Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. M 2023
Mountjoy Prison
8 August 2023
Aged 45

To the Minister: 19 December 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
AGS	An Garda Síochána
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CCTV	Closed Circuit Television
CPR	Cardiopulmonary Resuscitation
DFB	Dublin Fire Brigade
IPS	Irish Prison Service
IV	Intravenous
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
SOC	Special Observation Cell

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 of 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. M's death and the management of the events associated with his death.

4. Administration of Investigation

4.1 On the morning of 8 August 2023, the OIP was notified that Mr. M had passed away in Mountjoy Prison. Members of the investigation team attended the prison and met with IPS managers and prisoners who had contact with Mr. M 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 long-standing best practice between the OIP and IPS is that the cell in which a prisoner has died must be preserved until the arrival of the OIP investigation team. Regrettably, this was not respected in relation to the death of Mr M. Prison management informed the investigation team that an officer had erroneously removed Mr. M's belongings from the cell following notification by An Garda Síochána (AGS) that their examination had concluded.

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 Inspectorate of Prisons' role when investigating a death in custody.

5.2 The investigation team met with five of Mr. M's siblings on 24 October 2023. A number of questions and concerns were raised and these are outlined in Section 7.

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

5.4 The OIP is grateful to Mr. M's family for their contributions to the investigation and we offer our sincere condolences on their loss.

6. Mountjoy Prison

6.1 Mountjoy Prison is a closed, medium security prison for adult men. It is the main committal prison for Dublin city and county. It has an operational capacity of 755 beds.

6.2 On 8 August 2023, Mountjoy Prison had a prisoner population of 819 prisoners. This meant it was operating at 108% of its capacity at that time.

6.3 At the time of his death, Mr. M's was the second death of a prisoner from Mountjoy Prison in 2023; and the thirteenth death in IPS custody that year.

7. Family Concerns

7.1 Mr. M's family provided the investigation team with helpful insights about Mr. M and his wellbeing. The family were of the opinion that Mr. M's "*paranoia was growing*." They also stated that he had refused temporary release three weeks before his death as he wished to remain on a waiting list for drug addiction treatment. The family had learned of Mr. M's passing from two prison chaplains who, they stated, treated the matter sensitively and in a caring manner.

7.2 The family were unclear about some aspects of Mr. M's life in prison and they were unhappy about other aspects that related specifically to his death. They expressed the hope that the OIP investigation would find answers which they had been unable to obtain themselves. Some answers to the family concerns are referenced in section 12 of this report. The remainder are addressed in section 14.

8. Background

8.1 Mr. M was a 45-year-old father from the Dublin area. He had been in custody since 22 November 2019 and had served sentences during this period. At the time of his death, he was on remand awaiting trial on other charges.

8.2 Mr. M was the sole occupant of cell 6 on the B3 landing. The B3 landing is a protection landing and Mr. M had asked to be accommodated there as he had concerns related to occupants on other landings within the prison. His protection status was reviewed at the end of every month throughout his time on the B3 landing. The B3 landing protection prisoners are classified into several groups which are distinguished by colour coding for management purposes. All prisoners in the same colour code can mix with each other. Mr. M was in the Black Group however, on 6 August 2023 at his own request, he changed to the Green Group. Mr. M declined to provide exact reasons for this requested change.

8.3 Mr. M did not make any official complaints while in custody, he had regular tuck shop transactions, and he was on standard level of the Incentivised Regime[1].

[1] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.

8.4 Mr. M's last in-person visit was on 20 January 2023, seven months before he died, with his sister and brother. The previous family visit had been on 2 December 2022. His final professional visit was with his solicitor on 17 July 2023.

8.5 Mr. M made ten phone calls between 24 July 2023 and 6 August 2023, six of these were made during the week before he died, five to his sister and one to his father. Analysis of the calls revealed that Mr. M sounded upbeat at times but was downcast on other occasions, making comments such as "My head is going" and sounding paranoid regarding other prisoners. There were many cryptic discussions about codes and money transfers. During his final call on 2 August 2022 to his sister, he reminded her not to engage with an unspecified person to whom he had previously requested she send money.

8.6 The investigation team met with three prisoners accommodated on the B3 landing who had interacted with Mr. M: Prisoner 1, Prisoner 2 and Prisoner 3. All three prisoners knew Mr. M prior to prison. They emphasised how much he loved his children and wider family circle. They made repeated references to a decline in Mr. M's mental health and behaviour for some time prior to his passing. All three prisoners were on Mr. M's previous colour coded group (Black) prior to him changing protection group on 6 August 2023.

8.7 Prisoner 1 stated that Mr. M would go through, what he felt were random periods of social withdrawal; he would then socialise for a while, but subsequently become paranoid, believing other prisoners were "after him." Despite reassurance from various fellow prisoners, Mr. M would still, on occasion, exhibit what Prisoner 1 considered was extreme paranoia. His fellow prisoners stated his mood had deteriorated in the weeks prior to his passing and he was spending a lot of time in his cell, sleeping during the day and eating infrequently. Prisoner 1 stated that Mr. M had withdrawn from social interaction for three months before Christmas 2022. Prisoner 1 stated that Mr. M then began to re-engage but in summer 2023 he had become withdrawn again. IPS records show Mr. M had declined recreation on 13 occasions during the month before his death.

8.8 Mr. M's fellow prisoners told the investigation team that Mr. M was not in dispute with anyone. His fellow prisoners stated that Mr. M may have taken drugs in the recent past, but they did not provide further details.

8.9 A member of the investigation team spoke with Mr. M's solicitor who also reported that Mr. M had recently expressed slightly paranoid views to him, particularly relating to his pending charges. It was reported by the solicitor that Mr. M had stated he was not eager to be released as he wanted help for drug addiction.

9. Events of 7 and 8 August 2023

9.1 The Class Officers Journal showed that on 7 August 2023, Mr. M availed of exercise (60 minutes) and cleaning out/showers (45 minutes) but declined recreation with other prisoners.

9.2 Four officers had contact with Mr. M during the 72 hours that preceded his death and all stated they had only limited interaction with Mr. M during that period. They noticed nothing untoward in his demeanour. Officer A was on duty when he died.

9.3 CCTV footage showed nothing unusual in Mr. M's activity on 7 August 2023. He interacted with other prisoners. At one stage, during the morning, he seemed to consider entering the recreation room but then decided not to and turned away. It was suggested by those close to him that he did so as he believed prisoners in there were going to harm him. He later collected his evening meal.

9.4 Prisoner 1 explained that the Mountjoy Prison cell walls are thin. Prisoner 1 stated that he and Mr. M would regularly watch late night television and communicate through the wall. He outlined a conversation he had, through the cell wall, with Mr. M on the evening of 7 August 2023. He stated that Mr M thanked him for all he had done for him over the years and told him he loved him. Prisoner 3 relayed how he provided Mr. M with hair clippers as he had been keen to cut his hair.

9.5 According to Prisoner 1, at approximately 22:45 on 7 August 2023, Mr. M told him he was "*sick of life and I'm checking out.*" Prisoner 1 thought Mr. M may have wanted to be sent to a Special Observation Cell[2] (SOC) for a few days to clear his head. Prisoner 1 stated that Mr. M had already bagged up his clothing and sent it to the laundry. Prisoner 1 took this as an indication that he wanted the clothes to be kept secure pending his return from the SOC to the B3 landing.

9.6 Prisoner 1 stated that it was later that night when he heard a loud crash from Mr. M's cell. He shouted to him, "*Don't tell me you're doing what I think you're doing.*" Prisoner 1 then activated his cell call light and shouted for other prisoners to do the same. After a few minutes, Mr. M reassured Prisoner 1 that he was fine, saying he had fallen in his cell. Prisoner 1 reported that after about 30 minutes, Officer A responded to his cell activation and spoke to him through the door. Prisoner 1 understood that at this stage, Mr. M was sitting in his cell drinking tea and informed the officer he had fallen in his cell but was fine. An analysis of the CCTV footage confirmed that the cell call light, indicating in-cell activation, illuminated outside cell 8 (Prisoner 1's cell) at 22:46; the officer responded to this 48 minutes later at 23:34. The officer could be seen pausing at the cell door before he reset the cell call light.

