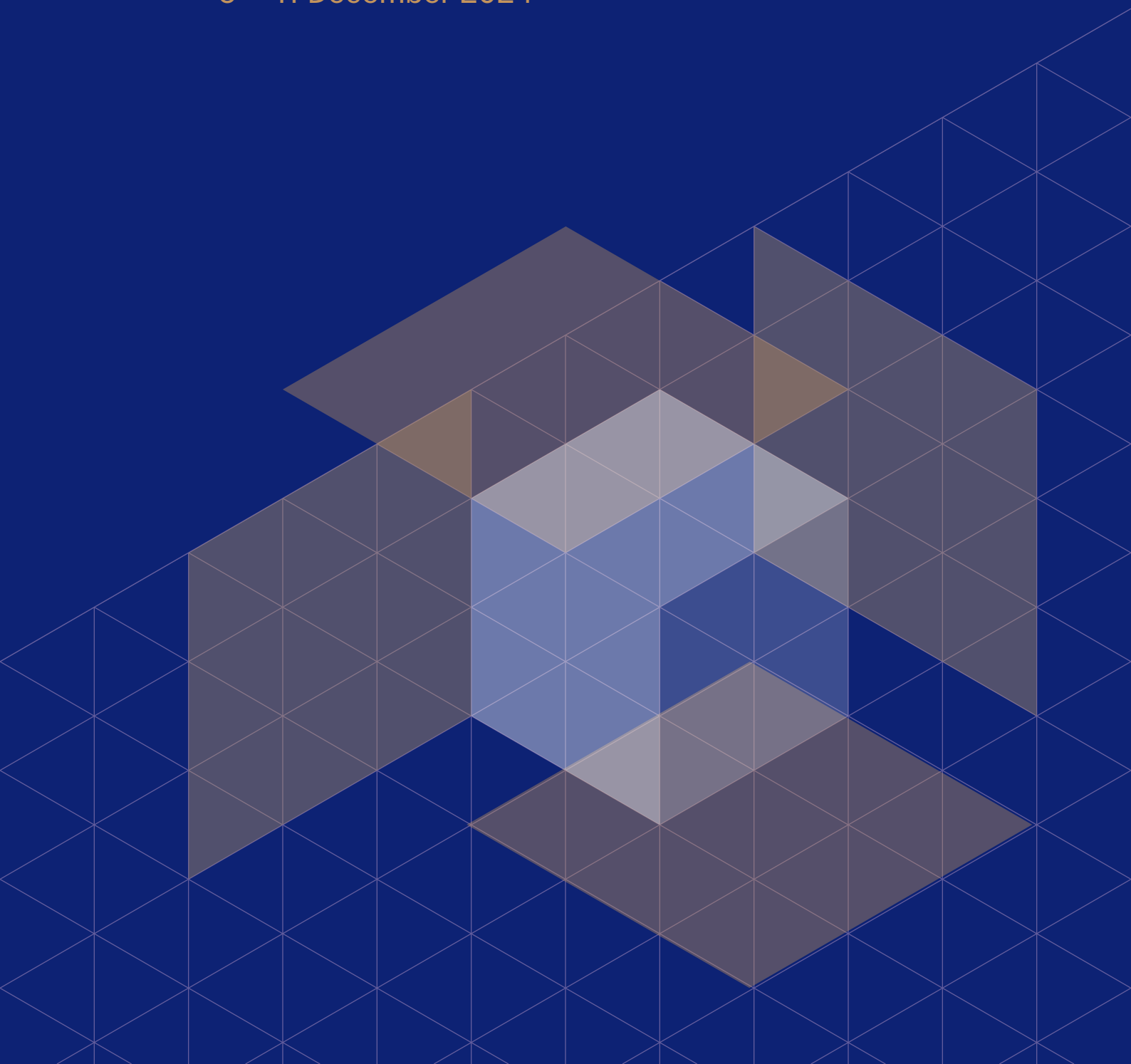
Oifig An Chigire Príosún
Office of the Inspector of Prisons

# Inspection Report
# Follow-up Inspection: Cloverhill Prison

9 — 11 December 2024



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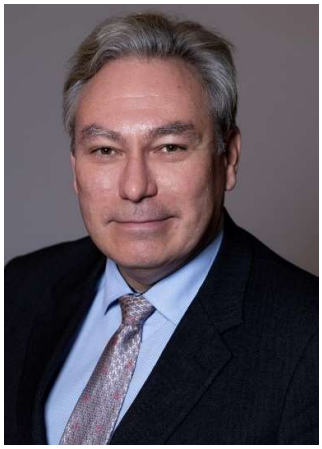
## Foreword by the Chief Inspector



Cloverhill Prison was one of the first prisons in Ireland to receive a full unannounced inspection under the Inspectorate's new inspection programme, which began in late 2022.

The unannounced general inspection of Cloverhill Prison took place in May 2023 and gave rise to profound concerns. Section 31(1) (c) of the Prisons Act 2007 provides that, "in the course of an inspection or arising out of an inspection" I may bring "any issues of concern" to the notice of the Governor of the prison concerned, the Director-General of the Irish Prison Service or the Minister. On 1 June 2023, I issued an Immediate Action Notification to the Minister for Justice and the Director General of the Irish Prison Service raising serious concern regarding the degrading conditions in the cells at Cloverhill. I highlighted, in particular, the conditions in cells designed for three persons, certain of which were accommodating four prisoners, one of whom was obliged to sleep on a mattress on the floor.[1] I also emphasised that "inter-prisoner violence is the inevitable result of confining four adult men in degrading conditions of this nature."

