (IPS). The Chief Inspector of Prisons and the staff of the OIP are independent of the Department of Justice, Home Affairs and Migration in the performance of their statutory functions.

1.2 The OIP can make recommendations for improvement where appropriate. Our investigation reports are published by the Minister for Justice, Home Affairs and Migration, subject to the provisions of the Act, in order that investigation findings and recommendations can be disseminated in the interest of public transparency, to promote best practice in the care of prisoners.

2. Objectives

2.1 The objectives for investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in the future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- Assist the Coroner's investigation and contribute to meeting the State's obligations under Article 2 of the European Convention on Human Rights, by ensuring, as far as possible, that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

3. Methodology

3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, next of kin (NoK); analysis of prison records in relation to the deceased's life while in custody; and examination of evidence, such as CCTV footage and phone calls.

3.2 This report is structured to detail the events leading up to Mr. D's death in prison on 4 February 2022 and the management of the events associated with his death.

4. Administration of Investigation

4.1 On 4 February 2022, the OIP was notified that Mr. D had passed away in Cloverhill Prison. The investigation team attended the prison on the same day and met with prison management who provided an overview of Mr. D's time in custody. Inspectors also met with persons who had contact with Mr. D during his time in prison.

4.2 Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of information required.

4.3 The cause of death is a matter for the Coroner.

5. Family Liaison

5.1 Liaison with the deceased's family is a very important aspect of the Inspectorate of Prisons' role when investigating a death in custody.

5.2 The OIP met with Mr. D's NoK, his sister, on 23 March 2022. Mr. D's sister provided background information about her brother and his life. She outlined family concerns and raised a number of questions, which are contained in Section 7 of this report.

5.3 Although this report is for the Minister for Justice, Home Affairs and Justice, it may also inform several interested parties. It is written primarily with Mr. D's NoK in mind.

5.4 The OIP is grateful to Mr. D's sister for her contributions to this investigation and we offer our sincere condolences on his loss.

6. Cloverhill Prison

6.1 Cloverhill Prison is a closed, medium security prison for adults, which primarily caters for remand prisoners committed from the Leinster area. At the time of Mr. D's passing, it had an operational capacity of 431 with 387 prisoners in custody. As such, it was at 90% of its operational capacity.

6.2 At the time of his death, Mr. D's was the first death of a prisoner from Cloverhill Prison in 2022; and the fourth death in IPS custody that year.

7. Family Concerns

7.1 Mr. D's sister shared with the investigation team that Mr. D had suffered with mental health illness for a long time. She expressed her belief that Mr. D had been let down by the mental health services in Ireland. Mr. D's NoK advised that, for two years prior to his incarceration, he rarely went out in public, due to his mental health difficulties.

7.2 Mr. D's sister asked nine questions regarding her brother's time in custody, which are as follows:

1. Was Mr. D on a medical wing?
   OIP Response: Mr. D was located on the D2 landing from 21 December 2021 until he died. This is a dedicated landing for prisoners with enhanced medical needs. Further information is contained in Section 9 of this report.

2. Was he being monitored?
   OIP Response: Yes, Mr. D's welfare was monitored by both operational and medical prison staff. See Section 8 for background information and Section 10 for details relating to Mr. D's medical care.

3. What medication was he on?
   OIP Response: Mr. D was prescribed Olanzapine 10mg (taken once per day) and Parox 'Paroxetine' (30mg once per day). Further information is contained in Section 10 of this report.

4. Was he prescribed a heroin substitute drug?
   OIP Response: As part of the investigation, Mr. D's medical records were reviewed and there is no evidence that he was prescribed a substitute medication for heroin during his time in custody.

5. Was he checked the night before he died?
   OIP Response: Yes, the investigation confirmed that prison officers observed Mr. D during the night, as per the requirements contained in their standard operating procedure for night checks.

6. Did Mr. D complain of any sickness the night before?
   OIP Response: Throughout the investigation there was nothing to indicate that Mr. D was feeling unwell the night before he passed away.

7. Was he suicidal?
   OIP Response: There was no evidence in Mr. D's records to indicate that he engaged in self-harm or had suicidal ideation during his time in custody.

