



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. A
Wheatfield Prison
1 January 2021
Aged 35

To the Minister: 31 July 2026

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GLOSSARY

ACO	Assistant Chief Officer
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
CSC	Close Supervision Cell
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prison Healthcare Management System

INTRODUCTION

1. Preface

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

2. Objectives

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

3. Methodology

- 3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It includes 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 prison on 1 January 2021 and management of the events associated with his death.

4. Administration of Investigation

- 4.1 On 1 January 2021, the OIP was notified that Mr. A had passed away in Wheatfield Prison. The then Chief Inspector attended the prison on the afternoon of 1 January 2021 and met prison management who provided an overview of Mr. A'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. A's, NoK, his widow, by telephone on 4 March 2021. She did not raise any questions or concerns.
- 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 NoK in mind.
- 5.4 The OIP offers our sincere condolences to Mr. A's widow and his family on their loss.

INVESTIGATION

6. Wheatfield Prison

- 6.1 Wheatfield Prison is a closed, medium security prison for adults which primarily caters for prisoners from the counties of Louth, Meath, Monaghan, Wexford, and Wicklow. At the time of Mr. A's death, it had an operational capacity of 610 beds, and on 1 January 2021, it was accommodating 506 prisoners, representing 83% of its capacity.
- 6.2 At the time of his death, Mr. A's was the first death of a prisoner in Wheatfield Prison in 2021 and the first death in IPS custody that year.

7. Background

- 7.1 Mr. A was 35 years old when he died in Wheatfield Prison.
- 7.2 On 26 August 2020, Mr. A was committed to Cloverhill Prison pursuant to a European Arrest Warrant. Mr. A was transferred to Wheatfield Prison on 29 September 2020.
- 7.3 Mr. A was transferred to Cork Prison on 6 December 2020 and was returned to Wheatfield Prison on 10 December 2020. On his return to Wheatfield Prison, Mr. A was accommodated in cell 14, a double cell, on the 9F landing, which he shared with Prisoner 1, whom he had known since childhood.
- 7.4 On his committal to Wheatfield Prison on 10 December 2020, Mr. A was reviewed by Nurse A and he denied previous drug use and any history of alcohol abuse. It was recorded on the Prison Healthcare Management System (PHMS) by Nurse A that Mr. A "*denies thoughts of self-harm or suicide*". Prisoner 1 reported, "*I am not aware if he took drugs or not*".

8. Events of 29 and 30 December 2020

- 8.1 The investigation team was advised that Mr. A had minimal interaction with officers in the days prior to his death.
- 8.2 On 29 December 2020, Assistant Chief Officer (ACO) A reported that Mr. A seemed to be happy and had attended the servery¹ for his midday meal. At 14:18, Mr. A went to the yard for his exercise, returning to the 9F landing at 15:33. ACO A noted that Mr. A had mainly engaged with a select number of prisoners from his landing and stated, "*he interacted most of the time with his cellmate*".
- 8.3 Officer A reported Mr. A as "*being in good form throughout the day, in good health, and courteous when addressed*". ACO A confirmed that other than retrieving his meals from the servery, Mr. A only left the landing twice to go for exercise.

¹ A counter, a hatch, or a room in a prison where meals are served.

9. Events of 31 December 2020

- 9.1 On 31 December 2020, ACO A reported that Mr. A attended the yard for exercise at 09:42 and returned to the 9F landing at 10:33. He also attended the servery for his meals at the required times throughout the day.
- 9.2 ACO B was the designated officer in charge of Wheatfield Prison for the night. Officer B provided ACO B with a copy of the Detail Sheet² which disclosed that there was no nurse on duty in Wheatfield Prison on the night of 31 December 2020. The absence of a nurse was known in advance by prison management and arrangements were made for nursing cover to be provided by the nurse on duty in Cloverhill Prison, which is in close proximity to Wheatfield Prison.
- 9.3 Governor A informed the investigation team that the absence of a nurse on the night of 31 December 2020 was due to high numbers of healthcare staff being absent, having contracted Covid-19 or being a close contact to a confirmed case.
- 9.4 ACO B at Wheatfield Prison contacted ACO C, who was in charge at Cloverhill Prison. They exchanged Tetra radio³ numbers in case of an emergency. ACO B reported also contacting Nurse B in Cloverhill Prison and exchanging Tetra radio numbers.
- 9.5 ACO B stated, *"I maintained regular tours of my area. I had reported to each post at 18:30, 20:30, 22:00, 00:30 finding all correct"*. Officer C was the Night Guard on duty and conducted checks on 31 December 2020 at 21:05, 22:31, 23:05, and 23:56. A review of CCTV has confirmed that checks were conducted as described.

10. Medical Emergency on 1 January 2021

- 10.1 Officer C conducted a check of the unit at 00:03 on 1 January 2021. Officer D conducted a further check at 01:15. At 01:42 on 1 January 2021, Mr. A activated the in-cell call bell. Officer C arrived at cell 14 at 01:49. Mr. A informed Officer C that his cellmate, Prisoner 1, was struggling to breathe and he (Mr. A) had failed to wake him. Officer C reported, *"I immediately informed [ACO B] that there was an unresponsive inmate via Radio and continued to assess the situation from the cell door"*.
- 10.2 Officer C reported that Mr. A was attempting to wake Prisoner 1, but he did not move. Officer C spoke with Mr. A through the cell door and asked him if Prisoner 1 had taken anything and Mr. A replied, *"some tablets"*.
- 10.3 ACO B reported receiving a radio call from Officer C at 01:50 and initiated a 'Code Red alert'⁴. ACO B then made his way to unit 9F and arrived at 01:52 with Officer C, Officer D, Officer E, Officer F, and Officer G. Officer H operated the cell unlock buttons and ACO B, Officer C, Officer D, Officer E, Officer F, and Officer H entered cell 14 at 01:53.
- 10.4 Officer D reported that Mr. A *"was in a distressed state, stating that his cellmate, had been unresponsive for a number of minutes"*, and he observed Prisoner 1 struggling to breathe. ACO

² This roster provides details of the personnel listed for duty along with their assigned post.

³ A Tetra Radio is carried by prison officers and is used to securely broadcast messages to other members of staff within the prison estate.

⁴ Prison code for an urgent medical situation – requiring medical staff and equipment.

B reported asking Mr. A if his cellmate had taken any substance and was informed that *“he had taken some tablets and had been like this for 5 or 6 minutes”*.

- 10.5 ACO B reported moving Prisoner 1, with the assistance of Officer D, into the recovery position on his side, tilting his head back to open his airway as much as possible. Officer D remained with Prisoner 1 and ACO B exited the cell to contact colleagues at Cloverhill Prison. ACO D who was the ACO in charge of the East/West proceeded to unit 9F on hearing the call from ACO B and arrived at cell 14 at 01:55. He was informed by ACO B that a prisoner was unresponsive.
- 10.6 ACO B made contact, via Tetra radio, with ACO C at Cloverhill Prison. ACO C stated he would escort Nurse B to the search area at Wheatfield Prison. ACO B made his way to the search area to remove the master locks and meet Nurse B.
- 10.7 ACO D entered cell 14 and reported that he *“checked for a pulse, a pulse could be detected but it was extremely erratic and the prisoner’s breathing was very unsteady”*. ACO D reported that Mr. A *“was also trying to rouse him and was in a distressed state”*. ACO D requested that Officer C retrieve the red emergency bag from the surgery and instructed that Mr. A be moved to another cell. CCTV has confirmed that Mr. A was removed from cell 14 at 01:59 and placed in cell 15 which was occupied by Prisoner 2.
- 10.8 ACO D, Officer D and Officer F moved Prisoner 1 from the top bunk onto a mattress on the ground. At 02:03, Officer C returned to cell 14 with the red emergency bag and oxygen. Officer D applied the oxygen mask and reported, *“this immediately helped the prisoner’s condition, the colour in his face returned and his breathing improved immensely”*.
- 10.9 At 02:00, Nurse B was informed by ACO C of a medical emergency at Wheatfield Prison. At 02:10, Nurse B arrived at cell 14 and administered care to Prisoner 1. Nurse B reported that Prisoner 1 *“appeared pale in complexion and not responding to officers”* and his breathing was laboured. Nurse B documented that an improvement in his condition was observed within 15 minutes and at this stage, Prisoner 1 was very alert and drank a few sips of water. ACO B reported that Prisoner 1 dressed himself and at 02:28 was escorted by ACO B and Nurse B to a Close Supervision Cell⁵, (CSC) cell 11, on West 2. At approximately 02:40, Nurse B left Wheatfield Prison and returned to Cloverhill Prison. Nurse B stated, *“at no time during my tours of duty to Wheatfield Prison on the 1 January 2021 did I have any dealings with [Mr. A.], nor was I asked by any Wheatfield staff to review/assess said inmate”*.
- 10.10 After Prisoner 1 had left cell 14, a search of the cell was conducted by ACO B, Officer C, and Officer D. They found no evidence of any prohibited substance or drug paraphernalia. The CCTV footage showed that at 02:28 Prisoner 1 was escorted from cell 14 and officers entered cell 14.
- 10.11 ACO B spoke with Mr. A in cell 15 and asked if he wished to remain there, but he requested to return to cell 14. ACO B stated that Mr. A *“was searched but there were no items on his person. I asked him if he had taken tablets, he told me he had not. He did not present as intoxicated”*. At 02:29, Mr. A was returned to cell 14 and two officers entered the cell with him. At 02:30, officers exited cell 14, closed the door, and walked off the landing.

