An Roinn Dlí agus Cirt,
Gnóthaí Baile agus Imirce
Department of Justice,
Home Affairs and Migration

Death in Custody Report for Mr. J 2020

Statement on the Redaction of Section 12 of the Death in Custody Report

Section 12 of the Death in Custody report for Mr. J 2020 contains a summary of information contained in the Postmortem Examination Report prepared by the State Pathologist for the Coroner.

Under the Coroner's Act 1962, as amended, it is the duty of a coroner to hold an inquest in relation to the death of a person who was, at the time of his / her death, in state custody or detention. The postmortem examination report is submitted to the coroner to assist in the death investigation process.

The Minister has, in accordance with section 31 of the Prisons Act 2007, omitted from this Death in Custody report section 12 relating to the post mortem examination, on the basis that it would be contrary to the public interest to publish it in this report.

13 February 2026

Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. J
Cloverhill Prison
28 September 2020

Submitted to Minister: 25 October 2024

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GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
C&R	Control and Restraint
CCTV	Closed Circuit Television
CPD	Continuous Personal Development
CPR	Cardiopulmonary Resuscitation
IPS	Irish Prison Service
IV	Intravenous
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PEA	Pulseless Electrical Activity
PICLS	Prison In reach and Court Liaison Services
PPE	Personal Protective Equipment
WTO	Work Training Officer

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 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, 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. J's death in prison on 28 September 2020 and management of the events associated with his death.

4. Administration of Investigation

4.1 On 28 September 2020, the OIP was notified that Mr. J had passed away while in the custody of Cloverhill Prison. The then Chief Inspector attended the prison on the same day and met prison management who provided an overview of Mr. J's time in prison.

4.2 Prison management provided the investigation team 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. J's NoK (his father) on 7 December 2020. Mr. J's father provided a detailed description of Mr. J's background and wanted to understand the circumstances surrounding his son's death.

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

5.4 The OIP is grateful to Mr. J's father for his contribution to this investigation and we offer our sincere condolences on his loss.

6. Criminal Investigation

6.1 An Garda Síochána conducted a criminal investigation into the circumstances surrounding the death of Mr. J while in custody.

6.2 As a criminal investigation takes precedence over other investigations, the OIP investigation was suspended pending the conclusion of the criminal investigation.

6.3 In June 2023, the OIP became aware of the Office of the Director of Public Prosecutions' decision that no person was to face criminal prosecution in respect of Mr. J's death. The OIP investigation team recommenced its investigation by examining the documentation, reviewing CCTV footage and requesting further information.

7. Cloverhill Prison

7.1 Cloverhill Prison is a closed, medium security prison for adult males, which primarily caters for remand prisoners committed from the Leinster area. At the time of Mr. J's death it had an operational capacity of 431.

7.2 Mr. J was the first death of a prisoner from Cloverhill Prison in 2020 and the tenth death in IPS custody that year.

8. Family Concerns

8.1 Mr. J's father requested information on the events that unfolded on 28 September 2020. He expressed deep concern that the actions of officers in restraining his son had contributed to his son's death.

8.2 The circumstances surrounding the death of Mr. J are outlined in this report.

9. Background

9.1 Mr. J was a remand prisoner, committed to Cloverhill Prison on 23 September 2020. His next court appearance was scheduled for 28 September 2020. This court appearance was arranged via video-link from the prison.

9.2 Mr. J was accommodated in single Cell 2 on the D2 landing on the first floor of Cloverhill Prison. The D2 landing accommodates prisoners with enhanced medical needs (somatic and psychiatric). Many of the prisoners require additional supervision and care, with all the prisoners on the landing being deemed too vulnerable to cope in the general prison population.

9.3 Prisoners on D2 landing are assessed by the Prison In reach and Court Liaison Service (PICLS) team. The objective of the PICLS team is to improve the identification of people suffering mental health issues when they are remanded to prison. The scheme aims to assist patients, the criminal justice system and local psychiatric services, by ensuring a rapid response and systematically identifying prisoners with a primary diagnosis of psychotic illness.