8. Was he prescribed anything for alcohol withdrawals and if so for how long?
   OIP Response: Medical records confirm that Mr. D was not prescribed medication for alcohol withdrawal.

9. Was he given medication for the chest pain after he left hospital?
   OIP Response: Yes, Mr. D was prescribed medication for high blood pressure after he left hospital. Further information is contained in Section 10 of this report.

8. Background

8.1 Mr. D was 41 years of age when he died in Cloverhill Prison on 4 February 2022. He was committed to Cloverhill Prison on 17 December 2021 for breaching a protection order. It was his first time in custody. He was initially accommodated on the A2 landing in the prison.

8.2 On 17 December 2021, Nurse A recorded in Mr. D's nursing committal interview notes that Mr. D's mood was scored as being 5/10 and he guaranteed his own safety. In addition, it was recorded that Mr. D reported he was taking medication for depression but that "*he didn't take it sometimes*". Nurse A entered in the Prisoner Healthcare Management System (PHMS), on 17 December 2021, that Mr. D tested positive for Benzodiazepines, Cocaine and Opiates.

8.3 On 20 December 2021, Doctor A recorded in the PHMS that she received an email from Chaplain A providing background information about Mr. D. Chaplain A shared that Mr. D's sister had been in contact and informed him that Mr. D was unwell and he had stopped taking his anti-psychotic and antidepressant medication.

8.4 Doctor A recorded in a separate entry, on 20 December 2021, that the Prison In-Reach Court Liaison Service[1] (PICLS) suggested moving Mr. D from A2 to the D2 landing in order to review him. Doctor A noted that she contacted the Chief Nurse Officer (CNO) to ensure the nurse covering the medication round on the A2 landing moved Mr. D to the D2 landing if there were any concerns regarding his mental health. Doctor A also recorded that a safety observation cell[2] (SOC) on the D2 landing would likely be used for Mr D "*overnight*" if no other room was available.

[1] Prison In-Reach Courts Liaison Service (PICLS) -The main objective of PICLS is to improve the identification of people suffering from mental health issues when they are remanded to prison. The scheme aims to assist patients, the criminal justice system and local psychiatric services by ensuring a rapid response and by systematically identifying prisoners with a primary diagnosis of psychotic illness.

[2] Safety Observation cells (SOCs) are used for prisoners who require frequent observation for medical reasons or because they are a danger to themselves or others. A prisoner placed in a SOC by the Governor must be examined by the prison doctor as soon as practicable after he has been accommodated in the SOC. They would also be subject to 15-minute checks by operational staff and frequent observation by healthcare staff.

9. The D2 Landing

9.1 The D2 landing at Cloverhill Prison is a unit for prisoners with enhanced medical needs. In general, the prisoners on this unit are deemed too vulnerable to mix with the general prison population. The D2 landing comprises ordinary accommodation consisting of both single-occupancy cells and shared cells. Single-occupancy cells are used for prisoners assessed as unsuitable for sharing. In addition to this ordinary accommodation, D2 contains two health-isolation cells, two SOCs, and four Close Supervision Cells (CSCs), all positioned around a central staff control room. The unit also has a dedicated exercise yard, which prisoners in the ordinary accommodation can access relatively freely during daytime hours.

9.2 Mr. D was accommodated on the D2 landing from 21 December 2021. He initially occupied single occupancy cell SE9, then single cell V04 from 7 to 15 January 2022 and, on 15 January 2022, he was moved to cell SE10, where he remained the sole occupant until the time of his death on 4 February 2022.

10. Medical Care

10.1 Following Mr. D's relocation to the D2 landing, on 21 December 2021, he was reviewed on several occasions by the PICLS team and the prison medical team continued to monitor his health.

10.2 A PHMS entry, dated 8 January 2022, recorded an urgent referral for Mr. D to St. James's Hospital in Dublin. The reason recorded for this referral was, "*chest pain and high blood pressure*", with a documented blood pressure of 207/120. The referral was signed off by Nurse B. The IPS referral recorded that Mr. D's medication (at that time) was Olanzapine 10mg (one per day) and Parox 'Paroxetine' (30mg one per day). Olanzapine is used in the treatment of schizophrenia and Parox for the treatment of depression and obsessive-compulsive disorder.

