Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. D 2024
Cloverhill Prison
21 February 2024
Aged 50

To the Minister: 19 December 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
BBV	Blood-Borne Virus
CIRM	Critical Incident Review Meeting
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DFB	Dublin Fire Brigade
IVDU	Intravenous Drug Use
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 Irish Prison Service (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. D's death in Cloverhill Prison on 21 February 2024 and management of the events associated with his death.

4. Administration of Investigation

4.1 On 21 February 2024, the OIP was notified that Mr. D had died while in the custody of Cloverhill Prison. The investigation team attended the prison on 21 February 2024 and met prison management who provided an overview of Mr. D's time in prison. The inspection team also met with persons who had contact with Mr. D in Cloverhill 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. D's NoK and extended family by letter, phone calls and once in person, over the course of the investigation. A face-to-face meeting with the family (with the NoK's solicitor present) took place on 21 November 2024. During the meeting, several concerns were raised about Mr. D's death in custody. These concerns are documented in Section 7 of this report.

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. D's NoK in mind.

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

6. Cloverhill Prison

6.1 Cloverhill Prison is a closed, medium security prison for adults, which primarily caters for remand prisoners committed from the Leinster area. At the time of Mr. D's death, it had an operational capacity of 433 beds and on 21 February 2024, it held 493 men (which represented 114% of capacity on that date).

6.2 At the time of his death, Mr. D's was the first death of a prisoner from Cloverhill Prison in 2024; and the fourth death in IPS custody that year.

7. Family Concerns

7.1 Mr. D's NoK expressed concerns about his respiratory distress, his gradual decline over several hours, and the promptness of the response and appropriateness of the actions taken by the IPS during his medical emergency. They emphasised that they considered that Mr. D's death was fundamentally different from a sudden death, such as one resulting from suicide or overdose, and they considered that his death could have been prevented if more appropriate action had been taken in a timely way.

7.2 The NoK requested that the investigation team to provide information on the following:

1. Did the Irish Prison Service have prior knowledge that Mr. D had medical conditions, particularly focused on respiratory illness?

   This information is provided in the Medical Care section of this report.

2. A detailed timeframe of the IPS response to Mr. D's medical emergency from when it was first raised, until the time of his death.

   This information is provided in the body of the report within Section 9.

8. Background

8.1 On 24 October 2014, Mr. D was sentenced at Dundalk Central Criminal Court to a term of imprisonment totalling 13 years and six months. Mr. D was nearing the end of his sentence when he absconded from Shelton Abbey open prison on 16 June 2020. He was unlawfully at large until 3 January 2024. Mr. D was due to appear in Arklow Court on 21 February 2024, in relation to the absconding charge.

8.2 At the time of his death, Mr. D had been accommodated in cell 13 on the A2 landing of Cloverhill Prison. He was on the 'standard' status of the incentivised prison regime[1]. Mr. D had disclosed previous addiction issues but stated to the IPS healthcare team that he had been drug free for the preceding six years.

8.3 Mr. D shared cell 13 with Prisoner 1, Prisoner 2 and Prisoner 3. Prisoner 3 had been sleeping on a mattress on the floor of the cell at the time of Mr D's death. Prisoner 1 gave a detailed account to the investigation team which is included in Section 10 of this report. Prisoner 2 was released on 21 February 2024 and his whereabouts are currently unknown, while Prisoner 3 (released on the same date) was deported from the State. As a result, the OIP investigation team was unable to meet with these men to request their recollection of events.

9. Events of 20 and 21 February 2024

9.1 On the evening of 20 February 2024, Mr. D was accommodated in cell 13 on the A2 landing. Officers stated that routine cell and landing checks were conducted, as per IPS protocols, that evening and overnight. Officers reported that nothing unusual, regarding Mr. D or relating to his cell, happened until the first cell-call activation from cell 13 at approximately 21:20 on 20 February 2024. This was the time Mr. D reportedly first requested medical attention.