In October 2024, I attended Cloverhill Prison in the sad circumstances of investigating the violent death of a prisoner. Based on my initial findings, I again wrote to the Minister for Justice highlighting that holding people in the overcrowded and degrading conditions at Cloverhill Prison, for 22 hours a day or more, was creating a breeding ground for violence and generating a risk to life.[2] I also stressed that the absence of effective risk assessment processes on admission to the prison exacerbates the threats to the physical integrity of people living and working in the prison.

In view of the gravity of the Inspectorate's findings, I decided to carry out a follow-up visit to Cloverhill Prison in December 2024, the findings of which are captured in this report.

Over the period that Cloverhill has been closely monitored by the Inspectorate, conditions of detention there have continued to degenerate. At the time of the Inspectorate's June 2023 Immediate Action Notification, the prison was 104% overcrowded and there were mattresses on the floor in 38 cells; by October 2024, this had risen to 121% overcrowded, with 72 mattresses on the floor.

This follow-up report focuses on the implementation of the recommendations made in the report on the Inspectorate's 2023 inspection of Cloverhill. Unfortunately, the Inspectorate has concluded that, at the time of its 2024 visit, the majority of those recommendations had yet to be implemented. As during the full inspection in May 2023, the conditions in which the vast majority of people were living in Cloverhill Prison could be qualified as degrading. The only significant difference was that a higher proportion of people in the prison were being held in degrading conditions.

[1] The text of the Immediate Action Notification, as well as the responses of the Minister and the Director-General of the IPS are set out in Appendix B to the OIP's Annual Report for 2023, available at this link: https://www.oip.ie/wp-content/uploads/2025/02/Office-of-the-Inspector-of-Prisons-Annual-Report-2023.pdf

[2] Letter from the Chief Inspector of Prisons to the Minister for Justice, dated 8 October 2024.

In the meantime, in September 2025, the Irish Prison Service produced an Action Plan for the implementation of the Inspectorate's recommendations.

The Inspectorate will continue to closely monitor the deeply concerning situation at Cloverhill Prison, and I look forward to our future oversight work in cooperation with the Director-General of the Irish Prison Service, as well as the Governor and staff of Cloverhill Prison.

**Mark Kelly, Chief Inspector of Prisons**

## Respect & Dignity

| Rec ID | Respect & Dignity Recommendations |
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| **CH23-1** | **Every prisoner should be provided with daily access to a shower in the interests of both personal and prison hygiene.**<br>In the main prison, there were no in-cell showers; prisoners were using communal showers on the landings. On larger landings, the allocated time for showers was insufficient to facilitate all prisoners showering each day. For example, on A1 landing, men reported that one hour (9.30-10.30am) was allocated for them to access showers, during which they also had to complete other activities, such as cleaning out their cells.<br><br>At the time of inspection, there were only five functioning showers on B1 landing which accommodated 70 prisoners. A number of other shower areas were also in need of repairs; these included broken showers (A1, B1, B2, E2), and broken shower screens (C1).<br><br>The Inspectorate recommends that a sufficient amount of time be allocated to ensure that all people in prison have daily access to a shower. Repairs to broken showers in the prison should be carried out expeditiously.<br><br>**This recommendation remains open.** |
| **CH23-2** | **The Governor should take all the necessary steps to ensure people in Cloverhill Prison are facilitated to wear their own clothing, including by making laundry facilities available to prisoners to wash their clothing.**<br>After a period of four weeks, people in Cloverhill Prison are permitted to wear their own clothes. However, a high proportion of prisoners continue to wear prison issue clothes and are dependent on weekly kit changes.<br>The distribution of clothing at Cloverhill Prison is of concern. The Inspection Team was informed that men received a weekly kit change of prison issue clothes; however, it was frequently reported that the weekly kit contained an insufficient number of socks and underwear. In consequence, men were observed by the Inspectorate washing and drying their clothes in overcrowded, poorly ventilated cells. It is axiomatic that this is unhygienic.<br>The Inspectorate reiterates its recommendation that the prison should improve the laundry facilities available to prisoners. Management should (i.) increase and record the weekly kit allotted to prisoners, (ii.) acquire additional laundry machines, (iii.) implement individually marked kit bags for weekly laundering.<br>**This recommendation remains open.** |