10.3 Mr. D's PHMS records contained a copy of the discharge letter from St. James's hospital which confirmed he was admitted on 8 January 2022 and discharged on 9 January 2022. The letter recorded that Mr. D's "*presenting complaint*" was, *"Headache, runny nose, ear fullness and shortness of breath Vertigo".* Mr. D left St James's Hospital on 9 January 2022 with a prescription for Serc (medication used in the treatment of vertigo and dizziness) and Avamy nasal spray.

10.4 The hospital discharge letter recorded an elevated blood pressure of 160/114 and suggested follow up care by stating, "*please consider starting anti-hypertensive (was prescribed in the past but did not take. Referred to FASU[3] for Epley[4]")* and stated that Mr. D was to "*Represent if deterioration/further concern"*.

10.5 On 9 January 2022, Doctor B recorded in the PHMS that Mr. D was "*returned from hospital - was admitted with chest pain*". The entry also recorded "*no chest pain this morning*" and that the plan was, "*as per hospital instruction*" and it recorded "*captopril 25mgs mane*" along with the discharge medication prescribed at St. James's Hospital. Captopril is a drug used to treat high

[3] The Falls and Syncope Unit (FASU) provides rapid, expert assessment and treatment for patients of all ages who suffer from dizziness, faints, falls and syncope (loss of consciousness).

[4] The Epley manoeuvre is a series of head movements to relieve symptoms of benign positional vertigo. Benign positional vertigo is also called benign paroxysmal positional vertigo (BPPV).

blood pressure and hypertension. It was recorded, in Mr. D's medication chart, that he was in receipt of 25mg of Captopril daily from the 9 January 2022 until his death.

10.6 On 11 January 2022, Psychiatric Nurse A recorded in PHMS that Mr. D was reviewed by the PICLS team. The review notes stated that Mr. D had "*reported paranoid ideation that his father had been killed and voiced bizarre beliefs that IPS staff were killing prisoners*". The plan, at that time, was to increase his olanzapine medication to 15mg due to his mental state and if no improvement was recorded, "*we will likely need diversion to Tallaght Hospital*". As previously stated, Mr. D had been prescribed 10mg of olanzapine and it was reflected in his medications chart that this was changed to 15mg and remained as such until he died.

10.7 On 17 January 2022, Mr. D was reviewed by Psychiatric Nurse B and a member of the PICLS team, Psychiatrist A who had reviewed Mr. D on the 11 January 2022. The PHMS entry recorded that Mr. D presented as unkempt with "*soiled clothing*" and appeared perplexed. He informed the PICLS team that he could hear voices "*screaming, that this had been happening since he was young and that everybody wants to hurt me*". The plan recorded in this PHMS entry stated, "*Due to deterioration in mood, discuss increase in Fluoxetine with team*" and "*If no improvement in mental state will likely need diversion to Tallaght hospital*". Mr. D's medications chart does record an increase in the medication as discussed by Psychiatrist A. The PHMS entry for 17 January 2022 recorded that the health care assistants, working on the D2 landing, would assist Mr. D with his personal hygiene.

10.8 On 21 January 2022, Nurse A recorded in the PHMS that they called to see Mr. D on the D2 landing in his cell. The entry stated that he was observed sitting on his bed and could not answer any questions and could not follow any comments. The entry recorded that Mr. D, "*refused to check BP [Blood Pressure] and pupils*" [Sic]. Nurse A requested that the night nurse was to monitor him. This was to be Nurse C.

10.9 On 22 January 2022, Nurse C recorded in the PHMS that they had received the request to monitor Mr. D during the night of 21 January into the morning of 22 January 2022. Nurse D stated that he received information from Assistant Chief Officer (ACO) B that Mr. D had been in the yard that day and something had upset him. After this incident, Mr. D was escorted to his cell, "*but walked independently*" and refused intervention from medical staff. Nurse D recorded that Mr. D did not enter conversation with him throughout the night and that Mr D had sat on his bed until approximately 02:00. He then noted that Mr. D slept from 02:00 to 06:00 and appeared to have been incontinent; new clothes were offered but Mr. D would not converse.