9.7 Prisoner 2 stated that at approximately 23:30, on 7 August 2023, he also heard a loud bang from Mr. M's cell describing it as, "*like him hitting the floor*." He reflected that in hindsight he believed it was Mr. M testing the ligature. Prisoner 2 stated that he called out to Mr. M, who reassured him he had fallen but was fine. Prisoner 2 explained that it was not unheard of for a prisoner to fall out of bed or trip in a cell; he himself had slipped on cell floor tiles in recent days.

[2] Special Observation Cells (or Safety Observation Cells) are designed and used in the Irish prison system to accommodate prisoners who require frequent observation for medical reasons or because they pose a danger to themselves.

9.8 At approximately 03:27, Officer A checked Mr M's cell and found him suspended from a ligature. The CCTV footage confirmed that Mr. M had been previously checked at 12:35:11, just under three hours prior. The three-hour gap in frequency of checking complied with the IPS Standard Operating Procedure for checking prisoners who are not deemed to require special observations.

9.9 Officer A immediately activated a code red call[3]. Officers B and C responded and accompanied Officer A as he unlocked the cell. They entered Mr. M's cell at 03:28:08. Mr. M's body weight was supported by the officers while Officer D used a Hoffman knife[4] to cut and remove the ligature from Mr. M. Assistant Chief Officer (ACO) A also responded, arriving at the cell at 03:28:18 as the officers were removing the ligature.

9.10 Nurse A arrived with the emergency bag at 03:29. Mr. M was not responsive and there was no pulse. Nurse A noted Mr. M had bruising around his neck, his pupils were dilated, and his body and extremities were warm.

9.11 An Automated External Defibrillator (AED) was applied to Mr. M but it advised "*No Shock*." A "no shock" message from the AED can mean one of three things: the person does have a pulse, the person has now regained a pulse, or the person is pulseless but is not in a "shockable" rhythm. ACO A then checked for a pulse before giving cardiopulmonary resuscitation (CPR). She commenced continuous cycles of CPR, as per AED guidelines, stopping for pulse checks. CPR was rotated with Officer B who carried out compressions.

9.12 Dublin Fire Brigade (DFB) paramedics arrived at 03:40; this was within ten minutes of being called. They took over CPR, inserted an intravenous (IV) cannula in Mr. M's leg and administered medication. However, it was to no avail and a DFB advanced paramedic pronounced Mr. M deceased at 04:07. There was no doctor on site at the time but a General Practitioner, Doctor A, gave consent, by phone, to certify death. The cell was secured immediately afterwards. An officer was posted to keep a record of everyone who needed access until AGS released the cell back to the IPS. It is notable that senior IPS staff, Governor A, Chief A and ACO B visited the log keeper on three occasions (06:35, 06:50 and 08:00) to check on their welfare.

9.13 Gardaí from Mountjoy Station arrived at 05:05. Mr M's body was removed at 08:40 by undertakers working on behalf of the Coroner. An inventory of the belongings in Mr. Ms cell was compiled by prison staff. The items were then removed to the Reception area at Mountjoy prison. The cell was then master locked.

9.14 Prisoner 3 reported waking at approximately 03:30 on the morning of 8 August 2023. He was able to view events through a small gap under his cell door. He confirmed the timeline of events, including the resuscitation attempts.

[3] Prison alert for an urgent medical situation – requiring medical staff and equipment.

[4] A Hoffman knife or "ligature knife" is a specialist knife commonly used by emergency services to safely cut ligatures or restraints such as rope, leather, electrical cords or other fibrous materials.

9.15 Prisoner 2 stated he heard a commotion during the night, but did not realise what had taken place until the next morning. He had thought it was Mr. M being taken to a SOC.

9.16 The CCTV footage confirmed that Mr. M was checked every three hours. This is as required by the IPS Standard Operating Procedure for a prisoner, such as Mr. M, who is not subject to any special observations. Officer A checked Mr. D at 12:35:11 and again at 3:27:07, which was when he discovered him unresponsive.

9.17 The investigation team were informed by prison management that a handwritten note was left by Mr. M in his cell. It was taken by Gardaí as evidence, along with the ligature that he used.

