



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. Z

**In the Mater Misericordiae
University Hospital
while in the custody of
Mountjoy Prison
15 November 2024
Aged 53**

To the Minister: 31 July 2026

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GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
CCTV	Closed Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DFB	Dublin Fire Brigade
IPS	Irish Prison Service
NAS	National Ambulance Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prison Healthcare Management System
SO	Service Support Officer
TARP	Treatment and Rehabilitation Programme
WTO	Work Training Officer

INTRODUCTION

1. Preface

- 1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Chief Inspector of Prisons has been obliged to investigate all deaths in prison custody. This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carries out regular inspections of prisons. The Office is independent of the Irish Prison Service (IPS). The Chief Inspector of Prisons and the staff of the OIP are independent of the Department of Justice, 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. Z's death in hospital, following his transfer from Mountjoy Prison on 15 November 2024, and the management of the events associated with his death.

4. Administration of Investigation

- 4.1 On 15 November 2024, the OIP was notified that Mr. Z had passed away in the Mater Misericordiae University Hospital, while in the custody of Mountjoy Prison. The investigation team attended the prison on 16 November 2024 and met prison management who provided an overview of Mr. Z's time in custody. Inspectors also met with persons who had contact with Mr. Z 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 communicated with Mr. Z's NoK, his father and mother, by letter on 6 February 2025 and followed up with telephone calls on 5 and 7 March 2025. The NoK did not have questions that they wanted answered as part of the investigation.
- 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. Z's NoK in mind.
- 5.4 The OIP is grateful to Mr. Z's NoK for their contributions to this investigation and we offer our sincere condolences on his loss.

INVESTIGATION

6. Mountjoy Prison

- 6.1 Mountjoy Prison is a closed, medium security prison for men. It is the main committal prison for Dublin city and county. It has an operational capacity of 755 beds. On 15 November 2024, there were 886 men accommodated in Mountjoy Prison, 117% of its capacity.
- 6.2 At the time of his death, Mr. Z's was the fifth death of a prisoner from Mountjoy Prison in 2024; and the twenty sixth death in IPS custody that year.

7. Background

- 7.1 Mr. Z was remanded to Cloverhill Prison on 3 September 2021. He was sentenced to life imprisonment on 3 March 2023 and was subsequently transferred to Mountjoy Prison.
- 7.2 Mr. Z was 53 years of age when he died. From 31 July 2024 until his death on 15 November 2024, Mr. Z occupied a number of cells in Mountjoy Prison's Progression Unit. At the time of Mr. Z's death, the Progression Unit at Mountjoy Prison, located separately from the main prison complex, was designated for prisoners who demonstrated positive behaviour and active engagement in rehabilitation. However, since March 2024 and due to overcrowding across the prison estate, the unit has been repurposed to accommodate a broader cohort of prisoners as part of the main prison regime. During Mr. Z's time in the Progression Unit, he worked as a cleaner in the Chaplain's office and Church.
- 7.3 Following an incident involving an assault of another prisoner on 14 November 2024, Mr. Z was the subject of a P19¹ disciplinary procedure. As a result, he was moved from the Progression Unit to cell 22 on the B1 landing located in the main prison.
- 7.4 The investigation team was provided with a copy of a letter left by Mr. Z in his cell on the B1 Landing, for the attention of his family and loved ones.

8. Medical Care

- 8.1 On 4 September 2021, Doctor A conducted a committal assessment of Mr. Z in Cloverhill Prison. Doctor A recorded in the Prison Healthcare Management System (PHMS) that Mr. Z denied any prior diagnosis of mental illness but disclosed having anger management issues.
- 8.2 On 14 December 2021, at Mr. Z's request, he was prescribed 50mg per day of Sertraline, an antidepressant, by Doctor A. Mr. Z reported his mood was low and he had used an antidepressant in the past. Mr. Z's Sertraline use was reviewed over the following months by Doctor A. On 22 March 2022, Doctor A increased the dosage to 100mg per day, as Mr. Z had reported that he was experiencing a "*lack of motivation*".

¹ The P19 system refers to the disciplinary system in place under the Prison Act 2007. A breach of prison discipline generates a P19 report, which allows Governors to impose sanctions, such as a loss of privileges, e.g. loss of phone calls.

- 8.3 On 26 August 2022, Psychiatrist A recorded undertaking a “*Mental State Examination*” as part of a court report requirement for Mr. Z. Psychiatrist A opined that Mr. Z did “*not convince as suffering any major affective or psychotic illness*” and that there was no indication for the need for psychiatric hospitalisation at that time. Psychiatrist A conducted a further review on 26 October 2022 and recorded that there was “*no acute symptoms of major mental illness elicited and no indication for psychiatric medication or hospitalization*”.
- 8.4 On 4 March 2023, Doctor B recorded a Mountjoy Prison committal interview for Mr. Z in the PHMS. Doctor B noted that Mr. Z presented as in “*good form*” with a medical history of “*depression, anxiety and heavy drinking*”.
- 8.5 On 6 March 2023, Psychiatric Nurse A submitted a transfer letter on the PHMS from Cloverhill Prison to Mountjoy Prison. This letter provided Mr. Z’s own account of his previous history with the criminal justice system. Psychiatric Nurse A recorded that when Mr. Z was requested to clarify certain details, he became irritable and left the assessment. Psychiatric Nurse A recorded that Mr. Z had “*no acute symptoms of major mental illness and no indication for psychiatric medication or hospitalisation*”. However, Psychiatric Nurse A requested that a follow-up appointment be arranged for Mr. Z with the in-reach psychiatric service at Mountjoy Prison.
- 8.6 On 22 November 2023, Mr. Z was written to by Psychologist A and advised that a meeting had been scheduled for him on 28 November 2023. Mr. Z was informed that this meeting was part of a joint initiative between the Psychology Service and the Probation Service for life-sentenced prisoners. The purpose of the meeting was to discuss a plan for Mr. Z’s engagement with both services which would contribute to the development of his sentence plan.
- 8.7 On 28 November 2023, the meeting, as scheduled, took place with Psychologist A, Probation Officer A, and Mr. Z in attendance. Psychologist A made a record of the meeting, which noted that Mr. Z was unhappy in Mountjoy Prison, as he viewed it as having limited opportunities for prisoners serving a life sentence. It was recorded that Mr. Z was motivated and open to engaging with rehabilitative programmes with a view of progressing his sentence. The meeting went on to outline the Parole Board process and associated engagement with psychology. Mr. Z was informed that he was on a waitlist for his first-year risk assessment, but it was also explained that due to the limited resources in psychology, there would be a delay in calling him for this assessment. The record added that they “*assured him he was not forgotten about*”.
- 8.8 From 19 December 2023 to 5 March 2024, Mr. Z was accommodated in the Mountjoy Prisons’ Medical Unit. While there, Mr. Z participated in a Treatment and Rehabilitation Programme (TARP). TARP is aimed at providing intensive recovery for addiction. On 13 January 2024 and 5 February 2024, Mr. Z tested negative for illicit substances as part of the TARP requirements. No other drug tests are recorded for Mr. Z at this time. While in the medical unit, Mr. Z was provided with Zimovane “*under supervision*” on 28 December 2023 and 4 January 2024. Zimovane is used in the treatment of insomnia and short-term sleeping problems.
- 8.9 On 5 March 2024, Mr. Z was moved from the Medical Unit to the Progression Unit, where he occupied six different cells on the B, D and C landings during the eight months he was accommodated there. At the time of the events of 14 of November 2024, he was occupying cell 11 on the C1 landing.