10.10 On 22 January 2022, Nurse D recorded in the PHMS that Mr. D declined to engage with staff throughout the medication round and that they "*repeated attempts to engage in conversation – with no succe*ss". Nurse D recorded that Mr. D responded minimally, "*with non-verbal gestures*" and that they liaised with ACO A who advised that Mr. D was refusing to attend to his personal care. Nurse D's later entry in the PHMS indicates that Mr. D attended to his personal hygiene in the afternoon.

10.11 On 23 January 2022, Doctor B recorded in the PHMS that they reviewed Mr. D and noted that, "*officer says* [Mr. D] *had a funny turn yesterday*. *Didn't seem to know where he was, seemed to be weak when lifting tea. Doctor was not asked to review".* Doctor B recorded in this same entry that, at the time of this incident, Mr. D "*was incontinent of urine*" and that there was "*No previous*

history of TIA[5]*/stroke*". The entry recorded that a prison officer stated that Mr. D was fully recovered the same day. See Section 13.5 for a description of the incident.

10.12 Doctor B further recorded, on 23 January 2022 in a PHMS entry, that Mr. D displayed no facial weakness or limb weakness, headaches or dizziness and recorded specifically that prison staff were to inform her if Mr. D had another "*funny turn*" and that there was "*need to consider possibility of a TIA*".

10.13 On 31 January 2022, Psychiatrist B entered in the PHMS that Mr. D was reviewed by Psychiatrist A. The entry recorded that Mr. D was not feeling well and that his mind was racing. It recorded that Mr. D showed what appeared to be cigarette burns on his fingers and that he was convinced that someone did this when he had a seizure. It recorded that Mr. D felt that someone had spiked his food with acid and that, "*It's after damaging my brain. It made me worse, paranoid*". The plan recorded in this entry was, "*review medication? Increase.*"

10.14 The investigation team reviewed Mr. D's medications chart; no increase of medication was recorded from the 31 January 2022 until his death on 4 February 2022.

11. Events of 3 and 4 February 2022

11.1 Officer A was the night guard on the D2 Landing from 20:00 on 3 February until 08:00 on 4 February 2022. She reported that Mr. D never came to her attention and she had conducted all of her checks as required. CCTV footage corroborated Officer A's account and confirmed her last cell check on Mr. D's cell was at 06:59.

11.2 At 07:20, Officer B commenced the undertaking of cell checks on the D2 landing. He recalled that when he checked Mr. D's cell, he observed that the white (main) light was on, he was turned on his side and that he appeared to be asleep. Officer B advised that Mr. D's presentation was not unusual as he would regularly sleep like this.

11.3 At 08:35, Officer C stated that he began to unlock cells on the D2 landing for breakfast. Officer C reported that when he unlocked cell 10, he offered Mr. D breakfast but did not receive a response. Officer C stated that he entered the cell and called Mr. D's name "*a couple of times*" but again a response was not forthcoming. Officer C described Mr. D as lying on his right-hand side, covered by a duvet, and he looked to be asleep. However, as Mr. D was not moving, Officer C stated that he called for an immediate medical response and notified ACO A over the radio.

11.4 After hearing the emergency radio call at 08:35, Nurse E, Nurse F, Nurse G, and Nurse H, all reported that they responded and attended Mr. D's cell. CCTV footage confirmed that this occurred at 08:37. At this time, Officer D and Officer E confirmed they were also present. Nurse F stated that on her arrival to the cell she checked Mr. D and noted that he was on his right side, "*stiff and blue in colour*" and no pulse was detected. Nurse F stated she then requested Nurse G to radio for Chief Nurse Officer (CNO) A.

[5] Transient ischaemic attack – HSE Abbreviations description. A TIA is also known as a 'mini stroke'. It's caused by blood temporarily not being able to get to part of the brain. This results in a lack of oxygen to the brain. This disruption can cause symptoms similar to a stroke. For example, speech and visual problems and feeling numb or weak in the face, arms or legs.

11.5 CNO A stated that upon hearing the request for nursing staff to attend D2 landing, she responded in the company of Chief A and Chief B. Both Chief A and B corroborate this in their reports and the CCTV footage confirmed that CNO A entered Mr. D's cell at 08:38.

11.6 Nurse G had responded to the incident with the red bag[6] and Nurse F stated they were about to commence Cardiopulmonary Resuscitation (CPR)[7]. Nurse B recalled that when CNO A arrived, she immediately requested that Mr. D be turned onto his back.

