Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. H 2024
St. James's Hospital on
Full Temporary Release
from the Midlands Prison
8 March 2024
Aged 23

To the Minister: 12 December 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
BLS	Basic Life Support
CIRM	Critical Incident Review Meeting
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
GP	General Practitioner
ICU	Intensive Care 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 Mental Health Service

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 and 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. H's death in hospital on 8 March 2024 and the management of the events associated with his death.

4. Administration of Investigation

4.1 On 8 March 2024, the OIP was notified that Mr. H had passed away in St. James's Hospital, Dublin. Mr. H had been transferred to hospital due to a medical emergency, following an act of deliberate self-harm, at the Midlands Prison on 19 February 2024.

4.2 The investigation team attended the Midlands Prison on 12 March 2024 and met with prison management who provided an overview of Mr. H's time in their custody. The investigation team also engaged with persons who had contact with Mr. H during his time in prison.

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

4.4 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 Inspector of Prisons' role when investigating a death in custody.

5.2 The investigation team communicated with Mr. H's NoK, his mother, initially by letter on 26 March 2024, followed by an in-person meeting, which took place on 11 April 2024.

5.3 Mr. H had made telephone calls to both his mother and his father, on the morning of 19 February 2024, before he was found alone and unresponsive in his cell. At the time, Mr. H's mother did not consider their call to be different to any other conversation they had shared and she confirmed that Mr. H's father also had no concerns for their son, following his conversation with him. However, with hindsight, Mr. H's mother expressed her belief that her son had called to say goodbye.

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

5.5 The OIP is grateful to Mr. H's mother for her contributions to this investigation and we offer our sincere condolences to her and Mr. H's wider family for their loss.

6. Midlands Prison

6.1 The Midlands Prison is a closed, medium security prison for adults. It is the committal prison for counties Carlow, Kildare, Kilkenny, Laois, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. It has an operational capacity of 875 beds. On 19 February 2024, the day Mr. H was admitted to hospital, the Midlands Prison had 947 prisoners in custody and was operating at 108% of its bed capacity. By the date of Mr. H's death, on 8 March 2024, the Midlands prison was operating at 109% of its bed capacity with 958 prisoners in custody at that time.

6.2 At the time of his death, Mr. H's was the third death of a prisoner from the Midlands Prison in 2024 and the eighth death in IPS custody that year.

7. Family Concerns

7.1 Mr. H's mother requested information on the timeline of the events that preceded the death of her son. She also wished to know how her son had harmed himself. Both points of information are set out in the body of this report.

7.2 Mr. H's mother asked if her son had left a letter or a note prior to harming himself. Throughout the course of the investigation, there was no indication or information to suggest that Mr. H had left a note or letter prior to his death.

8. Background

8.1 Mr. H was 23 years of age when he was found unresponsive in the Midlands Prison on 19 February 2024 and subsequently died in St. James's Hospital, Dublin on 8 March 2024.

8.2 On 21 November 2022, Mr. H was sentenced to a period of custody of three years and six months with eighteen of those months suspended. Mr. H was to be supervised by the Probation Service following his release from custody. On 21 November 2022, Mr. H was committed to Cloverhill Prison but was subsequently transferred to the Midlands Prison on 23 November 2022. He was accommodated on the G3 landing in cell 11. Mr. H shared this cell with Prisoner 1. His earliest release date, on remission, was 21 May 2024. This was Mr. H's first time serving a custodial sentence.

8.3 Mr. H was on the enhanced level of the incentivised regime[1]. He worked in the prison laundry for five days a week. In relation to employment in the community, Mr. H's NoK stated that her son's employer had reserved his job for him and Mr. H was planning to return to work upon his release.

[1] Incentivised regime refers to a national policy across all Irish prisons that provides incentives to prisoners to engage in good behaviour and participate in structured activities. There are three levels – basic, standard and enhanced. All prisoners enter the system at the standard level of the regime.

8.4 Mr. H's mother informed the investigation team that Mr. H had become a father for the first time whilst he was serving his sentence. She advised that Mr. H had been planning to return to live with his girlfriend and their son upon his release. However, the relationship ended in February 2024. Thus, in addition to the breakdown of his relationship, Mr. H's accommodation status, post-release, was a cause of uncertainty for him, as was access to his son.

9. Events of 19 February 2024

9.1 According to Prisoner 1, on the morning of 19 February 2024 Mr. H woke a short time after he did at approximately 07:45. Prisoner 1 recalled that Mr. H had been feeling *"a bit down the last few weeks"* due to his relationship ending with his son's mother. However, he stated that on the morning of 19 February 2024, Mr. H *"seemed ok"*, to the point where the two shared *"a laugh"* before Prisoner 1 went to work. Prisoner 2 expressed a similar view as he recalled witnessing Mr. H on the landing, on the morning of 19 February 2024, and stated that there was nothing to indicate that anything was amiss.

9.2 Records confirm that at 09:00, Mr. H made a telephone call to his mother and was upset about his relationship ending and not being able to have contact with his son as a result. According to prison staff, the call also included a discussion about a potential threat to Mr. H's safety in the community when released. Furthermore, records confirm that at 09:07 on 19 February 2024 Mr. H made a telephone call to his father.

9.3 At approximately 09:22, officers commenced unlocking cells on Mr. H's landing. Officer A reported that he was opening cell doors when he heard Prisoner 3 shout to him to look at Mr. H. Officer A recalled quickly proceeding to Mr. H's cell where he found him suspended by a ligature made from a piece of a duvet cover. Prisoner 3 corroborated Officer A's account, noting that once he witnessed Mr. H in his cell, he screamed for help and within seconds, officers "*sprinted*" up the landing.

9.4 Officer A recalled that he shouted for assistance, entered the cell and attempted to remove the ligature from Mr. H's neck whilst also holding him, by his waist, to support his weight. He described removing one of the knots from the ligature but there was a second knot that he was unable to undo. Within seconds, Officer B arrived at Mr. H's cell and Officer A recalled directing him to obtain the Hoffman Knife (which was kept in the Class Office at the end of the same landing). In the meantime, Prisoner 2 assisted Officer A with lifting Mr. H. Prisoner 2 confirmed that he was there after he ran to Mr. H's cell after hearing Prisoner 3 shout. He recalled that he offered his assistance to Officer A who was trying to free Mr. H and hold his weight. Upon finding Mr. H in his cell, Officer A described him as being *"unconscious and unresponsive*" and this account was corroborated by Prisoner 2.

9.5 Officer C reported that he responded to the call for assistance and began assisting Officer A by trying to free Mr. H. Assistant Chief Officer (ACO) A also responded, at approximately 09.24, and proceeded to call a 'code red'[2]. The CCTV footage confirmed that several officers ran to Mr. H's cell at 09:25.

[2] A 'code red' is called to notify others of a state of emergency in the prison and to request assistance.

9.6 Officer B reported that he immediately retrieved the Hoffman Knife from the Class Office and used it to remove the ligature from Mr. H. Officer A recalled placing Mr. H on the ground with the assistance of Officer C.

9.7 Officer C stated that he opened Mr. H's airway and checked for a pulse in his arm and neck, and it was not present. Officer A and Officer C's statements describe how Officer A commenced Cardiopulmonary Resuscitation (CPR) chest compressions whilst Officer C intermittently checked Mr. H for a pulse or any breathing activity. Officer C recalled deciding to run to obtain the resuscitation defibrillator whilst Officer A continued doing CPR until the medical staff took over when they arrived a few minutes later. CCTV footage recorded medical personnel running along the landing to Mr. H's cell at approximately 09:26.

9.8 Officer A reported that he informed prison staff arriving at Mr. H's cell to immediately intercept an ambulance crew who were already on site attending to another matter. ACO A confirmed that he contacted staff at the main gate of the prison to find out if the ambulance personnel had left. Upon learning that they were still in the building, ACO A contacted Reception (the prison committal area) and asked staff there to notify the paramedics that they were required on the G3 landing, stressing the urgent nature of the request.

9.9 Nurse A recorded that the prison's medical team, upon arrival, inserted an airway and connected an 'AMBU bag'[3] to Mr. H. An AED[4] was also attached and chest compressions were performed. Records indicate that four rounds of CPR were delivered and Mr. H remained in asystole[5] and a 'no shocks' message was advised[6]. The paramedics who were already on site, arrived at Mr. H's cell at approximately 09:35.

9.10 Nurse A confirmed that the ambulance crew took over CPR with the use of a LUCAS device[7]. Also attending to Mr. H, at that time, were two of the prison doctors – Doctor A and Doctor B. Nurse A reported that Mr. H's pulse returned and slow respirations were observed. However, according to Nurse A, Mr. H "*remained deeply unconscious (with) no reaction to external stimuli*".

9.11 At 09:54, additional ambulance staff arrived on the G3 landing and Nurse A noted that Mr. H was intubated[8] and continued to have a weak pulse. At 09.57, additional Fire Brigade paramedics arrived. At 10:03, Mr. H was removed from his cell, on a stretcher, with the LUCAS device still attached. He was transported by ambulance to the Midland Regional Hospital in Portlaoise.

9.12 Mr. H's mother informed the investigation team that she received a telephone call from the prison chaplain, at approximately 10:01, advising her that Mr. H was unresponsive and that she should

[3] An AMBU Bag is a manual resuscitation device used to provide respiratory support to patients.

[4] An AED is an Automated External Defibrillator which is a portable electronic device used to analyse a patient's heart rhythm and deliver a shock to the patient's heart, if appropriate,

[5] Asystole refers to when a patient's heart stops beating, also known as when the heart 'flat lines'.

[6] A "no shock" message from the AED indicates either; there is a pulse present, a pulse has been regained, or the person is pulseless but is not in a shockable rhythm. An AED will only shock a heart when a shockable rhythm is detected. When a "no shock" message is received from an AED, the advice is to continue with chest compressions.

[7] The Lund University Cardiopulmonary Assist System (LUCAS) device provides consistent mechanical chest compressions when a patient is deemed to be in cardiac arrest.

[8] Intubation is a medical procedure which involves inserting a tube into a patient's trachea to keep it open to allow air to pass through more easily.

go to the hospital. Mr. H's mother confirmed that the chaplain called her a second time to check that she was on her way to the hospital and to ensure she was not on her own.

10. Hospital Care (19 February 2024 to 8 March 2024)

10.1 At 19:42, on 19 February 2024, Nurse A contacted the Midland Regional Hospital for an update on Mr. H's condition. Records state that she was advised that he was ventilated and his pupils were reacting to light; he had been admitted to the Intensive Care Unit (ICU).

10.2 On 20 February 2024, Nurse A contacted the hospital for a further update on Mr. H's condition. Records state that the hospital nurse advised that they had reduced Mr. H's sedation in an attempt to wean him off the ventilator, but it had not been successful and as such, he remained ventilated with full sedation. Mr. H's family were with him.

10.3 On 22 February 2024, Chief Nurse Officer (CNO) A recorded that she had spoken with the nursing staff in the ICU on several occasions over the previous 48 hours. According to her notes, there was no change in Mr. H's condition and it was beginning to appear that the outcome was unlikely to be positive. Mr. H was transferred to the ICU in St. James's Hospital and the prison's healthcare records were updated accordingly.

10.4 On 23 February 2024, Doctor A provided the prison governors with an update on Mr. H's condition, in writing, which evidenced compliance with Rule 105 of the Prison Rules 2007[9].

10.5 On 25 February 2024, Nurse A contacted St. James's Hospital and noted that there was no improvement in Mr. H's condition. It was documented that he was scheduled to have further scans over the following days but his outlook remained poor. His family continued to be with him.

10.6 On 27 February 2024, Nurse B recorded that the hospital had advised that there was no change in Mr. H's condition.

10.7 Doctor A noted that she contacted a registrar in the ICU, on 29 February 2024, seeking an update on Mr. H's condition. Doctor A recorded that she provided her contact details and requested that the doctor, who was overseeing the care of Mr. H, contact her with an update.

10.8 Records evidence that Doctor A placed a further call to the ICU on 1 March 2024 as she had not received an update. On this occasion, she recorded that the doctor she spoke with informed her that there was evidence of clinical and neurological improvement in Mr. H's condition. He remained intubated and ventilated at that time.

10.9 On 7 March 2024, Nurse B recorded that she contacted the ICU and was informed that Mr. H was receiving end of life treatment. His family were with him. The notes also evidenced that chief officers were notified of Mr. H's condition. On that same date, 7 March 2024, Mr. H was granted Full Temporary Release from prison custody on compassionate grounds.

10.10 On 8 March 2024, Mr. H passed away in St. James's Hospital in Dublin.

[9] Prison Rules 2007-2013 Rule 105 refers to information provided to the Governor, from a prison doctor, on the state of health of a prisoner.

11. Healthcare

11.1 The Prisoner Healthcare Medical System (PHMS) records evidence that when Mr. H was first committed to Cloverhill Prison, at the beginning of his sentence, he had a nursing committal interview that took place on 21 November 2022. The notes for that meeting recorded that Mr. H had no thoughts of deliberate self-harm at that time. The following morning, on 22 November 2022, Mr. H was seen by a prison doctor, Doctor C, who also documented that Mr. H had no thoughts of deliberate self-harm. However, later that evening, Mr. H superficially cut himself. Nurse C assessed Mr. H, that same evening, and recorded that he described his actions as *"just a release"*. Nurse C referred Mr. H to the prison doctor.

11.2 On 23 November 2022, Mr. H was assessed by Doctor D at Cloverhill Prison. He recorded that Mr. H had several cuts to his left wrist, all of a superficial nature. Mr. H reiterated that it was "*just [a] release"*. During the consultation, records document that Mr. H disclosed that he had previously attempted to end his life, in May 2022, by way of driving his car into a pole whilst drunk. Mr. H informed the doctor that he had sustained a number of injuries as a result of his actions but ultimately recovered from the crash. Doctor D confirmed with Mr. H that he was safe and not at risk of further self-harm. Mr. H also gave a commitment that he would inform prison staff should his mood change. Doctor D subsequently requested an urgent review of Mr. H by the prison's psychiatry team.

11.3 That same day, 23 November 2022, Mr. H was transferred to the Midlands Prison. He attended a nursing committal interview on the date of transfer and met with Doctor E on 24 November 2022, where his need for psychiatric input was noted. Healthcare staff in the Midlands Prison had also received a letter from a psychiatrist, Doctor F, at Cloverhill Prison to advise them about Mr. H's recent self-harm.

11.4 On 29 November 2022, a psychiatric nurse, Nurse D from the Prison In-Reach Mental Health Service[10] (also known as PICLS) met with Mr. H. This was an in-depth meeting which yielded detailed notes about Mr. H's life history. Included in those notes was a disclosure from Mr. H that he previously required psychiatric intervention when he was admitted to hospital in December 2021 due to his deteriorating mood. Mr. H reported that this was associated with his difficulty coping with the criminal charges (relating to this sentence) which he faced at that time. Regarding his thoughts and feelings following his transfer to the Midlands Prison, according to the notes, Mr. H informed Nurse D that he felt, *"much safer and less stressed"* in his new accommodation, further stating that he felt comfortable talking to prison staff should he again have any thoughts of self-harm or mood deterioration.

11.5 On 30 November 2022, Mr. H was assessed by a psychiatrist, Doctor G. Doctor G noted that Mr. H did not present with any major mental illness nor any concerns regarding his well-being or safety at that time. Records document that Mr. H advised Doctor G that he felt more settled,

[10] PICLS: Psychiatric In-reach and Court Liaison Service: The main objective of the 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.

was eating and sleeping well, and had spoken to prison staff about obtaining a job. The doctor's notes document that he did disclose that he was aware that his name had been shared on social media regarding his offence and his family were seeking legal advice on the matter. Doctor G discharged Mr. H back to the care of the prison GP.

11.6 Mr. H's next contact with the prison healthcare team was on 27 April 2023, when he was seen by Doctor A due to an infected cyst behind his ear, for which he was prescribed medication. During this consultation, records document that Mr. H had reported feeling 'dizzy' at times, stating that after his involvement in a car crash, he felt he was not the same. Doctor A recorded that due to time constraints she planned to review Mr. H again however from the medical notes received by the OIP, it does not appear that a further consultation took place.

11.7 In June 2023, Nurse E spoke with Mr. H as he had learned that Mr. H was requesting intervention from the psychology team within the prison. The medical notes recorded that Mr. H confirmed that he was not experiencing any thoughts of self-harm but stated that at times when he felt under pressure, when he was residing in the community, he would talk with his psychologist. Nurse E's notes state that he confirmed with the prison psychology team that they would meet with Mr. H, following his self-referral, noting the referral would be provided to Mr. H to complete. This was the last entry on PHMS prior to the medical emergency from which Mr. H passed away. The investigation determined that the prison psychology team never received a referral relating to Mr. H. The investigation team also learned that it is not standard practice to ask a person, who is detained in the prison, to action their own referral. Unfortunately, there was no record within the PHMS notes as to who provided Nurse E with the advice he received that day, and Nurse E could not recall the name of the person concerned.

12. CCTV Footage

12.1 As part of the investigation, the CCTV footage of Mr. H's landing, in the Midlands Prison on 18 and 19 February 2024, was reviewed. The footage supports the accounts provided by the healthcare and operational staff in relation to their involvement and response to Mr. H's medical emergency.

13. Critical Incident Review Meeting

13.1 On 20 February 2024, a Critical Incident Review Meeting[11] (CIRM) was held by Governor A with the following staff in attendance; Assistant Governor A Chief Officer A, CNO A, Doctor H, Chaplain A, and Officer D. Prison Clerical Officer A took the minutes.

13.2 During the meeting, it was noted that there were no visible signs, reported by operational staff, that Mr. H was in distress or going to engage in any self-harm. Based on this, Governor A expressed his view that Mr. H's intention to harm himself was possibly impulsive and not pre-meditated. The meeting heard how Mr. H had contacted both of his parents by telephone prior to being found unresponsive.

[11] 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.