9.4 In accordance with the IPS COVID-19 algorithm in operation at the time, Mr. J was placed on a restricted regime under Rule 103[1] of the Prison Rules 2007-2020. This was part of the IPS COVID-19 infection control measures to reduce the risk of COVID-19 entering the prison through new committals.

[1] Where a prison doctor believes there is a serious risk to the health of a prisoner and makes a recommendation in writing on medical grounds in relation to that prisoner to the Governor, the Governor shall, subject to paragraph (2), implement the recommendation as soon as may be thereafter. (2) Subject to any direction of the Director General under paragraph (4), the Governor may, for the purpose of maintaining good order and safe and secure custody or on other reasonable grounds, decide not to implement a recommendation under this Rule (other than a recommendation that a prisoner, who is suffering from, or suspected of suffering from, a contagious or infectious disease or condition that threatens the health or well-being of others, be segregated in order to prevent the spread of the disease or condition) after - (a) discussing the matter with the prison doctor, and (b) taking account of the likely impact of not implementing the recommendation on the prisoner.

10. Events of 28 September 2020

10.1 As per the committal warrant, Mr. J was due to appear before the District Court via video-link at 10:00 on 28 September 2020.The video-link booth was located on the ground floor, just off the main circle[2] at Cloverhill Prison.

10.2 At approximately 10:36, Assistant Chief Officer (ACO) A, Officer A, Officer B and Officer C arrived at Cell 2 on the D2 landing. Officer D, Officer E and Officer F were already at the cell and were engaging with Mr. J regarding his appearance before the Court. ACO A reported speaking to Mr. J at his cell door and Mr. J was refusing to attend the Court. Officer E reported that "*we tried to cajole him to come with us, but he kept saying no I'm not going and where am I going and why am I going there"*. It was reported by ACO A that Mr. J initially refused to leave his cell by holding the bed frame but then he became compliant and agreed to attend the Court.

10.3 At approximately 10:40, Officer D, Officer E and Officer F donned Personal Protective Equipment (PPE) before entering Mr. J's cell. Officer D and Officer E exited Cell 2 with a light hold of both Mr. J's arms. Mr. J was wearing a PPE face mask which was the standard Covid-19 face mask in use across the prison estate at this time. ACO B joined colleagues in escorting Mr. J from the D2 landing.

10.4 Escorting Officers and Mr. J descended the central stairwell from D2 landing, entering the stairwell at 10:44:54 and arrived at the main circle on the ground floor at 10:45:26. Mr. J, escorted by the officers, walked across the circle towards the video-link booth but, as they approached the video-link booth, Mr. J refused to enter - this was at 10:45:34. The CCTV footage showed Mr. J physically resisting and he grabbed the metal partition bars of the entrance gate from A1 landing to the circle.

10.5 Work Training Officer (WTO) A joined the escort team at 10:45:47 and could be seen on CCTV footage assisting officers as they were physically removing Mr. J's grip from the bars. Mr. J was then carried in a prone position by nine officers to the center of the circle and placed on the floor in a prone position - this was at 10:45:53.

10.6 On 28 September 2020, WTO A in his role as a Work Training Officer had been detailed to work in the kitchen. WTO A was not involved in the escorting of Mr. J from his cell to the video-link booth. The footage shows WTO A enter the circle area wearing kitchen worker attire (whites) and taking the lead role in the Control and Restraint (C&R) of Mr. J. WTO A reported that he first observed the situation unfolding and stated that Mr. J became aggressive and was failing to comply with officer orders. WTO A reported that he "*immediately responded to this spontaneous incident and made myself available to be of assistance to staff*". WTO A was seen on CCTV footage leaving the circle briefly and returning with restraint handcuffs. At 10:47:18, WTO A proceeded to place handcuffs on Mr. J while in he was in the prone position on the floor, with his hands placed behind his back and restrained by officers.

10.7 ACO B stated that WTO A "*signaled*" to him that he would take over the relocation of Mr. J. ACO B reported being satisfied with WTO A taking charge as WTO A was a C & R Instructor. WTO A confirmed that he was a C & R Instructor and further reported that he "*was the only qualified control and restraint instructor on duty that day and normal custom and practice would be that a control and restraint instructor would take charge of an incident like this*".

[2] The main circle is a central location for accessing all prisoner wings and the healthcare unit.

10.8 At 10:50:30, Mr. J was raised to his feet under the physical control of officers. Officer D had control of Mr. J's right arm. Officer F had control of the left arm. Officer E had control of Mr. J's head and Officer C was standing behind Mr. J. There was a large number of other officers present in the circle but at this time they did not have physical contact with Mr. J.

10.9 It was reported by officers involved that Mr. J physically refused to walk. The CCTV footage viewed corroborated the officers' accounts, the footage showed Mr. J's body language as appearing to resist moving. At 10:50:50 officers brought Mr. J to the floor again. Mr. J was held in a prone position on the floor of the circle. WTO A reported that Mr. J struggled on the floor and kicked his legs at officers. Officer E reported that "*at this stage he (Mr. J) was spiting [sic]".*

10.10 At 10:51:20, WTO A placed Velcro straps around Mr. J's legs. He then placed a spit hood[3] over Mr. J's head. The footage showed Mr. J on the floor, face-down kicking and he appeared to be firming his limbs and struggling to get free. At this time Mr. J was surrounded by officers. In relation to the placing of a spit hood on a prisoner the IPS C&R Manual states that "*an anti-spit mask may be placed over a prisoners head but the 'prisoner shall continue to be monitored for medical warning signs'*." Officer E reported that "*there was mucus and a small bit of blood coming out of his mouth and nose*" but there was no evidence in any of the documentation reviewed by the investigation team or in the footage viewed that a doctor or nurse was called to medically assess Mr. J at this time.

10.11 At 10:52:57, officers physically lifted Mr. J and carried him in a prone position. Mr. J's legs were not in contact with the floor. Officer B carried Mr. J's right leg and Officer C his left leg. Officers carried Mr. J towards the stairwell entrance located off the circle. ACO B reported that he hunched down to speak to Mr. J in an effort to persuade him to walk back up the stairs to the D2 landing. The ACO reported that Mr. J did not answer but continued to physically struggle with officers. It was not possible for the investigation team to verify from the CCTV footage if an officer '*hunched down to speak to Mr. J*' as the view of Mr. J's head was obscured by the number of officers involved in the escort. However, it could be seen from the footage that Mr. J was physically struggling. The C&R team carrying Mr. J entered the stairwell at 10:53:42.

10.12 WTO A reported that while on the fourth or fifth step of the stairwell Mr. J was placed in a rest position and the spit hood was removed. It was reported that Mr. J refused to comply with officers and "*growled*" at officers. Officer B and Officer C reported that WTO A instructed officers how to carry Mr. J and directed that Mr. J be carried up the stairs to the D2 landing. WTO A's account of what occurred in the stairwell differed from that of ACO A and the officers as WTO A's recollection was that "*someone suggested we carry him up the stairs*". It was not possible for the investigation team to verify what occurred on the stairwell as only the entrance to the stairwell and a few of the initial steps of the stair were covered by a CCTV camera. It could be seen that Mr. J was in a prone position as the ascent of the stairs commenced. However, any further interactions between Mr. J and the C & R team in the stairwell during the following two and half minutes took place in a CCTV "blind spot".

10.13 Mr. J arrived back to the D2 landing at 10:56:31 carried in a prone position. It had taken Mr. J 32 seconds to descend the stairs to attend court and 2 minutes 37 seconds to be carried back up the stairs by the C&R team to D2 landing.

[3] A spit hood is a restraint device intended to prevent a person from spitting or biting.

10.14 Officer E reported that on entering D2 landing from the stairwell he checked Mr. J's head and stated "*I knew something wasn't right with him [Mr. J] I immediately told everyone to stop and we placed Mr. J on the ground. His head got very heavy and didn't seem to be supporting itself. I also couldn't feel him breathing on my hands. When I turned his head it was blue*". Officer D reported that upon arriving on the D2 landing "*someone said to put him down he's gone blue or purple or something along those lines".*

10.15 At 10:56:34, Mr. J was placed on the D2 landing floor in a supine position. Officers immediately called and gestured towards Nurse A to assist. Nurse A was present on the D2 landing at the time. Upon observing Mr. J, Nurse A immediately called a Code Red[4] medical emergency. Officers removed all restraints from Mr. J. Nurse A departed towards a central stairwell on the D2 landing to collect medical equipment.

10.16 At 10:57:45, WTO A began Cardiopulmonary Resuscitation (CPR) on Mr. J and this was continued in rotation by Officer D and Officer G. At 10:58:11, Nurse A, Nurse B, Nurse C and Nurse D arrived with an Automated External Defibrillator (AED) and other medical equipment including an oxygen mask which was placed on Mr. J by nursing staff, who also took over CPR attempts.

10.17 At 11:02:16, an AED was placed on Mr. J which administered a shock. Nursing staff continued CPR attempts between AED shocks being administered. At 11:04:16, Doctor A, arrived followed at 11:05:33 by Doctor B. At 11:12:36, Doctor B reported that upon his arrival he observed the actions of the nursing staff and believed everything was being done to revive Mr. J.

10.18 At 11:12:11, paramedics from Dublin Fire Brigade arrived on the D2 landing and took over resuscitation attempts of Mr. J. Paramedics from the National Ambulance Service also arrived on the landing. An intravenous line was inserted into Mr. J and manual CPR attempts continued with two further AED shocks administered.

10.19 Doctor B recorded on the Prisoner Healthcare Management System (PHMS) that during resuscitation attempts Mr. J was asystole[5], commonly referred to as 'flat lining'. However, on three occasions Mr. J displayed Pulseless Electrical Activity[6] (PEA) meaning there was cardiac activity. Doctor B, using a stethoscope could not hear a heartbeat or feel Mr. J's pulse (carotid, femoral or radial) during indications of PEA. Doctor B further reported that after approximately 20 minutes of attempts to resuscitate Mr. J the ambulance paramedics requested his (Doctor B's) clinical opinion. Doctor B recorded on PHMS that he gave instructions that Mr. J be transferred to hospital with CPR to be continued *en route*. Dr. B noted that the ambulance PEA protocol recommend transfer to hospital unless a doctor advises otherwise.

10.20 At 11:39:40, Mr. J was placed onto a stretcher and removed from D2 landing via a lift located on the D2 landing. At 11:42:28, Mr. J was conveyed through the central circle and departed Cloverhill Prison by ambulance at 11:50:00 to make the 10km journey to Tallaght University Hospital.

[4] Emergency call to initiate an immediate response to a serious medical emergency.
[5] When the heart's electrical system fails entirely, causing the heart to stop pumping.
[6] Type of irregular heart rhythm, a malfunction of the heart's electrical system.

10.21 The death of Mr. J was pronounced at 12:12 at Tallaght University Hospital. At approximately 12:30, Cloverhill Prison was informed that Mr. J was pronounced deceased. Members of An Garda Síochána relayed the sad news of Mr. J's passing to his father.

11. Medical History

11.1 Mr. J had a history of health issues including: psychosis, personality disorder, anxiety and epilepsy. Mr. J had been prescribed the anti-psychotic drug Olanzapine following committal which was administered daily during the evening medical rounds. Mr. J had also a history of self-harm and had suffered drug overdoses in the past.

11.2 As stated earlier in the report Mr. J was placed under the care of the PICLS team. Psychiatric notes created by Psychiatric Nurse A recorded that Mr. J informed them that while in the community members of An Garda Síochána had made attempts to have him admitted to mental health services. He reported that he was repeatedly turned away.

12. Post Mortem Findings

[redacted]

13. CCTV Review

13.1 The investigation team reviewed CCTV footage of Mr. J. The timeline was as detailed in **section 10.** The investigation of the circumstances leading to his death was complicated by the absence of CCTV coverage of some critical areas. For instance, part of the footage from the circle was from the nurse's station which was viewed through partitioned bars. Further, as already mentioned, there was a camera covering entry to the stairwell from the circle which captured the first section of the stairwell but there was no camera covering the remainder of the stairwell to D2 landing. The OIP was pleased to learn that a camera was installed in the stairwell following this incident.

13.2 Mr. J refused to enter a remote court sitting, a video-link booth, by taking hold of partition bars. The situation escalated quickly on the arrival and instruction of WTO A. It is clear from CCTV footage that WTO A took the lead role and was the person who gave direction to other staff involved in restraining Mr. J.

13.3 Mr. J was viewed resisting the C&R techniques of officers and was secured in a prone position on the floor. It is not possible to ascertain the exact level of physical force used in keeping Mr. J secured in a prone position but officers could be seen placing pressure on Mr. J's back which in turn placed pressure on Mr. J's chest, which was in contact with the floor.

13.4 Restraints were applied to Mr. J's hands and to his feet which were crossed before the restraints were applied. A spit hood was placed over Mr. J's head. At no point was Mr. J placed on his side or given an opportunity to sit upright on the floor. He was held in the prone position by the C & R team. Mr. J was then lifted and carried in a prone position to the stairwell.

13.5 Mr. J appeared to wriggle while being held in a prone position. While being lifted up the initial few steps of the stairs one of Mr. J's shoes fell off. The investigation team was only provided with footage of the lower part of the staircase (D1) given the absence of a camera covering the remainder of the stairwell. On arrival on the D2 landing, 2:37 minutes from the time the C&R team entered the stairwell, Mr. J appeared motionless and lifeless. Mr. J was wearing grey tracksuit bottoms which on arrival on D2 landing appeared to be soiled at the front.

13.6 On exiting the stairwell Mr. J was placed on the D2 landing floor. Only at this point did prison officers appear from the footage to become concerned about his state of health, gesturing to the nurse on the landing for urgent assistance.

14. Critical Incident Review Meeting

14.1 On 28 September 2020, a Critical Incident Review Meeting[7] was held by Governor A and Governor B. In attendance were Chief Officer A, Doctor B, ACO A, ACO B, WTO A, Nurse C, Officer D, Officer G, Staff Support Officer A, Chaplain A and Psychologist A.

14.2 At the opening of the meeting Governor A commended staff for their "*excellent reactions and professionalism*" during a stressful incident. A timeline of events was provided by staff. Information was recorded that, on the previous day, Mr. J had prevented his cellmate from exiting his cell to attend recreation.

14.3 WTO A provided details on how he heard a commotion as he was passing through the circle and noted how Mr. J was holding onto the gate near the video-link room and WTO A began giving advice to officers.

14.4 ACO B stated that it was decided amongst staff that as WTO A was a Control and Restraint Officer that he would take the lead role.

[7] Staff meeting held following the death of a prisoner.

14.5 WTO A reported that Mr. J was non-compliant throughout and dropped to the ground repeatedly. WTO A described Mr. J as a "*dead weight*" and that officers had to rotate positions as they were tiring.

14.6 Doctor B reported that he had received a call that a prisoner was unresponsive on the D2 landing. When he arrived he could see that everything was being done to revive Mr. J. Paramedics inserted an IV line, continued manual CPR and use of an AED which delivered shocks to Mr. J a further two times following nursing staff having already shocked him twice. Doctor B commended staff for "*their calm and concise reaction to the situation*".

14.7 Staff Support Officer A raised concerns that members of An Garda Síochána arrived at Cloverhill Prison and wanted to interview staff so soon after the incident.

14.8 Chaplain A reported that members of An Garda Síochána had informed Mr. J's NoK of his passing. Chaplaincy confirmed they had been in direct contact with the NoK and stated that the family were informed that the IPS would make a contribution to the cost of Mr. J's funeral.

14.9 Five observations were recorded at the conclusion of the Critical Incident Review Meeting:

1. Cloverhill Prison required more Staff Support Officers.
2. An Garda Síochána interviews took place immediately which was more traumatic for officers immediately after the incident.
3. There was need for a chest compression machine.
4. More CPR training was required for officers.
5. There were Trainers already working in Cloverhill Prison who could provide CPR training.

15. Control and Restraint Manual

15.1 The investigation team reviewed the IPS Control and Restraint manual. The aim of control and restraint training is stated as being *"to provide the service with legitimate and humane means of resolving promptly, with minimum injury to staff and prisoners, those incidents where the use of force is necessary*."

15.2 It is axiomatic that all officers trained in C&R should be fully aware of the dangers associated with C&R outlined in the manual.

15.3 It is acknowledged in the manual that serious medical incidents are extremely rare in the application of physical or mechanical restraint. The manual also points out that it should be known that persons have died as a result of being restrained in both prison and police custody. The manual directs that if it is possible a prisoner's abnormal behavior may be a result of mental illness advice should be sought urgently from healthcare staff before control and restraint techniques are employed, if possible.

15.4 Mr. J was accommodated on the D2 landing which is a designated area to accommodate vulnerable prisoners suffering from mental illness but there is no evidence in the medical records provided to the investigation team or in any other documentation examined that the escorting

staff sought the advice of the healthcare staff prior to C&R techniques and restraints being applied. Mr. J was accommodated on D2 landing so consequently the escorting staff and particularly the ACO should have known that Mr. J may have been suffering from mental illness.

15.5 The manual also states that the supervising officer must observe the prisoner for exceptional or unexpected strength, bizarre behaviour, noisy or laboured breathing, coughing or foaming at the mouth and appearance becoming blue/purple or very pale. The number of staff involved in restraining Mr. J indicates that he may have displayed exceptional or unexpected strength; there were nine officers originally involved in the restraint who were changing position, others were coming and going while other officers looked on. Officer E reported that Mr. J had spat and appeared to have mucus and blood coming from his nose and mouth area. This occurred prior to the application of a spit hood to Mr. J, yet with this knowledge a spit hood was placed over Mr. J's head and there is no evidence that any healthcare advice was sought. This is contrary to the guidance given in the C&R manual.

15.6 A number of adverse effects arising from the use of C&R restraint are listed in the manual expressly including the dangers of positional asphyxia. The manual warns that *"restraining an individual in a position that compromises the airway or expansion of the lungs (i.e., the prone position) may seriously impair an individual's ability to breathe and lead to asphyxiation*". Factors that predispose persons to positional asphyxia and sudden death under restraint include; drug /alcohol intoxication, sedative drugs that reduce oxygen intake, physical exhaustion and obesity. Mr. J was prescribed Olanzapine and had an increased Body Mass Index of 40.2. The control and restraint of Mr. J took place over approximately 11 minutes (10:45:34 physically grabbed partition bars to 10:56:41 when Mr. J was placed on the D2 landing floor having exited the stairwell).