10. Medical Care

10.1 The investigation team were provided with access to Mr. M's medical records. At the time of his death, he was seen regularly for sleeping difficulties, stomach pain and back pain. Prior to this, he has been prescribed medication relating to opioid addiction.

10.2 On 5 June 2022, Mr. M was referred by an officer to a nurse for strange behaviour, namely shouting on the landing. Mr. M stated that he was psychotic and admitted to *"using a huge amount of benzos".* On 23 October 2022, Mr. M acknowledged smoking heroin 2-3 times per week, and he tested positive for benzodiazepines and opiates. On 9 November 2022, he told Doctor B about his ongoing use of heroin and stated he wanted to start opioid substitution therapy.

10.3 On 7 January 2023, ACO F reported concerns he had for Mr. M's mental health as he was displaying paranoid behaviours. Mr. M was reviewed by Nurse B, during which Mr. M denied he had taken any illicit substances. Mr. M spoke about being in possession of his book of evidence for his upcoming trial and it was causing him to think about his trial. According to the records, he informed the nurse that he was not stressed about the trial but indicated he was stressed about his protection status.

10.4 On 21 February 2023, Mr. M was seen by Nurse C in relation to a mental health referral as Mr. M was again displaying paranoid behaviours. Mr. M denied he was taking any illicit substances but was not willing to discuss in much detail. Mr. M was quoted as stating, "*they want you to think there is something wrong in my head*", and that, "*they are putting things under my door*". Nurse C informed Mr. M that she was asked to check on him as concerns were raised for his well-being. Mr. M reportedly responded, "*I'm fine I've been to every prison in the country its them trying to get in my head*".

10.5 On 14 March 2023, Nurse B recorded on the Prisoner Healthcare Management System (PHMS) that they had reviewed Mr. M in his cell noting, "*concern voiced from family recent telephone call*". It was recorded that Mr. M had no thoughts of deliberate self-harm but that his mind was racing relating to his upcoming court appearance. Nurse B also noted that Mr. M "*did not appear in any distress and maintained eye contact throughout conversing and appeared relaxed in cell*." Mr. M informed the nurse that he was "*still"* protected from 'All Others' on the landing. Nurse B

logged a conversation they had with ACO B noting that Mr. M "*isn't mixing for security reasons and therefore cannot be brought to the yard.*" Nurse B placed Mr. M on the doctors list for review.

10.6 The following day, 15 March 2023, Doctor C along with Nurse D reviewed Mr. M in his cell. Doctor C placed the following note on Mr. M's records, "*Telephone call from brother, concern that [Mr. M] isn't well*." Mr. M reported that he was having difficulty sleeping. It is recorded that Mr. M denied thoughts of self-harm. Mr. M was described as slightly aggressive but had no "*psychotic features*". It was noted that Mr. M "*doesn't get out to yard*" and "*has difficulty sleeping.*" The doctor prescribed circadian for two weeks and noted that they "*will encourage*" Mr. M to go to the yard. Doctor C referred Mr. M to psychology.

10.7 On 10 May 2023, Mr. M met with Addiction Counsellor A as he had requested support in making an application for a residential drug treatment facility. Mr. M was provided with application forms. The Addiction Counsellor again followed up with Mr. M, on 23 May 2023, to further discuss his application for the purpose of facilitating a move to a residential centre.

10.8 On 1 August 2023, after appearing in court, Mr. M told a nurse he hoped to be released in October 2023 and asked to be referred to Coolmine Addiction Rehabilitation Centre.

10.9 There was no evidence in the documentation received that Mr. M had therapeutic interventions in response to his mental health while in Mountjoy Prison. He was referred for addiction treatment and psychology but these had not begun as there is a significant waiting list for both. He had undertaken twelve sessions of compassion therapy in Wheatfield Prison during 2020.

10.10 Mr. M was not prescribed medication at the time of his death. It was in May 2023 when he received his last prescription. Mr. M's prescribed medications in the year prior to his death were:

- Circadin prescribed in May 2023
- Deltacortril in November 2022
- Bisolvon in November 2022
- Vivomin in October 2022
- Augmentin in October 2022

11. CCTV Footage

11.1 The investigation team reviewed CCTV footage for 17 cameras from the B3 landing, recreation hall and exercise yard. This footage covered the period from 08:00 on 7 August 2023 to 08:50 on 8 August 2023, when Mr. M's body was removed from the landing.