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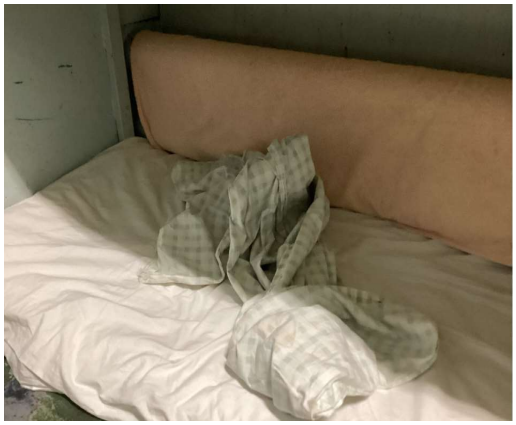
| **CH23-3** | **Prison managers should conduct regular and ongoing recorded audits of the availability of bedding, and where necessary, ensure the replacement of mattresses, duvets and pillows. Every prisoner should have a mattress in a good state-of-repair, a clean duvet, sheet, pillow and pillowcase, and a sufficient number of towels to meet their needs.**<br><br>Records are maintained at the reception area of the prison for the issuing of duvet covers, sheets, pillowcases, and towels. However, the Inspectorate observed cells in which men had no pillows, or had created makeshift pillows with towels, or from their own clothes.<br><br>  <br>**Figure 1: Example of makeshift pillow**<br><br>Prisoners had access to one towel a week which is insufficient.<br><br>**This recommendation remains open.** |
| **CH23-4** | **Prison management should develop a recording mechanism to ensure that actual out-of-cell time is properly recorded for all prisoners in custody, with a particular emphasis on restricted regimes and out-of-cell time record-keeping. [See also, CH23-9]**<br><br>Out-of-cell time was not generally recorded within the prison, with the exception of the out of cell time for prisoners held on restricted regimes.<br><br>Gaps were observed in the out of cell time records on C1 and C2, where the majority of prisoners on restricted regimes were held. As was the case during the general inspection in 2023, these records only captured the time out-of-cell *offered* and not the time of which people actually spent out of their cells.<br><br>In contrast, better recording practices were observed on D1 and D2 landing (landings that accommodated prisoners held under Rule 62 as well as men with severe mental illness) in which the amount of time offered was captured alongside whether the individual availed of it or not. No out-of-cell time record books captured the *reasons* prisoners declined out of cell time.<br><br>Effective record-keeping of out-of-cell time for all of the prisoner population is essential in order to ensure that no prisoner is spending prolonged periods of time locked back in their cells or experiencing *de facto* solitary confinement.<br><br>**This recommendation remains open.** |

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| **CH23-7** | **A Governor grade staff member should conduct the daily Governor's Parade; delegation of this function to Assistant Chief Officers should cease.**<br><br>The Inspectorate notes that a Governor conducted Governor's Parade for new committals. However, Assistant Chief Officers (ACO) conducted parade in other areas of the prison such as A2, C1 and C2.<br><br>It is important that people in prison have regular access to Governors and that their entitlement to meet with the Governor under Rule 55 of the Prison Rules, 2007 is upheld.<br><br>**This recommendation remains open.** |

## Safety & Security

| Rec ID | Safety & Security Recommendations |
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| **CH23-9** | **Records should be kept in relation to all restricted regimes, including in instances where prisoners are separated from the general population on a temporary basis. Records should be (i) comprehensive and detailed; (ii) maintained in sequential order in distinct logbooks; and (iii) include thorough explanations for the (ongoing) placement of prisoners on restricted regimes, as well as the services and supports offered to and availed of by prisoners during their placement on a restricted regime. It is axiomatic that every use of force and control and restraint must be scrupulously recorded and the Inspectorate would like to receive confirmation that this is now the case.**<br><br>Similar to the findings made during the general inspection of Cloverhill Prison, manual logbooks could not be reconciled with electronic records in the *Prisoner Information Management System (PIMS)*.<br><br>For example, it was recorded that 25 prisoners had been temporarily transferred into holding cells in the reception area during the period from 30 October 2024 to 23 November 2024; the reasons for these movements were typically cited as searches, fights, or other altercations. The movement of these prisoners to the reception area was logged in a manual record book; however, these movements were not captured in PIMS. In the interests of accountability, it is imperative that these movements are also entered in PIMS.<br><br>Overall, the level of detail recorded on Use of Force forms has improved since the general inspection; however, the inclusion of additional details such as individual statements from those involved in these incidents should be embedded in record-keeping practices. Additionally, records should specifically record who performed what action during the incident. For example, in one case of a man placed in handcuffs and a spit hood, the form did not capture who placed these restraints on the individual. Detailed documentation on instances where restraint is used is essential for transparent record keeping, and to safeguard both prisoners and staff.<br><br>On restricted regimes, the Inspectorate attended a Rule 62 review meeting. It was evident from this meeting that staff have a detailed knowledge of the prisoners placed on Rule 62. Behaviour is monitored while under the Rule, and there is good discussion on the justification for continuing or discontinuing the use of the Rule.<br><br>**This recommendation remains open.** |