9.2 In her medical notes, entered on the Prisoner Healthcare Management System (PHMS) at 23:23 on 20 February 2024 (and in later written accounts), Nurse A recorded that she had been called to review Mr. D who had reportedly complained of difficulty swallowing over the past few hours. Nurse A noted that when she attended the landing and spoke to Mr. D at approximately 22:00, Mr. D stated that he *"feels like tonsils are enlarging/becoming painful [but] nil other concerns voiced".* Mr. D reportedly told Nurse A that the symptoms had only arisen in the preceding few hours. Nurse A provided Mr. D with paracetamol for pain relief and placed him on the GP list for review, the following morning. In her initial post-death report to the Governor, dated 21 February 2024, Nurse A further stated that when first asked to attend Mr. D by Officer A she was informed by the officer that Mr. D *"was in no obvious signs of distress and was agreeable to wait for a while before I attended A Division".*

9.3 At 03:11, on 21 February 2024, Nurse A added further clinical notes on the PHMS regarding her interaction with Mr. D. She recorded that she was "*called to cell [13] by Officer A at 12.55am when Mr. D complained of a sore throat – stated had difficulty breathing – had inhaler in possession".* Nurse A applied oxygen therapy (which was removed after ten minutes when Mr. D's oxygen levels reached 96%). She recorded in her PHMS notes that the blood pressure cuff

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

in the emergency bag would not fit around Mr. D's arm so an officer was sent to get the blood pressure machine with a cuff that would fit. At this time, Mr. D was reportedly sitting up in bed unsupported. The nurse noted that Mr. D was *"attempting to verbalise throughout [the] review – [he was] advised to allow [the] oxygen to work – When asked if he was experiencing pain elsewhere – [Mr. D] stated – no just my throat".*

9.4 The nurse took Mr. D's blood pressure reading at that point, with a recorded result of 130/88. Nurse A also stated that she administered *"Brufen liquid"* to Mr. D before she departed Mr. D's cell at 01:25. Five minutes later she was phoned and simultaneously called over the prison radio to re-attend Mr. D's cell. Upon arrival, she observed Mr. D lying on his back on the floor of the cell, unresponsive and with no pulse discernible. Nurse A, with the help of officers present, commenced cardio-pulmonary resuscitation (CPR) on Mr. D but to no avail. An Automated External Defibrillator (AED[2]) was brought to the cell but as no rhythm could be found, no shock was delivered. Reasons for no shock include that a pulse rate was detected or that there is no pulse detected but not in a shockable rhythm. According to Governor A, an ambulance was called at 01:05 and at 01:50, Dublin Fire Brigade (DFB) paramedics attended the cell and took over rendering medical assistance to Mr. D. Unfortunately, this additional medical intervention proved unsuccessful.

9.5 The prison doctor who attended Mr. D's cell on 21 February 2024, Doctor 1, recorded on the PHMS that she had been called-in to pronounce the death of Mr. D as a result of a phone call from Chief Officer A at 03:21 on 21 February. Doctor 1 noted that she arrived at Cloverhill Prison at 03:55 and attended the A2 Landing at 03:59 approximately (accompanied by Chief A and Governor A. She recalled that Assistant Chief Officer (ACO) A, Officer B and Garda A were also present.

9.6 Doctor 1, stated that she entered cell 13 on the A2 Landing at 04:00 and observed Mr. D, *"lying on the floor of cell with his upper body exposed [….] his eyes were semi-closed, there was an oropharyngeal airway[3] in situ secured in place, there was small traces of dried blood around mouth."* A visual check of the deceased's body by Doctor 1 revealed no visible signs of trauma or wounds and there were *"no obvious signs of life – no muscle movement, no respiratory effort, no response to verbal stimuli."* Mr. D's pupils were fixed and dilated and there was no *"palpable pulse"* or heart or breathing sounds. Time of death of Mr. D was pronounced by Doctor 1 at 04:05 on 21 February 2024.

10. Account of Mr. D's cellmate: Prisoner 1.

10.1 Prisoner 1, a cellmate of Mr. D since January 2024, provided a detailed statement to the investigation team on 21 February 2024. Prisoner 1 was one of four prisoners (including Mr. D) accommodated in cell 13 at the time of Mr. D's death. He recalled that, in his opinion, Mr. D "generally was of good health - he was healthy" but from about 20:00 on 20 February 2024, Mr. D complained of "having difficulty breathing with his throat".

[2] An AED is a portable, simple to use, computerised device. When someone suffers a sudden cardiac arrest ("heart attack") the device delivers a shock to the heart to allow it to resume its normal rhythm..