⁵ Close Supervision Cells may be used when alternative and less restrictive methods of control are considered by the Governor as inadequate, in circumstances which include protection of the prisoner or others, preservation of good order and/or reasons of security and safety.

- 10.12 Prisoner 1 was placed on a P19 disciplinary report⁶ for alleged breach of Prison Rules by ACO A. Mr. A was not the subject of a P19 and had not been the subject of a P19 report in the previous six months.
- 10.13 Officer C reported that Mr. A *“did not appear drug affected and my dealings with him were very coherent”*. Officer D stated that Mr. A *“did not appear intoxicated, and gave me no reason to be concerned as to his own health”*. ACO D reported that Mr. A *“appeared to be completely sober and in no way drug affected. I had no concerns for this prisoner’s well-being”*.

11. Discovery of Mr. A unresponsive on 1 January 2021

- 11.1 At 02:48, Officer C checked cell 14 and reported Mr. A was cleaning the cell after the medical emergency. Officer C stated that Mr. A *“was in bed on subsequent checks with no signs of distress”*. Officer C conducted further checks on Mr. A’s cell at 03:13, 04:03, 05:02, and 06:34. Officer I conducted a check on Mr. A at 07:10.
- 11.2 At 8:25 on 1 January 2021, the 9F landing was unlocked for breakfast. Breakfast Guard⁷ Officer J entered cell 14 with Mr. A’s breakfast and saw him on the bottom bunk. Officer J reported that Mr. A *“grunted something at me, I was aware his English was very poor so I was satisfied with this response”*.
- 11.3 ACO E took charge of the West 2 unit at approximately 08:35 and proceed to check on all eight prisoners with Officer K and Officer L. On arrival outside cell 11 where Prisoner 1 was located, Officer K called out but received no response. ACO E entered cell 11 with Officer K and Officer L and found Prisoner 1 unresponsive and his breathing was laboured. Officer K contacted Nurse C via Tetra radio and an emergency response was put in place and an ambulance called.
- 11.4 At approximately 08:45, Nurse C, Nurse D, and Chief Nurse Office (CNO) A attended cell 11 and immediately began to administer medical treatment to Prisoner 1. At 09:10, Dublin Fire brigade with four crew members arrived at the front gates and two members made their way to West 2 Unit escorted by Officer L. ACO E contacted Chief A and advised them of the situation and Chief A contacted ACO F and requested him to speak with Mr. A to determine the type and quantity of drug consumed by Prisoner 1. ACO E reported Prisoner 1 was revived and discharged by ambulance at approximately 10:30 to Tallaght Hospital.
- 11.5 At 9:15, ACO F accompanied by Officer M and Officer N attended cell 14 to speak with Mr. A to obtain more information on what had happened to his cellmate during the night. Officer J unlocked the cell at approximately 9:20 to allow ACO F, Officer M and Officer N to enter the cell. On entering the cell, Officer N observed Mr. A lying on his right side in the bed and reported that, *“His face looked grey and there was a white substance around his lips”*. Mr. A did not respond to the officers, prompting Officer N to call a ‘Code Red’ seeking medical assistance.

12. Healthcare and Ambulance Services Intervention

- 12.1 At 9:20, Nurse E responded to the Code Red emergency call and on arrival at cell 14, Nurse E asked officers to lift Mr. A onto the floor of the cell to enable chest compressions to commence.

⁶ This is a form that Prison Officers use to submit allegations of breaches of prison discipline to the Governor.

⁷ The Officer who is in charge of the landing during breakfast break.

A decision was taken not to remove Mr. A from the bed due to his physique; Mr. A. weighed 222kg. Mr. A was moved into a supine position⁸ on the bed to allow chest compressions to be delivered. It is recorded on PHMS, by Nurse E, that Mr. A *“was found lying on his right side, on his bed, and he was unresponsive. Oximonitor did not give a reading for saturation levels or heart rate. Prisoner was not breathing and his chest was not rising”*. Approximately three minutes later, CNO A and Nurse F arrived at cell 14 to offer medical support.