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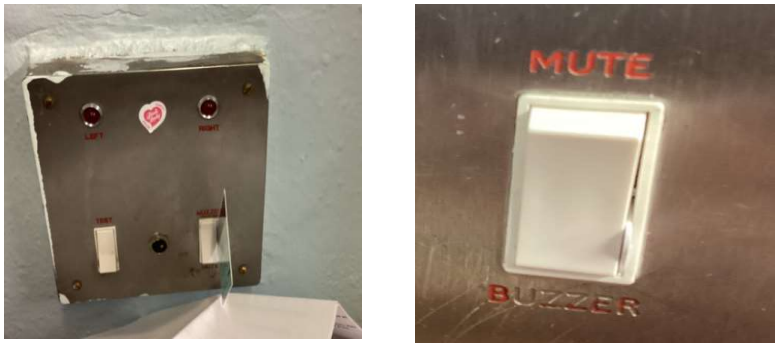
| **CH23-10** | **There is a duty of care on prison managers to ensure that all persons held in prison are kept safe. Increased efforts should be made to promote safe interactions in Cloverhill Prison, including application of conflict mediation and restorative practices to ease tensions amongst prisoners, and prisoners and staff.**<br><br>The Inspectorate has identified a number of risks that impact on prisoner safety. There was no formal cell sharing risk assessment tool in place. This is the case across the prison estate. In the absence of such a risk assessment tool, prison management are not equipped to fully ensure the safety of prisoners.<br><br>Over the past 12 months, there had been 297 recorded prisoner-on-prisoner assaults and 27 recorded prisoner-on-staff assaults. There was no record of staff on prisoner assaults or staff on staff assaults. Control and restraint had been used 40 times over a three-month period (September-November 2024). The prison should make greater use of conflict mediation/restorative practice programmes.<br><br>During the follow-up inspection, an audit of the cell call system[3] was conducted on 11 December 2024. The cell call system is a basic system and does not include the capability to log or track cell call activations. There is no reactivation of the audio alarm after a period of time and there is no queuing or stacking system to identify if a number of cells have activations.<br><br>  <br>**Figure 2: Card wedged to mute cell call system on various landings**<br><br>On a number of landings (A, B, C, D1, and E), the Inspectorate found that there was extensive evidence of interference with cell call systems by prison officers including in the high support unit on D2. As seen in Figure 2, there were numerous instances in class offices of tape or card being placed over the system to mute calls. This practice, evident throughout the prison, implies that prison officers were not responding to calls and that ACOs were not overseeing the system. The issues identified during the inspection with the cell call system pose a serious risk to the safety and wellbeing of prisoners at Cloverhill Prison.<br><br>**This recommendation remains open.** |

[3] The cell call system, with the exception of F wing, is a basic signal system.

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| **CH23-11** | **The Director General of the Irish Prison Service and the Governor of Cloverhill Prison should ensure a clear demarcation between an incident recording system and the P19 (disciplinary sanction) recording system.**<br><br>There is still an insufficiently clear demarcation between the P19 system and the incident recording system (primarily recorded through National Incident Management System (NIMS)) at Cloverhill Prison. For example, the Inspectorate found that text entered into NIMS forms in relation to an incident was essentially the same text as that entered in P19 reports submitted for the individuals involved. This is despite the two systems serving different purposes. In addition, NIMS forms – which are used as the primary incident management system at Cloverhill and at other prisons across the estate – did not contain pertinent details and intelligence related to serious incidents. The Inspectorate examined a series of three violent incidents that occurred within a short period of time and which involved the same individuals.<br><br>This review led to the following findings. First, the nature and severity of injuries were not captured on the NIMS form or were only recorded in very brief detail. Most notably, in one incident, the NIMS form did not record that an individual had been stabbed or mention of the presence of a contraband weapon, despite this information appearing on the associated P19 documentation. Second, in one of the incidents reviewed, the four associated NIMS forms did not include the names of other individuals involved in the incident (or whether they were victims, instigators, or aggressors) which could be used to inform dynamic security. This is particularly salient given that this appeared to be the third incident of this kind involving the same individuals.<br><br>The Inspectorate acknowledges that there have been improvements in the rapidity with which NIMS forms are being issued and completed. This is welcome, although it remains the view of the Inspectorate that the NIMS system is not fit for the purpose of recording serious incidents in prisons and places a wholly disproportionate administrative burden on Chief Officers.<br><br>**This recommendation remains open.** |
| **CH23-12** | **Senior management should regularly conduct and record audits of P19 sanctions to ensure consistency of approach and application of sanctions. To facilitate this audit process, the PIMS system should be reviewed and amended to reduce compartmentalised effects of siloed record-keeping and ensure safeguards are put in place.**<br><br>Over the period of 5 September 2024 to 5 December 2024, 257 men were issued with P19s and a total of 540 P19s were issued.<br><br>Carrying out regular audits of P19s would help ensure consistency of application of sanctions.<br><br>**This recommendation remains open.** |

## Health & Wellbeing

| Rec ID | Health & Well Being Recommendations |
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| **CH23-14** | **Ensure a clear roster for an out-of-hours General Practitioner service is in place. The roster should make clear the clinical responsibility of nurse and General Practitioner cover, particularly for out-of-hours and weekend shifts.**<br><br>GP cover arrangements and a roster was in place up until the end of 2024. It is positive that there are now two full-time equivalent General Practitioners (GP) that work Monday to Friday in the prison. In addition, there is a 0.6 locum GP that worked Tuesdays, Thursdays and Fridays. A 0.4 locum GP also works Saturdays and Sundays.<br><br>**This recommendation can be considered closed.** |
| **CH23-16** | **Delivery of addiction services in Cloverhill Prison should be enhanced in such a way that waitlists to access counsellors and treatment are reduced, prisoners are provided with tandem medical and psychological supports and clear links are established with community drug treatment programmes to support sustainable continuity of care for people on release from prison. Consideration should be made to ensuring regular allocation of an addiction nurse to Cloverhill Prison.**<br><br>There are 37 patients accessing addiction counselling in the prison. 57 people are on the waiting list to access addiction counselling. The average wait time to access an Addiction Counsellor is approximately eight weeks. Currently, the addiction counselling team is resourced with 0.8 full time equivalent staff, which is half the approved resource of 1.6.<br><br>A number of men had addiction issues. For example, there were 110 patients on Opiate Substitution Therapy, 103 patients on Opiate Substitute Therapy (Maintenance), 43 on Librium Detox Therapy and seven on Methadone Detox Therapy. There is no dedicated Addiction Nurse and no on-site pharmacist.<br><br>**This recommendation remains open.** |
| **CH23-17** | **Efforts should be made to ensure compliance with Rule 11(1) of the Prison Rules 2007-2020; all committals to Cloverhill Prison should be examined on the day of their admission to the prison, "save in the most exceptional circumstances".**<br><br>On one night during the inspection, 11 persons were committed to the prison. The process is that the nurse carries out the assessment at reception with committals the following morning, and committals are seen by the GP service within 24 hours.<br><br>There is a need for a second night nurse in order to manage committals intake overnight, while also ensuring that the medical needs (including medical emergencies) of the general prisoner population are managed.<br><br>The Inspectorate noted that during committal healthcare assessments the door is left open as standard practice which impacts on medical confidentiality.<br><br>**This recommendation remains open.** |

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| **MHT1** | **It is recommended that the vacancies for IPS nursing staff in Cloverhill Prison be urgently filled (by recruitment or initially, partially, by redeployment). Recruitment may be enhanced by targeted recruitment events.**<br><br>The Inspectorate welcomes the appointment of a Chief Nurse Officer in May 2024, filling a crucial vacancy found at the time of our general inspection in May 2023.<br><br>During our 2023 inspection, we expressed serious concern that the prison did not have a nurse on duty at night. It is welcome that there is now a night nurse on duty; however, one night nurse on duty in Cloverhill Prison is insufficient, especially within the context of increased prisoner numbers. The Inspectorate has also had cause to raises its concerns about nursing under-staffing at night at Cloverhill Prison in the context of death in custody investigations. It welcome that a submission has been by the Governor to IPS Workforce Planning made for a second night nurse.<br><br>**This recommendation remains open. The Inspectorate would like to be informed of the outcome of the Governor's request for a second night nurse.** |
| **MHT3** | **It is recommended that efforts to fill the vacancies for psychology staff across the prison service are redoubled as a high priority, including reconsidering the terms and conditions of the employment of such staff, including enhancing incentives, to try and stem the loss of such staff overseas, and enhance the recruitment and retention of psychologists from home and abroad.**<br>There is one-full time Senior Psychologist, one Assistant Psychologist and one staff grade locum psychologist in the prison. 22 people are regularly availing of Psychology Services in Cloverhill Prison. An additional 86 people were on the waiting list for a Psychology Service. The average waiting time to see the psychologist is reported as approximately nine weeks.<br><br>**This recommendation remains open.** |
| **MHT5** | **It is recommended that the vacant 0.5 WTE consultant psychiatrist post at Cloverhill Prison is filled. Liaison with the HSE regarding this should occur without delay.**<br><br>There are 1.2 Whole-Time Equivalent consultant psychiatrists in the prison. The prison also had one specialist registrar, one psychiatric registrar, two forensic nurses, and one forensic nurse vacancy. There was also a Mental Health Advanced Nursing practitioner.<br>However, the Prison In-Reach Court Liaison Service (PICLS) caseload had nearly doubled since the OIP's 2023 general inspection, from 43 to 70. There were 16 people awaiting diversion to the Central Mental Hospital and beds in the community. The situation on D2, which is housing a number of patients who simply should not be in prison, remains critical.<br>The Inspectorate again commends the dedication and commitment of staff working in this unit. However, it cannot be considered to offer the therapeutic environment required by people with mental illness accommodated there. |

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| | **This particular recommendation can be considered closed. However, urgent action is still required to establish rapid clinical pathways to transfer people with mental illness held in D2 at Cloverhill Prison to appropriate therapeutic environments.** |

## Purposeful Activity & Resettlement

| Rec ID | Purposeful Activity & Resettlement Recommendations |
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| **CH23-18** | **The Governor of the Prison should strive to increase access to work and training opportunities in the prison, in particular, by developing sustainable collaborative initiatives with the school and external programmes and services.**<br><br>Opportunities for work training within the prison should be strengthened. There are currently 104 prisoners engaged in work training, just 20% of the population. Additional spaces have been added to existing work posts since May 2023; however, this has barely kept pace within the context of increased prisoner numbers. The level of engagement observed in December 2024 remains virtually unchanged from that seen during the 2023 general inspection (19%).<br><br>It is positive to note that the prison's name does not appear on training certification, as recommended in the Inspectorate's Work Training and Education thematic report.[4] However, it is still the case that there are extremely limited opportunities for accredited training. Currently, the only available option for certification is through the kitchen. Avenues to expand the opportunities for certification should be explored.<br><br>There were no examples of collaborative work training initiatives with external programmes and services. The Inspectorate was pleased to learn of plans for a new material recycling programme at the prison, and would appreciate receiving further information as to how these plans progress.<br><br>**This recommendation remains open.** |
| **CH23-20** | **The Cloverhill Prison RMP should be reviewed to prioritise the availability of prison staff to engage in interactions with prisoners that amount to meaningful human contact. In particular, prison officers working on the landings should be actively encouraged to engage with prisoners in a more meaningful way.**<br><br>The Inspectorate retains a positive view of the principles around which the prison's Regime Management Plan (RMP) is organised, which include prioritisation of prisoner-support roles, such as the school and escorts to medical appointments. It is welcome that the new RMP will assign extra staff to supervising visits and facilitating education.<br><br>**This recommendation remains open. The Inspectorate would like to receive a copy of the new RMP, which was due to enter into force immediately after the follow-up inspection.** |

[4] OIP (2023). Thematic Inspection on Education & Work Training.

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| **CH23-21** | **The Governor of the Prison should ensure that, in line with Section 42 of the Public Sector Duty, foreign national prisoners have easy access to communicate with family, for example through the provision of information and materials in other languages to enable non-English speaking prisoners to set up their phone cards. This should be done alongside recommendation DG23-2, in which the Inspectorate recommends the Irish Prison Service should, within its policies and procedures, (provide) ready access to interpretation and translation services.**<br><br>Positively, there was evidence on some landings of some information materials provided in languages other than in English. This is an important measure for people whose first language is not English.<br><br>For committal interviews with non-English speaking committals, prison staff relied on Google Translate to bridge the language barrier. As the committal interview is a crucial step in induction to the prison, the Inspectorate would like to see greater use of on-call interpreters for this purpose.<br><br>Similarly, an on-call interpreter service or speech-to-speech translation for healthcare staff should be operational in Cloverhill Prison; this would greatly assist healthcare clients who are non-English speakers and would be particularly beneficial when health care staff record medical histories during committal interviews. It is positive to note that medical professionals in the prison had engaged with the Irish Prison Service regarding the possibility of obtaining a voice to audio translation tool.<br><br>**This recommendation remains open.** |
| **CH23-24** | **All prisoners, irrespective of their legal status, should be provided with a release pack (i.e., map, transport timetables) at the time of release.**<br><br>It is positive that prisoners are provided with relevant contact information, and maps for local transport. People being released are permitted to make calls and to charge their mobile phones for use outside the prison gate.<br><br>**This recommendation can be considered closed.** |

An Roinn Oideachais
Department of Education

# Education Centre, Cloverhill Prison: Follow-Through Inspection

## Context

The purpose of this inspection was to follow up on the unannounced General Inspection of Cloverhill Prison which was carried out by the Office of the Inspector of Prisons (OIP) from 15 to 25 May 2023. The Department of Education (DE) Inspectorate formed part of the OIP team, which conducted the Follow-Through inspection of Cloverhill Prison. The inspection was led by the OIP, and the DE aspect of the inspection focused on evaluating the progress the education centre had made on implementing recommendations made as part of the original General Inspection.

Cloverhill Prison is a closed, medium security prison for adult males that primarily caters for remand prisoners from the Leinster area. There is a purpose-built Education Centre located off the prison circle, which is accessed through a dedicated corridor. Access to education provided by the centre is the main form of structured purposeful activity offered in the prison.

At the time of the evaluation, the centre had the capacity to accommodate 140 people each day. The week prior to the evaluation saw a unique number of 94 students; this was the number of students who attended the education centre at least once over the course of the week. There was a waiting list for the centre of 47 people who expressed an interesting in attending. The average waiting time was 4.3 weeks.

## How to read this report

The first part of the report describes what the inspector did during this follow-through inspection.

The main section of the report describes the progress the school has made in implementing each of the main recommendations made in the original inspection. Inspectors use one of the following terms in describing this progress: very good progress, good progress, partial progress or no progress.

**The DE inspectors spent one and a half days in the education centre and the following activities took place during the Follow-Through inspection:**

- Meetings with the head teacher and deputy head teacher
- Classroom visits
- Discussion with teachers
- Discussion with students
- Review of centre documentation and records
- Feedback meeting with the head teacher and deputy head teacher

## Findings on progress made on recommendations

1. **There is scope for the Education Centre to further explore how they could embed initiatives to support students' social, emotional, and physical wellbeing across the curriculum.**

**Good Progress**

To address this recommendation the centre had broadened the curriculum. Cookery, crafts, yoga and mindfulness lessons had been integrated into the weekly timetable and uptake of these curricular options was good. Students spoke positively about these opportunities. To support students' social and physical wellbeing students who had completed the cookery courses were selected on a weekly basis to cook a meal for their peers, which they shared together. The centre facilities were also expanded since the original inspection to include three new classrooms.

The Red Cross volunteer programme continued to be developed and played a central role in supporting student wellbeing. For example, students involved in this initiative spoke with other people on their landings and conducted a survey to identify any issues related to their wellbeing. A number of Red Cross volunteers received training to deliver a workshop developed by the assistant psychologist to support various issues identified in the survey, facilitating peer-to-peer learning.

There was scope to further embed opportunities to support students' social, emotional and physical wellbeing across the curriculum, for example, through cross-curricular or themed initiatives. Staff should continue to engage with this recommendation.