13.3 The only apparent exception to Mr. H presenting with a positive mood was recorded as being observed by Chaplain A. Mr. H had requested to speak with a prison chaplain on 17 February 2024. Chaplain A stated that he met with Mr. H on that same day and that Mr. H wanted him to contact his mother, by telephone, to apologise for what he had said to her during their call the day before. Chaplain A stated that he did so and reported that Mr. H's mother asked for a message to be conveyed back to Mr. H, which was for him not to worry. Chaplain A recalled that he met with Mr. H again the following day, on 18 February 2024, and described Mr. H as "*quite upset*". Chaplain A advised Mr. H that they, the chaplaincy service, could link him in with a resettlement worker regarding his release plans.

13.4 The meeting participants heard that there was a potential threat associated with Mr. H returning to his mother's home upon release. As noted previously, Mr. H had been aware of this.

13.5 Governor A commended all those who responded and assisted with the care of Mr. H. The swift use of CPR by the officers, who found Mr. H, was mentioned and Governor A noted how not all staff are trained in CPR. The meeting discussed support measures for staff and prisoners who witnessed or were involved in the emergency as well as those who worked with Mr. H in the laundry. The meeting heard how both staff and prisoners were saddened by what had happened to Mr. H.

13.6 The following actions were recorded at the conclusion of the critical incident review meeting:

- Check the length of the phone call made at 9:07 (the call to Mr. H's father).
- Possibly run a CPR campaign.
- Debrief with the landing and the prisoners in the laundry and the cleaner on the G3 landing.

14. The Probation Service

14.1 As mentioned previously, Mr. H was subject to a partially suspended sentence which in practice meant that once he had completed his time in prison, he was due to be supervised by the Probation Service in the community until his sentence was completed. As part of the investigation, the Probation Service was contacted regarding their involvement with Mr. H.

14.2 The Probation Service confirmed that Mr. H was allocated a Probation Officer in custody but they did not have any engagement with him during his time in the Midlands Prison prior to when he passed away.

14.3 The Probation Service had not been notified that Mr. H had passed away and they found out, by chance, sometime after the event. The investigation team has been advised that there has been a positive change in practice since that time. There is now a system in place where the IPS will formally notify the Probation Service of any death in custody.

15. Recommendations

15.1 The OIP wishes to acknowledge the swift response and ongoing care provided, by both prison staff and healthcare personnel, to Mr. H from the initial moment when he was found unresponsive to the time when he passed away.

15.2 It is also appropriate to acknowledge the care afforded to Mr. H during the process of his transfer from Cloverhill Prison to the Midlands Prison in 2022, in relation to both healthcare teams ensuring he had continuity of care and that his emotional well-being remained paramount.

15.3 In addition, the granting of Full Temporary Release to Mr. H, when it was clear that his condition was not going to improve, allowed his family to be by his side in his final hours without the presence of officers. The compassion shown to Mr. H's family, at such a difficult time, is commended by the OIP.

15.4 The OIP makes **two recommendations**:

1. The investigation into Mr. H's death has indicated that the lines of communication between different agencies, teams and specialities that operate within the criminal justice system are not always clear. This was evident on two occasions in relation to Mr. H. The first was when the Probation Service was not notified that Mr. H had passed away, despite Mr. H having an allocated probation officer. The subsequent establishment of a notification process, between IPS and the Probation Service, regarding a death in custody, is a welcome development.

   The second occasion was during the IPS healthcare team's interaction with psychology regarding the referral process in June 2023. Records indicate that Mr. H was to self-refer for psychology assistance, however psychology management has indicated this is not standard practice. **The OIP recommends that clear guidance to be issued by the IPS Director of Care and Rehabilitation in relation to the referral process to psychology services**. **The guidance should include a requirement to document all relevant interactions between health care staff and psychology services insofar as they relate to the well-being of persons in custody.**

2. In a published Death in Custody Report, Mr. I 2019, the OIP made a recommendation for the **IPS to consider including Basic Life Support (BLS) training for recruit prison officers during the early part of their training and refresher courses for established staff**. This recommendation was rejected by the IPS; however, it should be reconsidered as a matter of urgency. Unfortunately, Mr. H did not survive, despite the administration of early CPR by the officers who first attended to him. Yet, this case evidences how the swift actions of first responders provided Mr. H with the best chance of survival and at the very least, allowed time for his family to say goodbye to him. Officers trained in BLS could lead to more positive outcomes in the future.

   The OIP again recommends that the IPS include Basic Life Support (BLS) in training for recruit prison officers during the early part of their training and introduce refresher courses for established staff.

16. Support Organisations

16.1 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.