- 12.2 Nurse F reported arriving on 9F at approximately 09:23 and described observing Mr. A lying flat on the bed unresponsive with Nurse E performing active compressions. CNO A reported arriving at the cell at approximately 09:25 and saw Mr. A lying on his back on the lower bunk with Nurse E performing chest compressions. CCTV footage confirmed the arrival time of CNO A and Nurse F at 09:25. Nurse F took over chest compressions from Nurse E and reportedly, *“did a cycle of 30 compressions, [Mr. A] still no pulse and unresponsive”*. CNO A then took over chest compressions from Nurse F. At 09:27, Nurse A arrived at cell 14 and it was recorded on PHMS that, *“Pupils pinpoint - Naloxone administered by myself right deltoid”*. It was recorded on PHMS, by Nurse E, that they *“administered the second 0.400mcg Naloxone IM injection at approximately 09:30 into the right thigh with no effect”*.
- 12.3 Paramedics were already at the prison and went to assist on 9F. CCTV footage confirmed that the paramedics arrived at the scene at 09:33. CNO A reported that upon their arrival, the ambulance paramedics provided direction on how to move Mr. A from the bed. Mr. A was placed on the landing in order to provide necessary assessment and emergency care.
- 12.4 Paramedics and nurse officers continued cardiopulmonary resuscitation (CPR)⁹ on the landing. Nurse F reported a defibrillator was attached with no sign of pulse noted. CPR continued, followed by regular cycles of oxygen until 09:54 when the decision was taken by the lead paramedic to discontinue. Mr. A was returned to the cell which was master locked.
- 12.5 Doctor A pronounced Mr. A deceased at 10:50.

13. Critical Incident Review Meeting

- 13.1 A Critical Incident Review Meeting¹⁰ took place on 4 January 2021. Attendees included prison management, officers and healthcare staff. Discussions focused on Mr. A's time in custody along with the sequence of events leading to his death. Healthcare staff explained how chest compressions were ineffective as there was no satisfactory angle. CNO A explained that paramedics provided instruction on how to handle Mr. A's large physique and Mr. A was placed on a monitor that examined the effectiveness of the compressions.

⁸ The supine position means lying on their back with the face and torso facing up, as opposed to the prone position, which is face down.

⁹ Cardiopulmonary resuscitation (CPR) is an emergency treatment that's done when someone's breathing or heartbeat has stopped. For example, when someone has a heart attack or nearly drowns. CPR can help save a life.

¹⁰ This meeting is between prison management and all prison staff who were involved in the incident of who may have relevant information. These are conducted to identify good practice, potential shortcomings and to address any welfare needs. In this case no issues of concern were raised or identified.

- 13.2 A recommendation from the meeting suggested training for nursing staff in the physical handling of large prisoners. It was believed that all procedures were followed. No recommendations were recorded at the conclusion of the meeting.

14. Recommendations

14.1 The Office of the Inspector of Prisons makes the following four recommendations:

1. Where there is suspicion that a prisoner has become unwell due to the ingestion of an illicit substance, all occupants of the cell should receive a thorough medical assessment.
2. If it is suspected that a prisoner removed from a cell, following a suspected overdose, may be concealing drugs internally (for example, because no drugs were found during a thorough cell search), health care professionals should take the lead in decision making regarding the supervision and care of that person. All such decisions should include a recorded risk assessment.¹¹
3. If it is deemed necessary to isolate a person from the general prison population because of a suspicion that they have internally secreted drugs or other items of contraband, they should be subject to medical, not security, observation – including at night – irrespective of whether they are held in a Special Observation Cell (SOC), Close Supervision Cell (CSC) or separation cell.
4. The Irish Prison Service should explore the viability of providing ‘chest compression machines’ to assist staff who are administering CPR.

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.

¹¹ It is recalled that, in its death in custody investigation reports into the deaths of Mr C 2021 and Mr E 2021, the OIP has already recommended a range of measures designed to improve the handling of cases involving the suspected internal secretion of drugs. The IPS has accepted the following recommendations,

- The Irish Prison Service should introduce a health care focused policy to respond to the threats and safety risks posed by the internal secretion of drugs and other items of contraband. This policy should clarify the roles and responsibilities of management, prison officers, and healthcare staff;
- This new policy should provide for a central role for health care professionals in decision making regarding the supervision and care of a person where there is a suspicion of internal secretion of drugs and other items of contraband. All such decisions should include a recorded risk assessment;
- The Irish Prison Service should intensify its efforts to physically prevent contraband from entering the prisons and to detect its presence once on the premises, including through technological means.