2. **It is recommended that the centre management explore opportunities for teachers to share very good teaching and learning practices with each other. Further teacher professional learning (TPL) on teaching and learning approaches, including for special educational needs (SEN), to support adult learners should also be provided.**

**Partial Progress**

In order to address this recommendation, the centre management, through the City of Dublin Education and Training Board (ETB), arranged teacher professional learning (TPL) on supporting students with dyslexia and Attention Deficit and Hyperactivity Disorder (ADHD), as well as trauma informed practice. Teachers also engaged with other relevant courses in their own time.

Staff meetings were held regularly, however these largely focused on organisational and administrative matters. Training, teaching, and learning should now be included regularly on the agenda to provide opportunities for staff to share practice. In addition, actions arising should be noted and reviews of progress should be included in subsequent meetings.

3. **It is recommended that the organiser of education, head teacher, and staff come together and engage in a process of self-evaluation and development of a centre improvement plan. This plan should include key priorities for development, associated actions for the achievement of these priorities and a process to monitor and review the implementation of the plan.**

**No progress**

The head teacher actively engaged with the organiser of schools and the heads of the other centres under the auspices of the City of Dublin ETB in the development of a centralised quality improvement plan. However, this plan was applicable to all educations centres and the process did not identify key issues that were relevant to the education centre in Cloverhill. The head teacher, in collaboration with staff and the organiser of schools, should engage in a process of self-evaluation and development of a centre improvement plan in order to address this recommendation.

4. **It is important that the time students are brought to classes is monitored closely by prison management and the head teacher, to ensure optimal access and time in the centre for students.**

**Partial Progress**

Access to education was the main form of structured purposeful activity offered in the prison, Centre management had effective systems in place to monitor attendance and punctuality at the education centre. From the records reviewed, classes did not begin at the scheduled time of 09:30 on most days. There was also a delay in the commencement of classes in the afternoon. Additionally, the centre was either fully or partially closed for 11 out of the 27 available education days in the month prior to the follow-through evaluation. The centre reported operational reasons for these closures. This situation impacted significantly on students' access, engagement, and continuity of learning. To ensure that people in the prison can fully avail of the services provided by the centre, prison management and the head teacher need to work more closely on these issues to ensure optimal access and time in the centre for students is maximised.

5. **Opportunities to extend educational access through blended learning and the use of digital technologies for people who are on protection and for those that wish to attend the school but are on the waiting list, should be explored by the IPS and prison management in collaboration with CDETB.**

**Partial Progress**

The centre implemented a recent initiative to provide a limited outreach programme to people in prison on protection. This involved staff from the centre working with individual students on the landings one afternoon per week. This positive initiative focussed on assessing and establishing a baseline of their educational needs with the view to supporting them to transition into courses within the centre, where possible.

Blended learning has been identified as a key pillar of the City of Dublin ETB Digital Strategy. During lesson observations it was evident that students had access to computers in the centre to complete various assignments and engage with relevant courses. However, at the time of the evaluation, the available technology was not being used to extend educational access through blended learning to the people who are currently not able to attend the centre for various reasons.

The IPS, prison management and City of Dublin ETB should continue to work collaboratively to ensure the available technology is utilised effectively to support the educational needs of people in prison.

**6. In order to better manage the day-to-day changes in the cohort, centre management should conduct a review of the current structures for managing the integration of new students.**

**Good Progress**

The centre has developed an appropriate induction programme for new students. The induction runs over two classes and concludes with a meeting with the head teacher so that students can choose subjects and are provided with a timetable. The induction included a class to welcome students and give them an overview of the educational courses available, the opportunities offered by the centre to support them to gain certification at various levels, and they are provided with information on co-curricular initiatives accessible to them such as the Red Cross programme and Gasice. Students' literacy and numeracy skills are ascertained using centre-designed assessments in another class.

To further manage the integration of new students, staff involved in the induction programme should develop induction activities to establish what students would like to achieve from participating in the centre and the expectations of the centre and relevant coursework. The use of teambuilding and ice breaking activities, and some practical sessions may support students in this transition stage. A student handbook could also be provided and contain useful information presented in a user-friendly format.

**7. There is a need to introduce more formal structures for sharing information on students' educational profile with teachers. As part of the induction process centre staff should create an Adult Basic Education (ABE) plan with each student which outlines needs, interests, learning and future goals and informs provision.**

**No progress**

Information continued to be shared on an informal basis. Teachers were provided with class lists each day. If there was a new student, teachers could speak with the centre management informally regarding the students educational needs. It is recommended that a formal system be developed to share information on students' interests, priority learning needs and strategies to support learning to inform planning for teaching and learning.

8. **Further planning is needed to safely facilitate the implementation of the proposed new subjects that will be in place following the expansion of the Education Centre. This planning should include a risk assessment to establish health and safety procedures that will need to be put in place to support effective engagement with teaching and learning in these subjects.**

**Good progress**

The prison management conducted a risk assessment of new classrooms developed to facilitate subject such as crafts and cookery. As a result, prison and centre management had put measures in place to mitigate risk for students engaging in cookery lessons, in particular. These included that all students who wished to attend this class were required to firstly complete the Food Safely Authority course (FSAI) and sign a code of conduct. In addition, there was a system in place to monitor food safety and hygiene within the cookery room on a regular basis.