[3] An oropharyngeal airway is a rigid plastic tube which sits along the top of mouth and ends at base of tongue and is used to help keep a patient's airway open.

10.2 At approximately 20:15 on 20 February 2024, Mr. D activated, what Prisoner 1 termed, the "*emergency light*" in the cell. After 20 minutes, he spoke to an officer requesting a nurse but, in the words of Prisoner 1, *"the Officer said the nurse was busy with committals and would come up after."* At this time, according to Prisoner 1, Mr. D's breathing was laboured and he was sitting on the bed.

10.3 Prisoner 1, in his statement, recalled that at about 22:00, the nurse came to their cell and Mr. D told the nurse that he needed to go to hospital. The nurse instructed Mr. D to take two paracetamol, *"but you could see his neck was swollen on his left hand side."* Mr. D allegedly responded to the nurse, *"what the fuck is paracetamol going to do, my neck is swollen, I can't breathe".*

10.4 At some point after that, Prisoner 1 went to bed but recalls being woken when Mr. D started banging the cell door at 01:00 (the time according to Prisoner 1's recollection). Mr. D was saying, *"Boys I can't breathe, help me, help me",* while pacing the floor of the cell. Prisoner 1 also began to bang on the cell door. According to Prisoner 1, the nurse arrived at the cell about 20 minutes later. She also had, what Prisoner 1 described as, *"oxygen"* with her on this occasion.

10.5 Prisoner 1 went on to recount that the nurse then asked Mr. D how he was feeling to which Mr. D responded: *"I can't breathe, I want to go to hospital."* At this point, according to Prisoner 1, the nurse asked where Mr. D's other asthma inhaler was (as one was beside his bed) – Mr. D answered, *"I've asked you for it but I'm still waiting to get it."* Prisoner 1 alleged that Mr. D. was attempting to tell the nurse that he could not breathe with the face mask on, but the nurse was telling him to stop talking. It was also recalled by Prisoner 1 that the nurse tried to take Mr. D's blood pressure *"but the thing [the blood pressure monitor] was too small and an officer went to get a bigger machine".* The statement given by Prisoner 1 went on to add that he remembered looking at Mr. D's blood pressure reading which he stated was 132/80.

10.6 After taking Mr. D's blood pressure, Prisoner 1 stated that the nurse gave Mr. D a mouthful of liquid. Mr. D allegedly said to the nurse, *"it's not going down, it's stuck in my throat."* Prisoner 1 continued his recollection stating that the nurse, *"wanted to put a second drink into his [Mr. D's] mouth but he said he couldn't swallow. [Mr. D] was sitting on his bed for all of this. She started to take off the blood pressure machine and the oxygen mask to go and she gave him 5/6 sprays into the mouth and left his cell".*

10.7 When the nurse left the cell, Mr. D, in the words of Prisoner 1, *"was over beside my bed trying to get air at the window. He was plaguing us saying I can't breathe. I jumped down out of the bed and went over to the cell door and put the alarm on and started banging the door for the Officer to come back".* The officer returned to cell 13 and Prisoner 1 told the OIP investigation team that he and his cellmates informed the officer that Mr. D could not breathe, stating *"[Mr. D] was holding onto the bunk stairs at this time and he was going pure white from the head down. The officer went away then came back and said the medic has already seen him and there was nothing she could do".* At this point, the officer exited the cell but within a minute Mr. D *"started going blue and purple from the neck upwards. He started sliding down the stairs [of the bunk bed] to his knees. I reached for him and put him on his side and got a pillow and put it under his head. I was going to do CPR but seen blood on his tongue. I went back banging the door again, [a cellmate] was back banging the door too".*

10.8 Finally, Prisoner 1 recalled, after a few minutes the officer returned to the cell with the nurse, *"but you could tell he [Mr. D] was gone. I was on the floor holding his hand saying 'stay with us [….]' but you could tell he was gone".* Prisoner 1 then added that, at that stage (when the nurse arrived), they removed Prisoner 1 and the other occupants from the cell.

10.9 Concluding his statement, Prisoner 1 declared that, in his opinion, Mr. D was a *"fit man"* whom Prisoner 1 had never seen taking drugs, believing that Mr. D had given up taking drugs three to four years prior to his death in Cloverhill Prison.

10.10 The account provided by Prisoner 1 is at significant variance, in certain respects, to the notes made and/or accounts given by some of the IPS staff regarding their interactions with Mr. D on 20 to 21 February 2024.

11. Medical Care

11.1 On 3 January 2024, Mr. D was interviewed by Nurse B as part of the routine committal procedure. The PHMS notes, from 16:14 on 3 January 2024, recorded that Mr. D had a medical history of asthma and he used a Ventolin inhaler. Apart from that, he had no known drug allergies and disclosed that he had not used illicit drugs for over six years.

11.2 The Nurse Committal Interview was followed, on 4 January 2024, by a Prison Doctor Committal Interview when Doctor 2 noted on the PHMS at 10:06 that Mr. D had no COVID-19 symptoms or history of any such contact in the preceding two weeks. The doctor further recorded that Mr. D had a history of chronic diseases and was treated for Hepatitis C in 2016. Mr. D complained of pains in his shoulders, wrists and knees for the past year, exacerbated by cold temperatures. Doctor 2 also noted, under the category 'substance misuse', that Mr. D had *"injected heroin for 10 years, off [heroin] for six years to date. Smokes about 35 cigarettes a day. Drinks alcohol recreationally. no addiction".* The doctor further recorded that Mr. D had no known drug allergies. Mr. D's heart and chest examinations were both classed as *"normal"*.

11.3 On 14 February 2024, Cloverhill Prescribing Nurse C recorded on the PHMS, at 12:06, that Mr. D had attended the prison Hepatology In-reach clinic and requested Blood-Borne Virus (BBV) testing. She noted that Mr. D had denied intravenous drug use (IVDU) or other risk factors. He disclosed that he had been treated for the Hepatitis C virus in 2018 and claimed that he just wanted to check that he was still clear of the virus. Samples were taken from Mr. D at the clinic and sent for laboratory testing (which later turned-out to be negative). Mr. D did not have any other recorded interaction with the prison healthcare team after 14 February until the events of 20-21 February 2024.

12. CCTV Footage

12.1 The investigation team reviewed CCTV footage from the landing which also covers the outside of Mr. D's cell. The times recorded are taken from the IPS CCTV displayed clock. The footage captured the following:

12.2 Between 21:16:33 and 21:16:53 on 20 February 2024, an officer can be seen arriving outside cell 13 where he presses the cell-call reset button outside the cell. The officer then opens the cell hatch and peers inside. Next, the officer closes the hatch and heads back down the prison landing at what the investigation team considers an unhurried pace.

12.3 At 22:34:22, an officer and nurse arrive outside cell 13. Just over a minute later, at 22:35:27, the nurse slides a white item under the door of cell 13. At 22:36:50, the Nurse and the officer depart from outside cell 13 and head back down the landing. A group of prisoners can be seen at the far end of the landing.

12.4 A short time later, at 22:37:57, the nurse returns on her own outside cell 13 and opens the hatch and a few seconds later, at 22:38:02, closes the hatch of the cell and walks back down the landing.

12.5 Between 22:48:57 on 20 February and 00:47:52 on 21 February, an officer conducts a series of checks on cell 13, consisting of opening the hatch and peering inside the cell. Notably, at 00:47:52, the officer stops outside cell 13, presses the "call-cell" reset button then opens the hatch and looks inside. The officer then calmly closes the cell hatch and walks back down the landing at a normal pace.

12.6 Just over six minutes later, at 00:54:13, the officer returns to cell 13 accompanied by a nurse. Both the officer and the nurse look through the open hatch using a torch to illuminate the interior of the cell. Less than 30 seconds later, both the nurse and the officer leave from outside the cell and head back down the landing together.

12.7 At 00:56:53, a large group of officers (numbering approximately nine) arrive and congregate outside cell 13. A few seconds later, more officers join the group. About two minutes later, at 00:58:36, a nurse goes to the cell door with more officers. Four seconds after that, at 00:58:40, an officer opens the door of cell 13 and enters followed by the nurse and other officers.

12.8 The nurse exits cell 13 at 01:15:10 carrying what appears to be a white oxygen bottle, followed a short time later, at 01:15:22, by officers – the cell door then appears to be locked by an officer, with the group (including the nurse) walking off down the landing. One of the officers can be seen carrying an emergency "red bag" on his shoulder.

12.9 The CCTV footage next shows that an officer lifts the hatch of cell 13 to peer inside. This officer then walks away at a slow pace. Just over three minutes later, the same officer comes to the cell and opens the hatch to look inside again, walks away but returns a matter of seconds after that and peers inside cell 13 with a torch before walking off. At 01:23:06, a different officer appears and waits outside cell 13 until a short time later when another group of officers arrive.

12.10 At 01:26:07, additional officers arrive outside cell 13, including the nurse, at which point the cell is opened and officers enter. A prisoner is then directed out of the cell, followed a few seconds later by two other prisoners. Less than a minute later, at 01:27:10, an officer departs cell 13 and

runs down the landing. The same officer returns at speed at 01:28:07, carrying medical equipment and re-enters the cell.

12.11 Between 01:28:07 and 01:53:06, a large number of officers can be seen on the CCTV footage entering and exiting cell 13. Two DFB personnel (identifiable by their yellow-fire-resistant trousers) arrive at 01:53:36 and enter the cell, followed a few seconds later by a third DFB officer.

12.12 At 02:15:19, a uniformed paramedic exits cell 13 carrying medical equipment. Two other uniformed paramedics are part of the larger group observed moving in and out of cell 13 during this period. The door to cell 13 is locked by IPS staff at 02:19:59, on 21 February, after all of the various personnel have exited. The group of prison officers, DFB personnel and paramedics all disperse.

12.13 Three uniformed Garda members arrive at cell 13 at 03:06:13, escorted by prison officers, and enter the cell. A few minutes later, at 03:19:20, two Garda members leave cell 13 and walk back down the landing leaving one Garda member stationed outside cell 13 with a prison officer.

13. Critical Incident Review Meeting

13.1 At 14:30 on 29 February 2024, a critical incident review meeting[4] (CIRM) was held by Governor A. In attendance were: Chief A, Chief B, Acting Chief Nurse Officer (CNO) A, Doctor 1, Doctor 3, Nurse A and Chaplain A. The minutes were taken by Prison Clerical Officer A.

13.2 Governor A opened the meeting by explaining that the purpose of it was to discuss what happened and what actions were taken during the course of the incident involving Mr. D's death in custody. It was noted that ACO A, who was the ACO in charge on the night, was not available for the CIRM meeting.

13.3 Governor A then went on to deliver his version of events regarding the death of Mr. D on 21 February 2024. As part of that account, Governor A told those attending the meeting that he was contacted at approximately 02:00 and informed that Mr. D had died. The Governor went through the sequence of events as he recalled them. These details have already been presented earlier in this report.

13.4 Nurse A informed the meeting, in detail, about her involvement in the events surrounding the death of Mr. D. She recalled that while reviewing new committals in reception, she was made aware that her attendance was requested to see Mr. D but that, *"I was made aware it was not urgent".* Nurse A next stated that at about 22:00 she went to the landing and spoke to Mr. D through the cell door (which was normal practice according to Nurse A. Mr. D explained his symptoms to the Nurse, informing her that he had been suffering from a sore throat, *"which started a few hours before pressing the cell bell. No other pain was advised".* Nurse A went on to recall that she administered pain relief of 1mg of paracetamol after checking the PHMS for any allergies or underlying medical issues. She also listed Mr. D for review by the prison doctor for the next morning.

[4] Staff meeting held following the death of a prisoner. The purpose of the meeting is to review the circumstances and activities surrounding an incident, identify learnings, commend good practice and recommend changes, if required, to prevent a similar occurrence.