11.2 The CCTV footage corroborated the accounts of staff as outlined in Section 9. At 03:27, Officer A discovered Mr. M unresponsive in his cell. At 03:28, four officers arrived, unlocked cell 6 before entering. At 03:29, Nurse A arrived. It is clear from the footage that all staff acted in a swift manner and began attempts to revive Mr. M.

11.3 DFB paramedics arrived and took over resuscitation attempts at 03:40. By 04:05, resuscitation attempts had ceased.

12. OIP Response to Family Questions and Concerns

12.1 Mr. M's family asked the following questions:

1. What cell checks were done, how was Mr. M discovered and when was the last cell check completed before he was found?

OIP Response: This is addressed in paragraphs 9.8 and 9.16 of this report.

2. Was Mr. M's cell call button functioning, did he use it?

OIP Response: Mr. M's cell call button was operational and showed no faults. Mr. M did not use his cell call in the 24 hours prior to his death. However, the person in the cell next to Mr. M activated the cell call during the night of 7 August 2023. See paragraph 9.6.

3. Family members were denied access to visit Mr. M some weeks before he died. Why was this the case?

OIP Response: The investigation team were informed by senior management at Mountjoy Prison that Mr. M had no visits since January 2023. They stated there was no record of any visit ever being refused for Mr. M.

4. Why wasn't Mr. M's overall deterioration in his mental health picked up on by the Prison?

OIP Response: This is addressed in Section 10 of this report.

5. Concerns regarding Mr. M's health were brought to the attention of the prison staff; was Mr. M told that his brother rang?

OIP Response: Medical records recorded that a call was received from Mr. M's brother – see paragraphs 10.5 and 10.6. There is nothing recorded to suggest that Mr. M was informed that his brother rang. The entry noted that the healthcare staff were speaking to him [Mr. M] on foot of concerns raised by the family.

6. Why would Mr. M not want to be released or attempt to take up temporary release?

OIP Response: The medical notes, dated 1 August 2023, referenced that Mr. M hoped to be released from court in October 2023 and asked healthcare staff to submit an application to Coolmine Addiction Rehabilitation Centre.

7. What charge(s) was Mr. M on and when was his actual release date? What was his official sentence time and duration?

OIP Response: As referenced in section 8 at the time of his death Mr. M was on remand awaiting trial on charges relating to trespass and criminal damage.

13. Critical Incident Review Meeting

13.1 A Critical Incident Review Meeting[5] (CIRM) was held. It was chaired by Assistant Governor A (Chair), Chief Nurse Officer A, Nurse A, Chief A, Chief B, ACO A, ACO C, ACO D, ACO E, Chaplain A, Acting Senior Psychologist A, Officer C and Clerical Officer A.

13.2 A timeline of events was read and discussed. No recommendations were recorded at the end of this meeting. The Assistant Governor and Chief Officer reported that they had spoken to officers directly about supports available following a critical incident.

14. Recommendations

The OIP makes the following three recommendations:

1. The Director General of the IPS should formally remind all Governors that every cell in which a prisoner has died is to be preserved until it has been inspected by the OIP.

2. Several prison officers, prisoners and family members reported having observed Mr. M display paranoia, social withdrawal and repeated behavioural changes. However, this did not result in enhanced monitoring or expedite his access to mental health or addiction supports. The OIP invites the IPS Director of Care and Rehabilitation to reflect upon the need to strengthen existing protocols in order to provide for more rapid access to mental health and addiction supports for prisoners presenting with this symptomology.

3. Neighbouring prisoners initially activated their cell call alarms as they believed Mr. M had attempted to self-harm. However, it was 48 minutes later when an officer responded. The OIP recommends that a new national standard be introduced by the IPS requiring prison officers to respond rapidly to cell call alarms. Compliance with this standard should be closely monitored by prison management, including by reviewing electronic records of cell call alarm response times on a regular basis.

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.

[5] 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.