



Death in Custody Report for Mr. A 2022 Statement on the Redaction of Paragraph 15.2 of the Death in Custody Report

Section 15 of the Death in Custody report for Mr. A 2022 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 paragraph 15.2 relating to the post mortem examination, on the basis that it would be contrary to the public interest to publish it in this report.



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. A
Mountjoy Prison
3 January 2022
Aged 38

To the Minister: 18 July 2025

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GLOSSARY

ACO	Assistant Chief Officer
AG	Assistant Governor
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CNO	Chief Nurse Officer
DiC	Death in Custody
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prison Healthcare Management System
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure
Swabbing	Saliva sample testing

INTRODUCTION

1. Preface

- 1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Chief Inspector of Prisons has been obliged to investigate all deaths in prison custody. This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carries out regular inspections of prisons. The Office is independent of the Irish Prison Service (IPS). The Chief Inspector of Prisons and the staff of the OIP are independent of the Department of Justice, Home Affairs and Migration in the performance of their statutory functions.
- 1.2 The OIP can make recommendations for improvement where appropriate. Our investigation reports are published by the Minister for Justice, Home Affairs and Migration subject to the provisions of the Act, in order that investigation findings and recommendations can be disseminated in the interest of public transparency, to promote best practice in the care of prisoners.

2. Objectives

- 2.1 The objectives of investigations of deaths in custody are to:
 - Establish the circumstances and events surrounding the death, including the care provided by the IPS;
 - Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in the future;
 - Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
 - Assist the Coroner's investigation and contribute to meeting the State's obligations under Article 2 of the European Convention on Human Rights, by ensuring as far as possible, that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

3. Methodology

- 3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, next of kin (NoK); analysis of prison records in relation to the deceased's life while in custody; and examination of evidence, such as CCTV footage and phone calls.
- 3.2 This report is structured to detail the events leading up to Mr. A's death in Mountjoy Prison on 3 January 2022 and the management of the events associated with his death.

4. Administration of Investigation

- 4.1 On 3 January 2022, the OIP was notified that Mr. A had passed away in Mountjoy Prison. The OIP investigation team attended the prison and met prison management who provided an overview of Mr. A's time in custody. The investigation team also met with persons who had contact with Mr. A during his time in prison.
- 4.2 Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of information required.
- 4.3 The cause of death is a matter for the Coroner.

5. Family Liaison

- 5.1 Liaison with the deceased's family is a very important aspect of the Inspectorate of Prisons' role when investigating a death in custody.
- 5.2 The investigation team met with Mr. A's family on 7 February 2022. Mr. A's family engaged extensively with the OIP and provided information on his life and time in prison.
- 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. A's family in mind.
- 5.4 The OIP is grateful to Mr. A's family for their contributions to this investigation and we offer our sincere condolences to them on their sad loss.

INVESTIGATION

6. Mountjoy Prison

- 6.1 Mountjoy Prison is a closed, medium security prison for adults which, in 2022, it comprised of three accommodation blocks: (i) Main Prison, (ii) Medical Unit and (iii) the Progression Unit. It is the main committal prison for Dublin city and county. At the time of Mr. A's passing it had an operational capacity of 755 beds with 682 in custody, of which 173 were accommodated in the Progression Unit.
- 6.2 Mr. A was the first death of a prisoner from Mountjoy Prison in 2022 and the first death in IPS custody at that point in the year.

7. Family Concerns

- 7.1 Mr. A's NoK, along with their advocate, met with the investigation team on 7 February 2022. On 8 February 2022, the NoK's advocate emailed the investigation team with a number of questions regarding the circumstances of Mr. A's death. A supplementary question was received on 13 June 2022. These questions are answered in Section 16 of this report.
- 7.2 To the extent that the questions raised fall within the OIP's investigative mandate, these are responded to in section 16 of this report.

8. Background

- 8.1 On 24 March 2021 at Cloverhill District Court, Mr. A received a custodial sentence of one year and one month. On 27 October 2021, Mr. A appeared before the Criminal Circuit Court in Dublin on separate charges and was sentenced to three years and four years respectively on these charges, to run concurrently on the legal expiration of the sentence imposed in March 2021. Mr. A had a remission date of 16 May 2024.
- 8.2 On 2 June 2021 Mr. A was transferred from Cloverhill Prison to Mountjoy Prison. While in Mountjoy Prison, Mr. A progressed from the standard to the enhanced level of the Incentivised Regime¹ in recognition of his good behaviour and work ethic. He achieved a Quality and Qualifications Ireland (QQI) accreditation in mathematics during his time in custody.
- 8.3 On 19 December 2021, Mr. A was moved from Mountjoy main prison to the less restrictive regime of the Progression Unit in the Mountjoy Prison complex. A requirement of Mr. A's transfer was that he agreed to a number of conditions outlined in a document entitled "*Mountjoy West², Drug Free Unit Compact*". Mr. A gave a commitment to abstain from illicit substance use, non-prescribed medication, alcohol and other intoxicating substances. He also agreed to toxicology screening, to engage in supportive measures whilst accommodated in the unit and not to have any prohibited article or contraband in his possession. Mr. A's signature on the document, which

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.

² This was the former name of the Progression Unit. The area concerned is now once again called Mountjoy West.

was witnessed, confirmed that he was aware that any breach of the conditions could result in him being removed from the Progression Unit and transferred back to the main prison.

- 8.4 Mr. A was the single occupant of cell 28 on the D2 West landing. At the time of his passing in Mountjoy Prison on 3 January 2022, Mr. A was 38 years of age.

9. Events of 2 January 2022

- 9.1 The investigation team reviewed CCTV footage from 07:45 on 2 January 2022 to 11:32 on 3 January 2022. At 08:08, on 2 January 2022, breakfast unlock³ of D2 West landing commenced allowing prisoners to leave their cells to collect breakfast. When breakfast was collected, prisoners returned to and were locked back⁴ to eat breakfast, this was at 08:15. The unlocking of the cells following breakfast commenced at 09:57, permitting prisoners to avail of morning recreation and to interact on the landing. CCTV footage confirms that Mr. A did not leave his cell for breakfast on the morning of 2 January 2022.
- 9.2 At 10:21 Prisoner 1 entered Mr. A's cell and departed approximately 45 seconds later. Mr. A is first seen on the landing at approximately 10:25 when he exited his cell and then returned a minute later to clean his cell. The CCTV footage showed Mr. A engaging with a number of fellow prisoners on the landing, there was no evidence of concerning behaviour. At 11:57 Mr. A collected his lunch from the servery and returned to his cell at 11:59, closed the cell door which was then locked by the class officer, along with all other cells on the landing, for 'dinner lock-back'⁵.
- 9.3 At approximately 14:12, all cells on D2 West landing were unlocked. Mr. A exited his cell at 14:15 and went into Cell 31, which was occupied by Prisoner 2. At 14:16, a group of prisoners were observed gathering outside Cell 31. The group could be viewed moving items of furniture, including a television, from one cell to another. Mr. A was present throughout this event.
- 9.4 At 14:22, Mr. A returned to his cell accompanied by two prisoners. There was frequent movement of prisoners to and from Mr. A's cell at this time. The CCTV footage showed that between 14:23 and 15:05 six different prisoners entered Mr A's cell on 12 occasions, all staying for short periods.
- 9.5 During that time, Prisoner 1 visited Mr. A's cell and found him sitting on a chair "*with his head down towards his knees*". Prisoner 1 stated that he left Mr. A's cell briefly and returned with Prisoner 3 who described Mr. A as being "*really drunk*". Together, Prisoner 1 and Prisoner 3 lifted Mr. A into his bed. Prisoner 1 stated that they "*put him on his side with his blankets over him*". Prisoner 3 stated that they left the cell and "*pulled the cell door closed*". CCTV footage recorded that this happened at approximately 15:05.
- 9.6 Prisoner 3 reported being worried about Mr. A and felt that they should "*call the medic*" but Prisoner 1 felt that Mr. A would "*sleep it off*". Prisoners 1 and Prisoner 3 told the investigation

³ Breakfast unlock: Officers unlock cells to permit prisoners who had been locked back in their cells for the night to leave their cell to collect breakfast from the Servery.

⁴ Breakfast lock back: prisoners are locked back in their cell to eat breakfast.

⁵ Dinner lock-back: Prisoners locked back in their cells during lunch time period of approximately two hours.

team that they were reluctant to seek assistance as they were afraid Mr. A would get into trouble and be transferred from the Progression Unit if officers became involved.

- 9.7 Prisoner 3 expressed his belief that Mr. A's condition was due the consumption of hand sanitiser. Prisoner 3 told the investigation team that prisoners removed the sanitiser from the dispensing units on the landing, boiled the contents in a kettle which reduced and liquefied it, stating that this process "*cooked off the bad stuff*" and made it easier to drink. Prisoner 4 also confirmed to the investigation team that prisoners regularly consumed hand sanitiser during COVID-19 restrictions. Prisoner 4 stated that many of the prisoners who expressed concerns regarding Mr. A's condition were also under the influence of hand sanitiser. Prisoner 4 likened the effects of drinking a mug of boiled hand sanitiser to drinking a bottle of vodka. He stated that a group of prisoners, including Mr. A, had been drinking the substance for a number of days prior to this event. Prisoner 3 expressed the view that Mr. A must have "*drank a bad batch or something*".
- 9.8 At 15:05, just after the cell door was closed, Prisoner 4 and Prisoner 5 were observed, in the CCTV footage, looking through the viewing panel on Mr. A's cell door. They appeared to be acting jovially.
- 9.9 At 15:07, two unidentified prisoners were seen checking on Mr. A through the cell door viewing panel. CCTV footage confirmed that prisoners checked on Mr. A at least nine times until 16:00 when prisoners attended the Servery to collect their evening meal, Mr. A remained in his cell.
- 9.10 At approximately 16:08, Officer A performed a check of Mr. A's cell by looking through the viewing panel of the cell door as the cell was being locked for the evening meal. Officer A confirmed to the investigation team that Mr. A did not come to his attention nor did he observe anything unusual while performing his checks. At 16:40, the Tea Guard was observed passing by Mr. A's cell and lifting the viewing panel on the door but did not look through it.
- 9.11 Officer A was observed on CCTV footage unlocked Mr. A's cell door at 17:26:35, he turned on the light, entered the cell and left the cell at 17:27:31. Officer A reported that he "*would have entered the cell because, he [Mr. A] was in bed*" and that at this point he received "*an appropriate response from him*".
- 9.12 The CCTV footage captured significant activity around Mr. A's cell following unlock. At 17:29, four prisoners were observed on CCTV footage in the vicinity of Mr. A's cell. Prisoner 1 confirmed that he checked on Mr. A once when his cell was unlocked at 17:30 and found him in the same position in bed as he had placed him earlier and he was "*snoring heavily*". Prisoner 1 informed the investigation team that he thought Mr. A was asleep and "*would be ok after sleeping off the effects of the drink*".
- 9.13 At approximately 17:30, Prisoner 2 briefly entered Mr. A's cell before departing with a white plastic bag and entering another cell on the landing. Ten different prisoners entered the cell of Mr. A on 44 occasions between 17:30 and 18:42 while others looked into the cell through the viewing panel on the cell door. Mr. A did not leave the cell during this period.
- 9.14 At approximately 18:42 and 18:44, Officer A looked into cell 28. He reported that Mr. A did not come to his attention or cause any reason for concern before he handed over responsibility for the landing to the Night Guard, Officer B. CCTV footage confirmed that Officer B locked Mr. A's cell, for the night, at 18:51.

- 9.15 On reviewing the CCTV footage it was noted that Mr. A's cell was checked by prison officers on seven occasions between 18:51 on 2 January 2022 and 7:36 on 3 January 2022. It was recorded by the Assistant Chief Officer (ACO) A in the Night Guard Journal that all areas were visited during the night and "*all was correct*". The checks conducted were in accordance with the IPS policy in place at the time⁶.

10. Events of 3 January 2022

- 10.1 On 3 January 2022, at approximately 08:13, Officer C reported that he unlocked Mr. A's cell for breakfast and called Mr. A but he did not respond. Officer C called Mr. A a second time and entered the cell when Mr. A again failed to acknowledge the call. Officer C reported that he found Mr. A unresponsive in his bed. Officer C attempted to locate Mr. A's pulse without success. He immediately requested a 'Code Red'⁷ response over his Tetra radio.
- 10.2 At approximately 08:15, Officer D, ACO B and Nurse A responded to the emergency call. Nurse A recorded on the Prisoner Healthcare Management System (PHMS) that Mr. A was found lying on his left side in his bed with a duvet over him. Nurse A conducted a clinical assessment and stated that Mr. A was cold to touch with no signs of breathing, his lips were cyanosed⁸, and his pupils were fixed and dilated.
- 10.3 Nurse A contacted the main Mountjoy prison surgery to request further medical assistance. Nurse B, Nurse C and Nurse D, immediately responded. They examined Mr. A and determined that no signs of life were present.⁹ Mr. A's cell was secured whilst the nursing team contacted Doctor A.
- 10.4 Doctor A arrived at Mr. A's cell at 09:20 and pronounced him deceased at 09:27. Members of An Garda Síochána (AGS) arrived at Mr. A's cell at approximately 09:30. At 11:20, Undertakers working on behalf of the Coroner removed Mr. A's remains.

11. Engagement with Healthcare

- 11.1 On 14 January 2021, while in the custody of Cloverhill Prison, Doctor B referred Mr. A to St. Vincent's Hospital to assess "*Chronic pain and serious discharge from small sinus right lower leg*" which was injured prior to his committal to prison.
- 11.2 Nurse E completed a committal interview with Mr. A on 2 June 2021 which was the date of his transfer from Cloverhill to Mountjoy Prison. Nurse E recorded that Mr. A had a fracture of the right tibia three months prior to committal, the wound was infected and he attended St. Vincent's Hospital "*weekly for wound dressing*."
- 11.3 Nurse E also recorded that Mr. A confirmed that he had received treatment from Mental Health Services in the community and had self-harmed as a teenager and also "3-4 years ago". Nurse

⁶ SOP 11/22 – Monitoring of Prisoners during Night Guard Duty. Prisoners are checked in their cells by a Prison Officer (Night Guard) taking charge of the landing, and thereafter, at regular and irregular intervals no greater than every three hours. In addition the Night Guard is required to patrol the landing hourly.

⁷ A 'Code Red' – Request for immediate assistance.

⁸ Exhibiting a blue or purplish discolouration.

⁹ PHECC, (Pre-Hospital Emergency Care Council) CPR guidelines state it is inappropriate to commence resuscitation when the following indicators of death are present: Decomposition, Rigor Mortis, Incineration, Decapitation, Pooling and other injuries totally incompatible with life.

E referred Mr. A to the psychiatric in-reach team for assessment. Doctor A assessed Mr. A on 3 June 2021 and noted that he “*was alert and in good form*” and was to continue with “*Arcoxia*¹⁰”.

- 11.4 On 9 June 2021, Doctor B received a letter from St. Vincent’s University Hospital dated 1 June 2021 advising that Mr. A “*had been booked for removal of metal in his right tibia and fibula in the near future*” and would be notified of the date in course. A further letter dated 6 July 2021 was issued by St. Vincent’s University Hospital cancelling the appointment on 12 July 2021. A new appointment date and time was provided in this letter but this was scratched over with a pen and could not be read. A hand written note “*no date yet*” was made opposite the erased date. CNO A confirmed to the investigation team that a further appointment to remove the metal had not been arranged prior to Mr. A’s passing.
- 11.5 On 30 June 2021, Psychiatric Nurse A referenced the committal interview when recording on the PHMS that Mr. A had reported to Nurse E a “*history of depression denying any concerns with mental health.*” Psychiatric Nurse A also noted that the “*GP committal interview highlights no concerns with mental health.*” Psychiatric Nurse A noted that Mr. A had been reviewed by the “*in reach Mental Health teams in Mountjoy (2020), Cloverhill (2020) and the Midlands (2017) no major mental illness evident at these assessments.*” It was also noted that there was a history of “*deliberate self-harm and suicide attempts complicated by substance misuse*”. Psychiatric Nurse A documented that Mr. A had been discussed at the multi-disciplinary meeting (MDT) on 29 June 2021 with case notes reviewed and it was agreed that as there was “*no current indication for mental health assessment*” that Mr. A be removed from the psychiatric list but could “*re-referred through the GP services*” in the event of “*new concerns regarding [his] mental state*”. There were no further referrals to the psychiatric services.
- 11.6 Mr. A was experiencing a skin irritation at night and attended Doctor C on 1 September 2021, who noted that there was no rash and no history of liver problems. The doctor recommended antihistamine and requested blood tests to check various functions including his liver function. Mr. A again attended the doctor’s clinic on 8 September 2021, there was an issue with his right inner ankle and the skin irritation which persisted. Doctor D recommended Silcocks Base cream advising Mr. A to speak to the nursing staff if there was no improvement with his ankle. Mr. A attended the phlebotomy clinic on 3 November 2021.
- 11.7 On 12 November 2021 Doctor A entered in the PHMS that the blood results received were “*suggestive of subclinical hypothyroidism*”[sic] with positive t¹¹ perox¹² ab¹³. Doctor A scheduled a consultation with Mr. A on 16 November 2021 to discuss his blood results however Mr. A declined to attend the appointment. On 18 November 2021, the remaining blood test results were received. Doctor A recorded that Mr. A’s liver ALT¹⁴ level was “*slightly*” elevated. Doctor A placed Mr. A on the list for a repeat blood tests in three months.
- 11.8 On 10 November 2021 Doctor C prescribed Cetirizine¹⁵ (10mg) and Arcoxia (60mg) for one month. Mr. A was not on prescribed medication at the time of his passing.

¹⁰ ARCOXIA helps to reduce the pain and swelling (inflammation) in the joints and muscles of people 16 years of age and older with osteoarthritis, rheumatoid arthritis, ankylosing spondylitis and gout.

¹¹ thyroid

¹² peroxidase

¹³ antibodies

¹⁴ ALT is the abbreviation of Alanine Transaminase which is an enzyme predominantly found in the liver. High levels of ALT present in a person’s bloodstream could indicate a problem associated with the liver.

¹⁵ CETIRIZINE prevents and treats allergy symptoms, such as red, itchy eyes, sneezing, a runny or stuffy nose, or hives. It works by blocking histamine, a substance released by the body during an allergic reaction.

12. Addiction Counselling

- 12.1 At the committal interview on 2 June 2021, Nurse E noted that Mr. A stated that he did not have a history of alcohol abuse. However, at a committal interview conducted in Cloverhill Prison in 2019, Mr. A had informed the nurse that alcohol was an issue and it was recorded at that time that Mr. A had “*an extensive history of polysubstance misuse and alcohol dependence*”.
- 12.2 PHMS records confirm that Mr. A attended nine video call appointments with the Merchants Quay Ireland (MQI) Counsellor while in Cloverhill Prison, prior to his transfer to Mountjoy in June 2021. It was recorded that Mr. A was concerned that his children would be placed into care while he was in custody and he was struggling to remain sober. The counsellor advised Mr. A on self-care, self-management relapse triggers and healthy coping skills.
- 12.3 MQI Addiction Counsellor Drugs Counsellor A, who was attached to Mountjoy Prison confirmed that a referral letter was received from his colleague in Cloverhill Prison. On receipt of the referral letter Mr. A was placed on the Mountjoy addiction counselling waiting list.
- 12.4 Addiction Counsellor A stated that in-person counselling sessions were not convened during COVID-19 restrictions. Consultations and counselling sessions were mainly via telephone.
- 12.5 Addiction Counsellor A informed the investigation team that leaflets had been distributed to all cells providing prisoners with information on how to contact the addiction counsellors during COVID-19 lock-down. Addiction Counsellor A also recalled that information on access to addiction counselling was relayed through the in-cell television channel.
- 12.6 As mentioned at 8.3 Mr. A’s agreed to toxicology screening and to engage in supportive measures whilst accommodated in the Progression Unit. Addiction Counsellor A confirmed that Mr. A did not make contact with the MQI addiction service during his time in Mountjoy Prison nor had he been reached on the Mountjoy addiction services waiting list prior to his passing. Based on the documentation provided to the inspection team, there was no evidence that Mr. A underwent saliva testing or a urine analysis test during his short time in the Progression Unit. There was no Standard Operating Procedure (SOP) in place at that time for collecting urine samples for testing. Since the passing of Mr. A, a policy and SOP entitled ‘Operational Drug Testing for Prisons’ has been introduced by the IPS.

13. Hand Sanitiser and Cleaning Products

- 13.1 Hand sanitiser was readily available on prison landings due to the efforts by the IPS to prevent the spread of COVID-19.
- 13.2 The investigation team obtained details of the hand sanitiser used in the Progression Unit at the time of Mr. A’s passing and can verify that the product did not contain alcohol.

- 13.3 Prison management confirmed that cleaning products used for industrial cleaning contained ethanol and these products were securely stored, in a steel locked cabinet, in line with the guidance of the Health and Safety Authority. Only the Work and Training Officers (WTO) had access to the locked cabinet containing chemical products. Chemicals were issued to prisoners who had completed the Clean Pass training. It was confirmed to the investigation team that the use of such products was to ensure surfaces and equipment were maintained to health and safety standards.
- 13.4 At the time of Mr. A's passing a number of the prisoners on the enhanced level of the incentivised regime were accommodated in the Progression Unit D Division and were employed in various work areas where cleaning products, containing chemicals, were used.

14. Critical Incident Review Meeting

- 14.1 On 4 January 2022, a critical incident review meeting¹⁶ (CIRM) was held which was chaired by Assistant Governor A. In attendance were: Assistant Governor B, CNO B (Chief Nurse Officer), Nurse A, Chief A, Chief B, Chief C, ACO B, Integrated Sentence Management (ISM) Officer A, Chaplain A, Prison Higher Executive Officer (PHEO) A and Prison Clerical Officer (PCO) A as note taker.
- 14.2 Chief A provided a timeline of the events leading up to when Mr. A was discovered unresponsive in his cell. Chief A reported that a prisoner had mentioned to staff, following the passing of Mr. A, that he had been drinking a 'clear liquid'. Chief A stated that the reference to a 'clear liquid' gave rise to concern that a chemical may have been consumed as normally prisoners would use the term 'hooch'¹⁷ when referring to a prison made alcohol.
- 14.3 Chief A stated that a number of prisoners accommodated on D2 landing worked in the laundry. Chief A confirmed that laundry surfaces were regularly sprayed with chemicals, some of which had a high ethanol content. However, he noted that there was no 'hard evidence' that Mr. A had ingested a chemical. IPS staff conducted a search of the entire D Division of the Progression Unit, on 5 January 2022 and did not recover any form of 'hooch'.
- 14.4 The CIRM minutes recorded that the Chaplain A made contact with Mr. A's NoK who were "very distraught, in shock and hung up the phone" devastated on hearing the news of Mr. A's passing. It was also noted that the NoK were given the Chaplain's phone number "for contact and support."
- 14.5 Assistant Governor A commended all those involved for their professionalism in response to the incident stating that protocols and procedures were followed.
- 14.6 No recommendations were recorded at the conclusion of the CIRM.

¹⁶ Staff meeting held following the death of a prisoner

¹⁷ Hooch: a drink with alcohol percentage made by prisoners using fermented fruit, sugars as yeast and bread.

15. Post Mortem Examination Toxicology Analysis

15.1 When a death occurs in prison custody a Post Mortem Examination is performed, the OIP usually receives a copy of the Post Mortem Examination Report. The Post Mortem Examination Report in relation to Mr. A was received on 31 July 2023.

15.2



16. Family Concerns and Questions

16.1 Mr. A's family had a number of questions directly relating to the passing of Mr. A. Those questions fall within the scope of the OIP's investigative mandate and answers are set out below.

The family had a number of other questions that related primarily to the treatment of Mr. A's brother, who was also in prison custody at the time of Mr. A's passing. The Inspectorate fully acknowledges the distress experienced by close family members who experience the loss of a loved one. That distress is no less (and may even be amplified) if the close family member is also deprived of their liberty at the time of death. Nonetheless, the OIP's investigative mandate does not extend to investigating matters that are not directly related to a death on custody. For that reason, the Inspectorate regrets that only very limited responses can be given to some of the additional questions raised by Mr. A's family.

Q.1 Why did the prison not send a representative to deliver the news of Mr. A's death as opposed to over the phone? Is it common practice to telephone NoK when somebody dies in custody as opposed to visiting the home? Why didn't a representative of IPS visit the family's home at a later stage? Again, is it not common practice for a representative from IPS to visit the family? Or attend the funeral?

OIP Response: The Prison Chaplain contacted the family by telephone to ensure the NoK was informed of the sad news as soon as possible. It was the practice during COVID-19 restrictions to contact the NoK by telephone. The OIP has been informed by local prison management that it is no longer common practice for a representative from the prison to attend a funeral or visit the family home following a death in custody.

Q.2 Did Mr. A receive his mental health medication on a regular basis while in prison? Can you get detail about the dates of meetings with psychologist/psychiatrist and the outcome of those sessions?

OIP Response: Mr. A was not prescribed mental health medication at the time of his passing, nor was he under the care of a psychologist or psychiatrist.

Q.3 Why wasn't Mr. A on special observation or some type of special watch? Was there any indication in Mr. A's medical records that he should be on special watch?

OIP Response: Mr. A was an enhanced prisoner (see section 8.2). He was not considered to be 'a risk' and therefore was not on special monitoring. There was nothing in Mr. A's medical records to suggest that he should have been monitored under special observation.

- Q.4 Mr. A's brother who was also in Mountjoy Prison wasn't allowed to attend Mr. A's funeral, why? Did a representative from Mountjoy request permission from IPS HQ for Mr. A's brother to attend the funeral? What was the reason for declining? Was this explained to Mr. A's brother?

OIP Response: The investigation team was advised that the funeral was streamed by the chaplaincy service to facilitating the attendance of close relatives/friends living in the prison. The OIP is not in a position to investigate IPS decisions taken in relation to Mr. A's brother.

- Q 5. Is Mr. A's brother continuing to receive the necessary support while in prison? What counselling services is Mr. A's brother receiving in the prison (dates offered/ attended). Was Mr. A's brother offered an opportunity to speak to a counsellor from the Traveller Counselling Service?

OIP Response: The OIP is not in a position to investigate IPS decisions taken in relation to Mr. A's brother.

- Q 6. The family only had two visits with Mr. A's brother immediately following his death, why? Would the prison usually facilitate more visits for a prisoner whose brother died in custody? Could/Should the prison have accommodated the family to have a visit without screens and allow physical contact?

OIP Response: In principle, additional compassionate visits may be facilitated by the Governor on a case by case basis. However, the OIP is not in a position to investigate IPS decisions taken in relation to Mr. A's brother.

- Q 7. Can you please confirm when Mr. A's brother was told of his passing?

Response: The OIP is satisfied that Mr. A's NoK was notified as soon as possible that Mr. A had passed. The OIP is not in a position to investigate IPS decisions taken in relation to Mr A's brother.

- Q 8. Why did someone telephone from the prison on 2 January 2022 between 14:00/15:00, using very offensive language? Can you look in to this? Was Mr. A's phone card used to make the calls?

OIP Response: No calls were made using Mr. A's phone card on 2 January 2022. The last recorded use of Mr. A's phone card was on 1 January 2022.

- Q 9. Mr. A's NoK asked for his tracksuit and runners (that he received as a Christmas present) for the burial. Who told her that the Gardaí had his clothes/and couldn't be released? Was this true? Why was this refuted by the Garda?

OIP Response: It is normal practice for AGS to take possession of items from a cell following a death. The evidence is gathered by AGS on behalf of the Coroner. The OIP was informed that prison management did not obtain a list of items removed from the cell by AGS so the investigation team are unable to establish if a track suit and runners were removed. Evidence gathered by AGS is retained until after the Inquest Hearing. However, the investigation team saw a record of the personal belongings of Mr. A which were returned to the family and these

included three tracksuit bottoms and three pairs of runners. It is recorded that these items were returned by the Chaplain to the family on 5 January 2022.

Q. 10 Did Mr. A show signs of being sleepy/lethargic before being locked into his cell?

OIP Response: This is addressed in section 9 of this report.

Q. 11 Who was in the cell with [Mr. A] on the evening prior to his death? Were any other prisoners sick after drinking the substance?

OIP Response: Mr. A was alone in his cell from 18:51 onwards on the evening prior to his passing. Section 9 of this report contains further details regarding the presence of other prisoners in his cell prior to that time.

Q. 12 Was the Governor informed of the family's request to speak to him?

OIP Response: The investigation team found no evidence that governors were informed that the family wished to speak to a governor.

Q. 13 Why did the Governor not contact the family? Is that usual protocol?

OIP Response: The Chaplain contacted the family at the request of the Governor, this is common practice following a death in custody.

Q. 14 Is there a record of the information provided by other prisoners about the period/activities before Mr. A's death?

OIP Response: This is addressed in section 9 of the report.

Q. 15 Was Mr. A found dead in bed? When the last time a prison officer entered his cell prior to being found dead? Was he awake or asleep at this time? Was there any signs of being unwell when last checked?

OIP Response: This is answered in sections 9 and 11 of this report.

Q. 16 A family member stated that they phoned Mountjoy Prison to speak to the Governor before the funeral of Mr. A. It is alleged that the person who answered the call informed them that the Governor doesn't take calls and when they wanted to leave their phone number they were informed *'they don't have to put up with your smart comments'*.

OIP Response: The investigation team found no record of this call having been received by the prison.

Q. 17 Can Mr. A's brother be accommodated to have longer phone calls (more than 6 minutes) with his family while he and they are in this stressed state? Mr. A's brother has five children and would benefit from longer calls to his family.

OIP Response: At present, the duration of phone calls is set electronically at six minutes and cut-off automatically. The number of calls permitted is determined by the regime level a prisoner is on i.e. Basic, Standard or Enhanced – those on the Enhanced Regime have more calls per

week than those on the lower regime levels. However, prison management may permit additional compassionate calls in particular circumstances, if requested.

Although the OIP is not in a position to investigate IPS decisions taken in relation to Mr. A's brother, the Inspectorate is of the view that 6 minute calls are inadequate to allow people living in prison to maintain contact with their families.

Q. 18 Clarification on how Mr. A's remains were removed from the cell.

OIP Response: Mr. A's remains were removed from the prison by Undertakers acting on behalf of the Coroner at 11:20 on 3 January 2022.

17. Recommendations

17.1 The OIP has made three recommendations in this report:

1. In order to facilitate the effective investigation of deaths in prison custody, and to ensure that all necessary lessons are learned, it is essential that a complete and accurate record be kept by the IPS of all items found in / removed from a prisoner's cell following a death in custody. This applies irrespective of whether the items are found/removed by IPS staff or by members of AGS. In the event that items are found/removed by members of An Garda Síochána, the prison's Governor should be provided with a complete list of the items concerned. Implementation of this recommendation may require the development of a protocol between the IPS and AGS, this was made in Mr. J 2022.
2. Tighter procedures should be introduced, including by Work Training Officers, to reduce the risk of prisoners removing cleaning products containing ethanol from work placements when returning to their accommodation.
3. When a prisoner is engaging with an addiction counsellor prior to transfer to another prison continuity of treatment should be ensured by prioritising their access to addiction services in their destination prison.

18. Support Organisations

18.1 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.