13.5 Nurse A continued her account by informing the meeting that *"I was called again to attend as [Mr. D] was complaining of a sore throat."* In her account, Nurse A did not mention a precise time regarding this re-call to attend to Mr. D. She continued her recollection saying: *"I requested the red bag [emergency medical kit] and the blood pressure machine […] as the BP [blood pressure] machine in the emergency equipment did not fit {Mr. D's] arm. I took his obs [observations] and gave him some oxygen."* Nurse A recalled that at this point, Mr. D was sitting on the edge of the bed without any assistance and attempting to speak throughout the Nurse's examination of him. *"His vitals settled and I advised him I would check on him again".*

13.6 Nurse A concluded her version of events by stating that approximately five minutes later she was *"called to attend A division again. On entering the cell [Mr. D] was on his back on the cell floor unresponsive with no pulse. I commenced CPR with the help of ACO A and Officer A taking turns. The AED device was used but as there was no response no shock was administered. The paramedics had then arrived and took over."*

13.7 Chief B told the meeting that at that point, Mr. D's cellmates were removed from the cell and brought to the recreation area. According to Chief B, after 30 to 40 minutes (at about 02:00), the paramedics decided to cease medical assistance and called for the doctor to attend the scene.

13.8 Officer A provided a very detailed recollection of his involvement in the response to the medical emergency and the events leading up to the death of Mr. D. He recalled that he was on night guard duty when he responded to a cell call activation from Mr. D at 21:20 [on 20 February]. Mr. D complained to him of a sore throat, but, according to Officer A, Mr. D said he *"could wait a while"* when asked by the officer if he required the nurse's attendance immediately. The officer informed the meeting that he then rang Nurse A and informed her of Mr. D's request. At approximately 22:20, Nurse A came to the landing and spoke at the cell door to Mr. D. Officer A did not provide any specifics as to what he may have heard of this verbal interaction between the nurse and Mr. D at that point.

13.9 The officer went on to inform the meeting that at 12:45, on 21 February, Mr. D used the cell call system again, to which Officer A responded. On this occasion, Mr. D *"seemed to be ok"* but he again complained of a sore throat so the officer told Mr. D that he would get the nurse. Officer A went off and located Nurse A who was in the surgery on D1 landing. The nurse and Officer A then immediately made their way together to cell 13 where Nurse A spoke to Mr. D again. After speaking to Mr. D, the nurse told Officer A that she would *"need to take his [Mr. D's] observations"*. Officer A next called ACO A over the Tetra radio – the Assistant Chief in turn called for all available staff. Nurse A went to the surgery to collect the *"red bag"* (emergency medical kit).

13.10 Officer A continued his account by stating that the cell was opened and the nurse entered the cell with another officer (Officer C) and ACO A. Mr. D was asked to sit down on his bed (the other prisoners in cell 13 were all in their beds at the time) to allow Nurse A to take Mr. D's *"OBS"*. As well as taking medical observations, the nurse spoke with Mr. D and *"placed him on oxygen to help his breathing".* Officer A recalled that at the request of the nurse, he went and got some liquid ibuprofen from the pharmacy as Mr. D had told the nurse that he was unable to swallow tablets. Officer A was also aware that a colleague (Officer D) had been sent to get a blood pressure monitor from the surgery. According to Officer A, *"We all left the cell at 01:10am".*

13.11 Continuing his account, Officer A recalled that, *"I did my security check on A Division and went back up to [Mr. D's] cell as he had the cell call light on and he spoke to me and I left."* The note

of the CIRM did not give any detail of the conversation between Officer A and Mr. D. The officer carried on his recollection saying that Mr. D, *"put back on the cell call light again [and] I went back up [and] spoke with him"*. Officer A then went to the key room and told ACO A that Mr. D was *"kicking the [cell] door and would not settle"*.

13.12 Officer A went on to tell the meeting that he returned to cell 13 and lifted the flap on the door, using his torch to look into the cell. He recalled, "*Mr. D was standing at the foot of the bed [,] he spoke to me saying ['] I can't breathe[.] I could see his face was changing colour [.] I called for Nurse A and proceeded towards the surgery to tell her the same [.] ACO A called for all staff [and] I got the oxygen bottle in surgery and myself and Nurse A headed for A2 landing*." Officer A continued his recollection by informing the CIRM meeting, *"we entered the cell [,] I asked the other prisoners to leave the cell [,] [Mr. D] was on the ground at this stage on his back".* At that point, according to Officer A's version of events, *"Nurse A started CPR [-] I asked her if she wanted me to take over so she could get the defib ready [.] She placed the pads on his chest and asked me to clear for shock [.] I immediately started back [on] compressions [.] I asked Officer C to stand by to take over when I needed a rest [.] We continued this as a rotation with ACO A and Officer E and Nurse A until the ambulance crew arrived at which [point] I left the cell".*

13.13 Chief A recalled that he made his way into the prison in response to a call from the Governor and assisted Doctor 1 as she carried out her checks. He then liaised with Gardaí who were already on-site and he next had an officer placed outside the cell. Finally Chief A asked relevant staff to provide statements where possible.

13.14 Acting CNO A informed the meeting participants that he was apprised of the incident involving Mr. D at 07:20 after a call from Nurse A. After speaking with Nurse A for about an hour, Acting CNO A reviewed his notes to see if there had been any requests to see a doctor. The minutes of the meeting, provided to the investigation team, do not record any further details regarding any such requests to see a doctor.

13.15 Doctor 1 recounted that she was called at about 03:00 and she attended the cell of Mr. D at 03:40 with Governor A. Doctor 1 informed the meeting that Mr. D was pronounced dead at 04:05. While there, Doctor 1 spoke to Nurse A and prison officers present and also checked Mr. D's committal notes. The Doctor noted that there were *"no red flags [,] [Mr. D was] classed as relatively well, is a heavy smoker and heavy set man. Asthmatic and using inhalers [,] no other medications".*

13.16 Doctor 3 told the meeting that he was made aware of Mr. D's death when he arrived into work and was *"surprised to hear the news."* Doctor 3 also told the meeting that he *"checked the notes and [it] looks like all protocols were made correctly."*

13.17 Four recommendations were recorded at the conclusion of the critical incident review meeting:

1. Two nurses should be rostered for night duty to alleviate pressure on the prison medical team.

2. More officers should be given First Aid training – specifically on CPR compression and breaths.

3. An emergency medical kit ("red bag") should be in place on each landing.

4. In the event that neither of the two prison doctors are available the locum doctor is to be called to the incident location.

14. Recommendations

14.1 The Office of the Inspector of Prisons makes three recommendations:

1. The OIP has repeatedly highlighted the dangers of nursing under-staffing at night, especially in large committal prisons such as Cloverhill. Mr. D experienced an – ultimately fatal – medical crisis at night, while the one nurse on duty was intermittently otherwise engaged in reviewing new committals in reception. These are precisely the kinds of circumstances that have previously led the OIP to recommend that nursing cover at night in Cloverhill Prison be increased.[5] It recommends that the IPS ensure that a minimum of two nurses are on duty in Cloverhill Prison every night.

2. Another potentially life-saving measure that has been repeatedly recommended by the OIP is that all prison staff, including recruit prison officers, should receive cardiac first responder training. This recommendation has been made in a number of OIP death in custody reports, including the report on the death of Mr. I 2019 but has yet to be accepted by the IPS. Noting that this issue was also highlighted by local management at the Critical Incident Review Meeting following Mr. D's death, the OIP calls upon the Director-General of the Irish Prison Service to implement this recommendation.

3. The IPS should improve its procedures for the monitoring and supervision for prisoners who show signs of serious medical decline, especially if they exhibit symptoms such as difficulty breathing, distress, or a history of requesting medical attention repeatedly. Continuous health care observation of prisoners with worsening health could lead to quicker recognition of the severity of the issue. This should include a standardised emergency response procedure for airway obstruction and respiratory distress; if a respiratory issue cannot be not dealt with by providing a prescribed inhaler, a nurse should monitor the prisoner and, if no rapid improvement is discernible, a doctor should be called or a transfer to hospital arranged.

15. Support Organisations

15.1 Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie.

[5] In the report on its full unannounced inspection of Cloverhill Prison in May 2023, the OIP found that "the lack of nursing staff during night periods was a significant safety concern. Incidents arose in the prison where medical issues were not addressed during the evening period as nursing staff was not available. Even in situations where a night nurse was available in the prison, this was not sufficient to address healthcare needs in the prison. Nurses experienced challenges with managing multiple emergencies or late committals, and lacked an on-site peer support system for immediate debriefings following incidents of self-harm, suicide, self-poisoning and violence. Nursing staff also lacked capacity to cross-check medication administration with a colleague or to be assisted by other healthcare staff when performing Cardio Pulmonary Resuscitation (CPR). See paragraph 4.32 of the inspection report.