11.7 CNO A recorded that Mr. D's face was discoloured with no signs of a pulse and were obvious signs of rigor and pooling[8]. CNO A instructed the nursing staff present that CPR was not required. CNO A then advised Chief Officer A that Mr. D was deceased and requested a sheet to cover him.

11.8 It is recorded in the PHMS that Doctor C was contacted at 08:55 by CNO A. Doctor C arrived at Mr. D's cell at 09:20 and following a physical examination of Mr. D, he recorded his time of death as 09:30.

12. CCTV Footage

12.1 As part of the investigation, the investigation team reviewed relevant CCTV footage of Mr. D's time in custody.

12.2 The review of the CCTV footage corroborated all statements provided by prison staff relating to the morning of Mr. D's death and the frequency of checks conducted throughout the previous night.

12.3 Mr. D was last viewed outside his cell on the evening of 3 February 2022, where he visited the D2 yard. Between 17:26 and 18:54 that evening, Mr. D spent most of his time in the television room, attached to the yard, which has a telephone for prisoner's use. During this time, he was observed using the telephone and had some short engagements with other prisoners as they shared tobacco.

12.4 Mr. D was observed returning to his cell at 18:55 when he entered, and then closed, the cell door. A prison officer was observed conducting a cell check after Mr. D entered the cell and a further cell check was conducted at 18:57, when Mr. D was locked back for the night.

13. Critical Incident Review Meeting

13.1 On 9 February 2022, a critical incident review meeting[9] was chaired by Governor A. In attendance were Chief B, Chief C, Chief D, ACO A, Officer C, Officer D, Officer F, Chaplain B,

[6] Emergency Medical Bag, containing medical equipment.

[7] CPR or Cardiopulmonary Resuscitation is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest.

[8] Pooling or Livor mortis (also called hypostasis) is the pooling of the blood in the body due to gravity and the lack of blood circulation as a result of the cessation of cardiac activity. These factors cause the blood to pool in the lowest points of the body, giving the skin a purplish-red discoloration.

[9] Staff meeting held following the death of a prisoner. The purpose of the meeting is to review the circumstances and activities surrounding an incident, identify learnings, commend good practice and recommend changes, if required, to prevent a similar occurrence.

Psychiatric Nurse B, Doctor C, Psychiatrist B and Psychiatrist C. CNO A sent her apologies. The minutes of the meeting were recorded by Clerical Officer A and Clerical Officer B.

13.2 Governor A provided a brief outline of what happened on the morning of Mr. D's death, including that members of An Garda Síochána, who attended the scene, interviewed a number of staff including nursing staff. Governor B contacted Mr. D's father and shared that it was a difficult phone call as the family were "*extremely upset*".

13.3 Chief D stated that all staff involved, on the day of the incident, were met by staff support officers and were provided with ongoing support options.

13.4 Psychiatrist C confirmed that Mr. D was committed to the prison with a history of mental health issues. An assessment of Mr. D, whilst he was on the D2 landing, evidenced symptoms of paranoia and it was noted that he had not been taking any medication. Psychiatrist C shared that Mr. D had commenced taking some medication, however, it was decided he would benefit more from hospital treatment. It was mentioned that a psychiatric report had been provided to the Court on 21 January 2022, along with a request for bail to hospital. A further court appearance was scheduled for Mr. D on 8 February 2022 and the PICLS team were due to make a second request for bail to hospital. Psychiatrist C reported that the PICLS team had maintained contact with Mr. D's family during his time in prison and kept them updated on his progress, last speaking to his father the day before Mr. D died. According to Psychiatrist C, Mr. D did not have an official diagnosis but a number of conditions were under consideration.

13.5 ACO A reported that he had been on duty, two weeks ago, when Mr. D had an "*episode*" where he was found to be incoherent and incontinent. ACO A stated that staff were unable to convince him to take a shower and that he had no co-ordination and was unable to follow instructions. It was recorded that such behaviour was unusual for Mr. D. ACO A advised that Mr. D was reviewed by nurses and a doctor the following day and that he had improved and could not remember the episode happening.