Health and safety risk assessments were conducted in the centre by an assistant governor with responsibility for Health and Safety. It is important that centre staff are also involved in conducting these risk assessments and a clear system was in place for reporting risks to the relevant personnel to ensure any risks identified were managed appropriately and efficiently. Best practice is to complete a risk assessment annually, or more often if a new piece of equipment is purchased or a room has been repurposed.

# Appendix: Press Release on Follow-Up Inspection to Cloverhill Prison

## Prisons Watchdog Returns to Cloverhill

**Dublin, 17 December 2024**

Ireland's statutory prisons watchdog, the Office of the Inspector of Prisons (OIP), has recently completed an unannounced follow-up inspection of Cloverhill Prison, Dublin. The Inspectorate's three-day visit concluded on Wednesday 11 December 2024, with a formal meeting at which the Inspectorate shared its preliminary findings with the Governor, senior staff and a representative of the Irish Prison Service (IPS).

The purpose of this inspection was to follow up on the unannounced general inspection of Cloverhill Prison carried out by the Inspectorate from 15 to 25 May 2023, as well as an on-site visit to Cloverhill by the Chief Inspector of Prisons on 5 October 2024, in the immediate aftermath of the violent death of a prisoner at that establishment.

Section 31(1)(c) of the Prisons Act 2007 provides that the Chief Inspector may "in the course of an inspection or arising out of an inspection bring any issues of concern to him or her to the notice of the Governor of the prison concerned, the Director-General of the Irish Prison Service, or the Minister". Following the unannounced general inspection of Cloverhill Prison in May 2023, on 1 June 2023, the Chief Inspector raised serious concerns regarding the degrading conditions in the cells at Cloverhill Prison with the Director General of the IPS and the Minister for Justice.

Speaking after the recent follow-up inspection, Chief Inspector Mr Mark Kelly said:

"At the time of our May 2023 inspection of Cloverhill, 38 people were sleeping on mattresses on the floor in overcrowded, stuffy and malodorous cells. Out-of-cell time was very limited for many prisoners. The in-cell lavatories at Cloverhill were not partitioned and prisoners ate breakfast, lunch and dinner in these highly restricted spaces. The Inspectorate concluded that inter-prisoner violence was the inevitable result of confining four adult men in these degrading conditions. By the time of our December 2024 follow-up inspection, the number of people sleeping on mattresses on the floor had risen to 68 and the prison was 117% overcrowded."

"The degrading conditions seen in cells at Cloverhill Prison continue to have a critical adverse effect on the people living there."

The follow-up inspection visit was carried out by:

- Mark Kelly, Chief Inspector
- Michelle Martyn, Lead Inspector
- Dr. Sarah Curristan, Inspector
- Matthew Butterly, Inspector

The Inspectorate of Prisons was assisted by Frances Moss and Ger Quirke, from the Department of Education Inspectorate. (*)

**Notes to the Editor**

The Office of the Inspector of Prisons is a statutory body, independent in how it carries out its work, set up under the Prisons Act 2007.

The law underpinning the role of Chief Inspector of Prisons is set out in Part 5, Sections 30 to 32 of the Prisons Act 2007. Section 30 provides for the appointment of the Chief Inspector, Section 31 sets out the functions of the Chief Inspector and Section 32 specifies the requirement to submit an Annual Report to the Minister for Justice, by 31 March in any year. The Inspectorate's Annual Report for 2023 was submitted to the Minister on 29 March 2024. Section 32(3) of the Act provides that, "as soon as practicable" after receiving the Annual Report, the Minister for Justice shall "cause a copy of it to be laid before each House of the Oireachtas and to be published".

Under Section 31 of the Act, the Chief Inspector of Prisons is obliged to carry out regular inspections of prisons and for this purpose may: at any time enter any prison or any part of a prison, request and obtain from the Governor a copy of any books, records, other documents or extracts from such documents, and, in the course of an inspection or arising out of an inspection bring any issues of concern to the notice of the governor of the prison concerned, the Director General of the Irish Prison Service or the Minister as the Chief Inspector considers appropriate.

The Chief Inspector may, and must if he receives a request from the Minister, investigate any matter arising out of the management or operation of a prison and shall submit to the Minister a report on any such investigation.

Governors, prison officers, other persons employed in prisons and prisoners, must as far as reasonably practicable, comply with any request for information that the Chief Inspector may make in the performance of his functions.

Since 2012, the Chief Inspector has also been obliged to investigate the circumstances of all deaths in custody and those within one month of temporary release from custody. To date in 2024, there have been 27 deaths falling within the Inspectorate's mandate, all of which are being independently investigated.

In addition to the legislative authority derived from the Act, the Chief Inspector has specified functions under Prison Rules 2007-2013 in relation to the Irish Prison Service Prisoner Complaints Procedure (Rule 57B) and letters from prisoners (Rule 44 (1) (h)).

It is anticipated that, in the near future, the Inspectorate will become the Inspectorate of Places of Detention, with an expanded remit as the National Preventive Mechanism for the Justice sector under the Optional Protocol to the United Nations Convention against Torture (OPCAT).

(*) The OIP has concluded a Memorandum of Agreement with the Inspectorate of the Department of Education, enabling it to benefit from the expertise of colleagues from that Inspectorate when assessing educational provision in prisons.

For further information, please see: www.oip.ie

**ENDS**

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