15.7 The manual also provides direction on the use of Velcro straps in the control and restraint of a prisoner. It details that Velcro straps may be required in "extreme circumstances" only and not to be used as routine day-to-day operation of a prison. "The use of Velcro straps will only be used on the authorization of an officer not below the rank of ACO". In this instance, the Velcro straps were drawn by ACO A, who was involved in the movement of Mr. J, but they were actually applied to Mr J by WTO A, who took the lead role relieving ACO B. This is visible on CCTV and is reflected in the agreed minutes of the Critical Incident Review Meeting, which record that "WTO A ordered for leg restraints to be put on the prisoner as he was kicking at staff". The investigation team were informed that WTO A had previously been a Control and Restraint Instructor. The investigation team were advised that the grade of WTO is a promoted grade but below the rank of ACO.

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15.8 The investigation team requested confirmation that officers involved in the C&R of Mr. J had passed control and restraint training and refresher courses. It was confirmed by the Irish Prison Service College that all the officers involved, at a minimum, had attended basic C&R training as part of their initial training entering the IPS.

15.9 The investigation team sought details on the nature of the training provided to officers.

Basic C&R training is provided to all prison officer recruits. It is delivered over 58 hours of practical instruction comprising many elements including:

- Use of Force
- Use of de-escalation techniques

- Medical considerations - Positional asphyxia, Excited delirium, Psychosis
- Personal Protection Techniques
- Wrist/Arm/Leg Locks
- Physical restraint
- Use of mechanical restraints
- Spontaneous incidents
- Stairs negotiation
- Compliant/Non-compliant/Armed violent inmate.

Qualification as capable of performing C&R is based on a practical assessment.

15.10 Continuous Personal Development (CPD) Training covers:

- Personal Protection techniques
- Use of batons
- Using mechanical restraints
- Control & Restraint techniques – Arm Locks/Wrist Locks, etc.
- Dealing with spontaneous incidents

15.11 The investigation team was informed that refresher training is provided to C&R Instructors only. It was further confirmed that WTO A had become a C&R Instructor in September 2013. WTO A obtained Instructor re-certification in 2014, 2015, 2016 and 2017.

15.12 In respect of the officers who had a central role in the C&R of Mr. J, the investigation team was advised that they all passed the Basic C&R initial training and completed refresher and CPD training as follows:

- Officer D completed last refresher training in early 2013 and attended CPD training in October 2018;
- Officer E attended refresher training 2016 and CPD training in 2019;
- Officer B completed refresher training in 2016 and CPD training in 2018;
- Officer C initial training was completed in February 2020; and
- Officer F completed initial C&R training in 2018.

16. Recommendations

16.1 The OIP has deep reservations about the manner in which Mr. J was restrained and about the extent of the external and internal injuries to his body revealed at Post Mortem.

16.2 It appears that some prison officers may not have complied fully with correct IPS C&R procedures, including by failing to seek healthcare advice when Mr. J showed initial signs of distress such as blood and mucus flow from his nose and mouth.

16.3 Consequently, the OIP has made five recommendations:

1. The IPS should review its control and restraint training programme to ensure that all officers called upon to perform restraint duties remain fully trained in the techniques and

are aware of the risks and dangers associated with C&R. In particular, all prison officers called upon to engage in the restraint of prisoners should receive ongoing awareness training on the risks of positional asphyxia and excited delirium associated with the use of C&R.

2. To be certified as competent in C&R, an officer should pass a technical and written examination to ensure officers performing C&R techniques fully understand the dangers in restraining prisoners in the prone position and the importance of seeking healthcare advice when considering restraining prisoners with physical and/or mental illness.

3. Where a prisoner with a mental health illness is non-cooperative, the advice of healthcare staff should be sought, if possible, before C&R techniques are applied. However, if a prisoner has a recognised mental health illness and/or has PICLS oversight, that prisoner should be risk assessed for any potential moves which may necessitate C & R.

4. The IPS should accelerate its programme of upgrading CCTV in Irish prisons, with a view to eradicating remaining “blind spots” in the coverage of communal areas, including stairwells.

5. Before chairing Critical Incident Review Meetings, Governors should seek to establish the basic facts regarding the incidents concerned, in order that they can highlight any shortcomings that need to be addressed as well as commending any good practices identified.

17. 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.