13.6 No recommendations were recorded at the conclusion of the critical incident review meeting and Governor A stated that all correct procedures were followed and that Mr. D was cared for by all staff while in custody.

13.7 An internal Cloverhill Prison report, compiled by Chief B on 10 March 2022, was reviewed by the investigation team. Chief B, within Section 13.0 of his report, provided an observation, which was as follows; "*The need for a machine for chest compressions. Although it wouldn't have helped* [Mr. D] *it could help others who face the same medical emergency. There are trainers already working in Cloverhill who could carry out the CPR training*".

14. Recommendations

14.1 The Office of the Inspector of Prisons makes the following four recommendations:

1. This report on the death of Mr D reinforces the findings and recommendations made by the OIP in its Thematic Inspection Report - An Evaluation of the Provision of Psychiatric Care in

the Irish Prison System published on 20 February 2024.[10] These include a recommendation that:

"*urgent consideration be given to the systemic changes that are required to facilitate the swift transfer of minor offenders who have mental disorders to local psychiatric hospitals. As this is likely to require the development and opening of long discussed, appropriately secure, intensive care facilities/designated beds in civil psychiatric hospitals, this calls for a multi-agency approach*".

In its report on a full unannounced inspection of Cloverhill Prison in May 2023, the OIP also reiterated its previous (2021) recommendation to the Director General of the Irish Prison Service that persons detained in Cloverhill Prison who require mental health care must receive it an appropriate therapeutic environment.[11]

On 13 January 2025, the Chief Inspector of Prisons wrote to the Governor of Cloverhill Prison, after a follow-up inspection of Cloverhill Prison from 9 to 11 December 2024, indicating that the *"situation on D2, which is housing a number of prisoner-patients who simply should not be in prison, remains critical."*[12]

Mr D was committed to prison despite his history of mental illness and, in the short time he spent in custody before his death, he displayed clear symptoms of psychiatric disturbance, coupled with neglect of his personal hygiene. Notwithstanding the efforts of prison officers, health care staff and the PICLS team, D2 at Cloverhill Prison did not provide him with the therapeutic environment that he required.

Urgent action is required to implement the OIP's long-standing recommendations in relation to the care of people with mental disorders admitted to prison.

2. The OIP acknowledges the dedication of the prison staff who work in the very challenging conditions in D2 in Cloverhill Prison. Nonetheless, it is of concern that officers who noticed the deterioration in Mr. D's physical wellbeing on 22 January 2022 did not report this incident to a doctor or nursing staff until the next day. **It is recommended that any noticeable changes in the physical or mental status of a prisoner on the D2 landing be reported in real time to medical staff for immediate assessment.**

3. While it is recognised that all checks, as per current standards, were conducted on Mr. D's cell throughout the previous night, it is clear from the CNO's decision not to commence CPR that Mr. D had been dead while some of these cell checks were conducted. To enhance the effectiveness of the health care monitoring of such persons, **the Inspectorate recommends that the IPS explore the potential of employing remote monitoring of vital signs technology in prisons in Ireland.** This was accepted as a recommendation in response to the OIP's investigation report in the case of Mr. K 2024.

[10] Available on the OIP's website, at this link: https://www.oip.ie/wp-content/uploads/2024/02/OIP-Thematic-Inspection-Report-on-Provision-of-Psychiatric-Care-in-Prisons_Feb-2024-Publish.pdf

[11] See paragraph 4.64 on page 72 of the OIP's report on its full inspection of Cloverhill Prison from 15 to 25 May 2023, reiterating recommendation OIP CHCT10 (2021).

[12] See Appendix D (pp. 149-153) to the the OIP's report on its full inspection of Cloverhill Prison from 15 to 25 May 2023.

4. The Office of Inspector of Prisons endorses the observation submitted by Chief B in his report of 10 March 2022 in relation to the usefulness of a chest compression machines to assist with the delivery of CPR. This recommendation was previously made in the OIP's report on its investigation into the death of Mr. E 2020 and the corresponding IPS Action plan confirmed, in its most recent update (Q2 2024), that the IPS was in the process of purchasing five machines. **It is recommended that this process be finalised and that Cloverhill Prison be equipped with such a machine.**

15. Support Organisations

15.1 Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie.