Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. Q 2024
Mountjoy Prison
18 July 2024
Aged 21

To the Minister: 19 December 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
CNO	Chief Nurse Officer
CCTV	Closed Circuit Television
CPR	Cardiopulmonary Resuscitation
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System

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. Q's death in prison on 18 July 2024 and management of the events associated with his death.

4. Administration of Investigation

4.1 On 18 July 2024, the OIP was notified that Mr. Q had died in Mountjoy Prison. The investigation team attended the prison on 18 July 2024 and met prison management who provided an overview of Mr. Q's time in custody. The investigation team also met with persons who had contact with Mr. Q 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 investigation team communicated with Mr. Q's NoK (his parents), by letter, on 22 August 2024 and met with them on 5 September 2024.

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. Q's family in mind.

5.4 The OIP is grateful to Mr. Q's parents for their contributions to this investigation and we offer our sincere condolences on their loss.

6. Mountjoy Prison

6.1 Mountjoy Prison is a closed, medium security prison for men. It is the main committal prison for Dublin city and county. It has an operational capacity of 755 beds. On 18 July 2024, Mountjoy Prison was overcrowded, with 893 men in custody, equating to 118% of its operational capacity.

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

7. Family Concerns

7.1 Mr. Q's NoK had the following questions:

1. What was the timeline of events leading to the death of [Mr. Q]?
   OIP Response: The timeline of events is provided in the body of this report.

2. If Mr. Q had been observed by the Chaplain under the influence of drugs, why was he not seen by a Nurse?
   OIP Response: Mr. Q was seen by a number of officers, on 17 July 2024, who suspected him to be under the influence of illicit substances. One officer monitored Mr. Q over the course of the day and reported there was no requirement for medical intervention.

3. Were any pills found in the cell after Mr. Q's death?
   OIP Response: Cell 9 on the D1 landing was searched, after Mr. Q's death, by IPS Operational Support Group specialist search officers. No drugs were found. A significant number of tablets were forfeited by fellow prisoners on the D1 landing following the death of Mr. Q.

4. Why were Mr. Q's personal belongings not handed over to the NoK by the IPS and instead given to his friend who then passed them onto [Mr. Q's] family?
   OIP Response: A small number of Mr. Q's personal items were incorrectly identified as Prisoner 1's belongings. Prisoner 1 returned the items upon his release.

8. Background

8.1 Mr. Q was committed to Mountjoy Prison on 14 August 2023 and was serving a two-year sentence. Mr. Q was due for release with remission on 7 December 2024. At the time of his death, Mr. Q was accommodated in cell 9 on the D1 landing. He shared the cell with Prisoner 1 whom he had known in the community. Mr. Q had several disciplinary sanctions in 2024 for incidents involving contraband and drug possession. In the days before his death, Mr. Q was served with a P19 disciplinary report for an alleged assault of a prisoner.

8.2 Officer A reported that on the afternoon of 15 July 2024, while on duty in the D yard hub, *"I observed, I believed [Mr. Q] was behaving in an erratic manner. I spoke with him to see if he needed a medic to which he declined".* Later that evening, Officer B observed Mr. Q who was *"visible though his spy glass for the entire period of the reserve and he didn't seem to be in any distress. At the end of the shift he [Mr. Q] was alert and the night guard took over."*

8.3 The following day, 16 July 2024, Assistant Chief Officer (ACO) A reported responding to a fight amongst prisoners at 15:05 in the D Recreation Hall. As Mr. Q was involved in this fight, he was removed from the yard and returned to his cell on the D1 landing. ACO A spoke to Mr. Q from outside the cell door as he was banging on the door asking to be let out. ACO A informed Mr. Q that he would not be allowed out of the cell until he had been seen by a nurse. It is further reported that Mr. Q denied fighting and stated that he did not need to see a nurse. ACO A viewed the CCTV footage of the incident in the yard which confirmed that Mr. Q and his cellmate, Prisoner 1, were involved in a fight with other prisoners. Later that evening, Mr. Q and Prisoner 1 were issued P19 disciplinary reports by ACO A.

8.4 ACO B stated that he was the detailed ACO Night Guard for Mountjoy Prison on 17 July 2024. He reported for duty at 19:15, to Chief A, and reported that, *"at no stage did [Mr. Q] or his cell mate request assistance or give cause for concern".* ACO B concluded his report stating that he finished his shift at 07:20 on 18 July 2024. Similarly, Officer B recalled that on 17 July 2024, he had "interactions" with Mr. Q throughout the day and *"identified nothing untoward to report to medical staff or management".* Other officers provided similar accounts in which most of them stated that none of their encounters with, or observations of, Mr. Q during the 24 to 48 hours leading up to his death gave any cause for concern. An exception to this was the account provided by Officer C, who was detailed duty on the D1 landing on 17 July 2024. Officer C reported that Mr. Q *"engaged well and appeared in good mood. Despite such [Mr. Q] did appear under the influence in the afternoon but still engaged with [the] regime throughout the day."*

8.5 It is clear from the accounts of some IPS staff, on duty in the days before his death, that Mr. Q was suspected to have taken illicit drugs of some form and that this had influenced his erratic and unusual behaviour. However, it seems that Mr. Q's demeanour did not cause sufficient concern to prompt staff to refer Mr. Q for medical or psychological assessment. As is mentioned later in this report, one prisoner observed that Mr. Q was not the only person suspected of being under the influence of drugs in Mountjoy around this time. Furthermore, it should be noted that there were a number of serious medical incidents associated with the misuse of illicit synthetic opioids in some of the prisons, during the summer of 2024, resulting in a significant amount of hospitalisations and near-fatal outcomes.

9. Events of 18 July 2024

9.1 At 08:10, on 18 July 2024, Officer D unlocked cell 9 on the D1 landing for breakfast. The officer called both Prisoner 1, who was lying on the top bunk, and Mr. Q who was lying on the bottom bunk. He spoke with Prisoner 1, but Mr. Q did not respond. Officer D then entered the cell and called for Mr. Q, again there was no response. Officer D reported viewing blood on Mr. Q's face whilst he remained unresponsive to the officer's calls. Officer D immediately instructed Officer E to call a "Code Red"[1]. Officer E did as directed and Officer D instructed Prisoner 1 to exit the cell.

9.2 At 08:13, Nurse A, arrived at cell 9 followed by Chief Nurse Officer (CNO) A. CNO A confirmed that, *"there were no signs of life, [Mr. Q] was cold to the touch. He appeared to be dead for a while and there was evidence of 'pooling'"*[2]. CNO A also observed that Mr. Q was lying on his back slumped to his right side. He noted that there appeared to be dried blood coming from Mr. Q's nostrils and trailing down his face. He approached and felt for a radial pulse; none was present. CNO A then sought a carotid pulse; none was present. He further noted that Mr. Q *"was cold to the touch. Discoloration noted to his arms, legs and torso. No CPR [cardio pulmonary resuscitation] commenced."*

9.3 Chief A reported that when he arrived at the cell, Nurse A was already there. Chief A added that breakfast unlock had commenced and those prisoners, already out of their cells to get their breakfast, were returned and locked back in their respective cells.

9.4 Doctor A arrived on the scene within minutes of the "Code Red" and he examined Mr. Q in the cell. The doctor recalled that when he conducted his examination, he observed that Mr. Q *"was cold, his eyes were closed. I listened for heart and breath sounds, there were none, 'pooling' was confirmed and time of death was recorded as 8:20am."*

9.5 Doctor A recorded on the Prisoner Healthcare Management System (PHMS) that he, *"Called to cell after alarm raised – prison officers tell me that his [Mr. Q's] cell mate raised the alarm this morning. Information from officers is that he [Mr. Q] took 'yellow tablets'. Pt [patient] in custody since August 2023. No major medical problems, no meds, no documented psych hx [history]. I had last seen [Mr. Q] on 13-2-2024 with head trauma and referred to casualty. Seen in cell with Nurse A and CNO A. Lying face up on bottom bunk, turned slightly onto his right side. Congealed bleeding from right nostril. Pooling of blood into bottom half of body. Eyes closed. Cold to touch. No heart sounds. No lung sounds. Declared dead at 8.20am".*

9.6 After Mr. Q was pronounced dead and the staff cleared the cell, Officer E was posted outside cell 9 and he commenced a "scene log"[3] until the arrival of An Garda Síochána. Mr. Q's remains were removed from the cell to the Mater Misericordiae University Hospital Mortuary by undertakers working on behalf of the Coroner's Office at 15:05 on 18 July.

[1] Code Red: Terminology used within the prison system to identify an emergency situation.

[2] "Pooling" is a term often used by medical personnel to describe Livor Mortis (also called hypostasis) which 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 (Knight, 2002).

[3] A scene log is written record containing the time of arrival and departure, and the names and details, of all persons permitted to enter or leave the scene of a sudden or unexplained death.

9.7 Chief B told the investigation team that there had been four "overdoses" in Mountjoy Prison that week, one as recently as the day before the death of Mr. Q.[4] Chief A expressed his opinion that it was likely "yellow tablets" were the cause of these medical emergencies. It was believed that Mr. Q had consumed the same yellow tablets. Word spread rapidly throughout the prison population as to the potential lethality of the contraband drugs as 300 to 400 "yellow tablets" were surrendered by prisoners to Mountjoy Prison staff later that day. The content of these tablets was swiftly analysed and, on the following day, confirmed to contain the synthetic opioid Nitazine.

10. Accounts of Prisoners

10.1 Eleven prisoners who may have had contact with, or were accommodated in cells near Mr. Q, were asked to make statements by Mountjoy Prison staff in the aftermath of Mr. Q's death. While most of the prisoners declined, two provided signed statements. In addition, Mr. Q's cellmate, Prisoner 1, provided his account to the OIP investigation team.

10.2 Mr. Q's cellmate, Prisoner 1, met and spoke with the investigation team in Mountjoy Prison on 18 July. He was co-operative and willing to engage but was understandably still extremely shocked and traumatised while giving his account. He stated that he woke up that morning to an officer shouting "breakfast"; the officer then entered the cell and said, "*come on lads, breakfast, Jesus he [Mr. Q] looks dead*". Prisoner 1 remembered the officer then started shouting for assistance and shouting "*code red*".

10.3 Prisoner 1 informed the investigation team that Mr. Q had consumed 10 yellow tablets throughout the day of 17 July 2024. Prisoner 1 stated that it was approximately 17:30 when Mr. Q consumed his final tablet. He stated that Mr. Q was "*buzzed*" during lock back, describing him as having been in a happy mood, as he was laughing throughout the night. Prisoner 1 stated that he did not consume tablets as he heard there was Fentanyl[5] in them. However, he stated these tablets are readily available and that many prisoners consumed them regularly and that Mr. Q would take tablets two or three times per week, often down to boredom. Prisoner 1 advised that the tablets were available for sale in the prison yard and recreation areas.

10.4 On 22 July 2024, Prisoner 2 was interviewed by prison staff and he provided an account of a significant encounter he had with Mr. Q on the night before he was found unresponsive. Prisoner 2 stated that he visited cell 9 three times at around 19:45 on 17 July 2024. He recalled that on the first visit, Prisoner 1 asked for cigarette papers and during that visit, Prisoner 1 allegedly told Prisoner 2 that Mr. Q had taken seven tablets. During the second visit to cell 9, Prisoner 2 asked Prisoner 1 to tell Mr. Q to wake up and speak to Prisoner 2. Prisoner 2 then spoke to Mr. Q when he woke up but *"he wasn't really making sense."* Concluding his recollection, Prisoner 2 asserted that *"over the last four days, I observed more than Mr. Q under the influence of some type of substance."*

[4] There was also a similar event on the evening of 16 July when a "Code Red" was called on D2 landing Mountjoy when a prisoner was transferred from his cell to Accident and Emergency by ambulance at 22:00 with a suspected overdose. In this instance the prisoner survived.

[5] Fentanyl is a powerful synthetic Opiate drug. It can be up to 600 times more potent than Morphine and may be sold as 'designer' fentanyl or 'synthetic' heroin. Therefore, even experienced heroin users are at risk if they take this drug. (Source: HSE.ie)

10.5 In contrast, Prisoner 3 stated that during the evening visits to cell 9, with Prisoner 2 on 17 July 2024, *"everything seemed fine [….] we were having a laugh and joke with Mr. Q and Prisoner 1 at cell 9. Everything was normal, just like any other day in the jail."*

11. Medical Care

11.1 The clinical records, obtained by the investigation team, included the standard Nursing Committal and Doctor Committal interview notes for Mr. Q.'s most recent prison committal on 14 August 2023. An entry made on the PHMS, by Doctor B dated 15 August 2023 at 10:13, noted that Mr. Q was a *"new committal Known to IPS Medical [with a history of] benzo w/d [withdrawal] seizure [….] Substance use: cocaine, benzos [….]".*

11.2 In the period between his committal and his death, Mr. Q was seen by prison medical staff on a number of occasions for minor injuries sustained in fights with other prisoners. For example, on 9 February 2024, Doctor A noted on PHMS an *"assault this afternoon. Boxed in the face. Denies LOC [loss of consciousness] o/e [on examination] swelling, bruising and laceration below left eye. Plan – refer to casualty".* Another PHMS entry dated 10 Feb 2024 by Doctor C recorded: *"self-discharge last night from ED [Emergency Department] […] large soft hematoma [blood bruise] to the left orbital, vital signs in normal level, advised rev [review]".*

11.3 The last direct interaction Mr. Q had with a Mountjoy Prison Doctor, Doctor A, before his death, was on 13 February 2024 at 15:17. The Doctor noted on the PHMS, *"recent assault with trauma to left side of [Mr. Q's] face. Referred to casualty but pt [patient] took own discharge. Assault this afternoon + punched in left side of face. No LOC [loss of consciousness]. Afterwards felt dizzy. No medical problems. No meds. Not on methadone. Denies any drugs. o/e bp 130/72 hr 77 initially right pupil was dilated + left pupil constricted. Feeling ok now – dizziness has settled. Large swelling and bruising under left eye. Plan – refer to casualty".* There was a later entry by Doctor A, dated 15 February 2024 at 12:38, where he recorded on the PHMS that Mr. Q had been seen in casualty regarding his upper jawbone.

11.4 Nothing in Mr. Q's prison medical records indicates any requirement for assessment or treatment for the after-effects of consuming illicit drugs during his time in Mountjoy Prison from his committal in August 2023 until his death in July 2024.

12. CCTV Footage

12.1 As part of the investigation, CCTV footage was reviewed by the investigation team. The times recorded are taken from the CCTV displayed clock. CCTV footage of the exercise yard is slightly blurred making it difficult to see clearly the features and actions of individuals. The footage, for 17 July 2024 from 14:25:28 onwards, shows Mr. Q on the D1 landing as he enters his cell, cell 9, and it appears there is nothing untoward about his demeanour or behaviour. There is a lot of activity on the landing throughout that time, from 14:25 until Mr. Q is locked back into his cell at 16:07:19. Prisoners and staff can be seen associating and chatting, and there is considerable coming and going during this period.

12.2 At 14:26:20, Mr. Q departs his cell and walks out of shot. He remained out of view until 15:59:00 when he re-appeared and could be seen talking to prisoners on the landing. For the next few

minutes, Mr. Q can be viewed coming and going on the landing until 16:06:55, when he appears in view of the camera exiting another cell. He is then escorted to his own cell by a female officer after he seems to be delaying going back to his cell. At 16:07:19, Mr. Q is placed in his cell and the door is closed by the female officer. At 16:15:52, Mr. Q's cellmate, Prisoner 1, returned with his dinner tray and is locked back into cell 9.

12.3 The footage on the morning of 18 July 2024 shows the routine morning unlock of Mr. Q's cell for breakfast at 08:12:49. Nine seconds later, at 08:12:58, an officer pushes the call button outside the cell door and entered cell 9. At 08:13:17, the same officer exits the cell, gestures down the landing and then re-entered the cell immediately. A female officer arrived and entered cell 9 at 08:13:24 and removed Prisoner 1 from the cell – she then presses the call bell button and speaks into her Tetra radio handset. Just over 30 seconds later, another male officer arrived and entered the cell. At 08:14:20, a nurse arrived with another officer. The nurse looked into cell 9 before departing and collected the emergency medical "Red Bag" and oxygen bottle and goes back into the cell.

12.4 At 08:14:38, more prison staff responded to the 'code red', including a third nurse who entered cell 9. A fourth nurse entered the cell at 08:15:46, carrying a bag of medical equipment. A prison doctor attended cell 9 at 08:18:29 and a few seconds after that, screens are positioned outside the cell door. The doctor and three other staff members leave the cell at 08:21:06 and the cell door is fully closed at 08:21:39. The time lapse between the alarm being raised at 08:13:17 and medical staff attending cell 9 at 08:14:20 is just over 60 seconds.

12.5 The CCTV footage corroborates the accounts given by the prison staff on duty on the morning of 18 July 2024. The response from the prison staff, from when the alarm was raised until medical assistance arrived, was very fast and is to be commended.

12.6 It should also be noted that an officer reported that on the afternoon of 15 July 2024, Mr. Q appeared to be under the influence of an unknown substance (suspected illicit drugs). Relevant footage from the Exercise Yard was viewed by the investigation team but the CCTV reviewed was inconclusive. Mr. Q can be seen, for an extended time on the CCTV footage, but it is not possible to infer whether or not he was under the influence of drugs, alcohol or otherwise.

13. Critical Incident Review Meeting

13.1 On 23 July 2024, a critical incident review meeting[6] was held by Deputy Governor A. In attendance were; IPS Risk & Compliance Manager A, Chief B, Chief C, Acting Chief Trades Officer A, Doctor A, CNO A, Supervising Officer A, Officer B, Officer E, Officer F, Officer G, Officer H, Chaplain A and Prison Clerical Officer A who was the minute taker.

13.2 Deputy Governor A opened the meeting by extending his sympathies and condolences to the family of Mr. Q on behalf of IPS, management and the staff of Mountjoy Prison. He went on to explain the purpose of the meeting as well as noting that the Director General of the IPS, IPS Operations, An Garda Síochána, the Office of the Inspector of Prisons, the Red Cross and the

[6] 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.

Samaritans had all been informed of Mr. Q's death. Deputy Governor A also informed the meeting that Chief B would be preparing the prison's "Death in Custody Report". The Deputy Governor concluded his remarks by informing the group that An Garda Síochána had organised for the Coroner to remove Mr. Q's remains to the Mater Hospital mortuary.

13.3 Acting Chief Trades Officer A confirmed that the cell call system was functioning normally at the time of the incident. Other staff members who attended the incident or who had relevant information or updates to provide also addressed the meeting. Details of their accounts are referred to previously in this report.

13.4 No recommendations were recorded at the conclusion of the critical incident review meeting. However, the meeting did set out, in detail, immediate actions taken by Mountjoy management and staff in the aftermath of the discovery of Mr. Q's death in custody.

14. Recommendations

14.1 The Inspector of Prisons makes four recommendations:

1. Where there are reasonable grounds to believe that a particular prisoner is intoxicated, a prompt and proportionate search of their person and their cell should be conducted in line with established security protocols. If multiple prisoners present with similar symptoms of intoxication, a general search of cells should be considered. Operational guidance should clarify the threshold for initiating such searches and emphasise the importance of timely action to prevent harm.

2. From a preventive standpoint, it is crucially important that prison management and healthcare staff have rapid access to reliable information about the composition of any drugs found in a prison. Samples of drugs found in prisons should be swiftly analysed and the results communicated to prison management and healthcare staff in a timely manner. The OIP welcomes the rapid action that was taken by the IPS in this case. The OIP would add only that if the analysis is conducted by, or on behalf of, An Garda Síochána, clear channels of communication between the IPS and AGS should ensure that the results are equally quickly made known to prison management and healthcare staff.

3. The Irish Prison Service should further intensify its efforts to physically prevent contraband from entering prisons and to detect its presence once on the premises, including through physical and technological means. In this regard, the OIP welcomes the recent installation of new and more effective anti-drone netting on certain exercise yards at Mountjoy Prison, and at other prisons in Ireland.

4. The Irish Prison Service should continue to engage with other relevant stakeholders, especially with An Garda Síochána, to further develop a multi-agency strategy to counter contraband entering a prison. This strategy should examine the use of technology, architectural disruptions, as well as how to prevent exploitation and coercion being used as a means to traffic drugs and other contraband into a prison.

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.