9. Events of 14 November 2024

- 9.1 On 14 November 2024, Assistant Chief Officer (ACO) A recorded that at approximately 11:30 he received a call from Visitor A. Visitor A is associated with Bohemians Football Club and regularly attended the prison to facilitate football sessions with prisoners in the Progression Unit. ACO A stated that Visitor A reported an “*altercation*” between Mr. Z and Prisoner 1 during the football session.
- 9.2 ACO A recalled that at lunchtime that same day, both Mr. Z and Prisoner 1 came to see him and informed that it was something minor and that there was no ill will between them. ACO A noted that he confirmed this with both prisoners separately.
- 9.3 A statement from Visitor A was provided to the investigation team. Recalling the event, Visitor A stated that it was towards the end of the football session when he observed an off the ball incident in which Mr. Z tackled Prisoner 1, causing both men to fall to the ground. Visitor A documented that Mr. Z stated that he did not know what had happened, only that he had blacked out. He described Mr. Z as seeming “*confused*” and Visitor A reported that the session concluded shortly afterward, with all participants leaving the yard without further incident.
- 9.4 Prisoner 1 recorded in his statement that he and Mr. Z were playing football, in the yard, and were on opposing teams. While waiting on a pass, he felt that Mr. Z “*kinda slammed into me*” [sic]. Prisoner 1 recalled that he thought Mr. Z was messing at first but then pushed him away. Prisoner 1 stated they went to ACO A, as described, shook hands and the matter was then considered forgotten about.
- 9.5 The investigation team reviewed CCTV of the football session. At 11:03:54, Mr. Z was observed to be the goalkeeper, standing at the corner of the goalkeeper’s box. Prisoner 1 was observed walking towards Mr. Z, who was watching the game and waiting for the ball, which was at the other side of the pitch. There was no visible indication of a verbal exchange between the two men. Then, Mr. Z could be seen running from the edge of the goal box with both hands raised, striking Prisoner 1 at his neck and shoulder area. At 11:03:56, Prisoner 1 fell to the ground and Mr. Z fell on top of him. At 11:04:01, both prisoners were observed struggling on the ground. At 11:04:03, two other prisoners are observed lifting both men off the ground and separating them. Prisoner 1 was observed attempting to approach Mr. Z but was guided away by another prisoner.
- 9.6 Later that day, Chaplain A was in the company of Mr. Z between 15:00 and 16:00 in the chaplaincy office. Chaplain A stated that Mr. Z was feeling a little upset from “*a minor altercation*” that had occurred while he was playing football. Chaplain A described how Mr. Z had been upset after reading correspondence he had received from the UK-based Innocence Project². Mr. Z had reportedly been advised that his case did not fit the criteria necessary for acceptance. According to Chaplain A, Mr. Z spoke of errors he perceived were associated with his case, and expressed frustration that he had not, in his view, been properly assessed by psychology during his time in Cloverhill Prison. Chaplain A recorded that he advised Mr. Z to discuss this with his solicitor. Before Chaplain A walked Mr. Z back to his landing he stated that he asked Mr. Z if he was feeling all right and he confirmed that he was.

² The Innocence Project (London) aims to undertake thorough and objective investigations into alleged wrongful convictions of individuals who maintain their innocence and have exhausted the criminal process.

- 9.7 ACO B reported that at approximately 17:40, she received a report from Officer A and Officer B that there had been an incident on the C1 West Progression Unit landing involving Mr. Z and Prisoner 2. Both officers reported that Mr. Z, Prisoner 2, Prisoner 3, Prisoner 4 and Prisoner 5 were observed talking outside a cell when, at approximately 17:28, Mr. Z had without warning or provocation punched Prisoner 2, who had been standing beside him, in the face, knocking him to the ground.
- 9.8 ACO B reported to the landing to investigate and when she arrived, she observed that Mr. Z was in his cell and Prisoner 3, Prisoner 4 and Prisoner 5 were standing outside Prisoner 2's cell. ACO B stated that Nurse A then arrived on the landing with ACO A, who spoke with Prisoner 2. ACO B recorded that when Nurse A was available, she requested that they check Mr. Z, as "*his behaviour was not normal*". ACO B communicated the incident to the Chiefs Office in the main prison and during her handover with the night shift ACO's. ACO B initiated the P19 disciplinary process for the incident.
- 9.9 Prisoner 3 stated that while the group were chatting on the landing, "*out of nowhere*" Mr. Z struck Prisoner 2 in the face for no reason. He recalled instinctively taking hold of Mr. Z and walked him away from the incident while restraining his hands. Prisoner 3 reported that he asked Mr. Z if he was all right and if he knew what he had done. Prisoner 3 recalled that Mr. Z's response was that "*he had no recollection of what he done*". This assessment of Mr. Z behaviour and recollection of the event was corroborated by Prisoner 5.
- 9.10 Nurse A reported that when they assessed Mr. Z, he was in his cell, sitting on his bed and presented as anxious. Mr. Z informed Nurse A that he was experiencing sleep disturbances and had not slept for the "*past four nights*". Mr. Z expressed to Nurse A that he felt his mental state was chaotic, he needed assistance with sleep management and requested medication to assist. Nurse A advised non-pharmacological interventions providing guidance to Mr. Z on breathing exercises to help with his anxiety. Nurse A reported that he placed Mr. Z on the Doctors list for the next day for review and recorded in the PHMS entry that Mr. Z "*may need psych input*".
- 9.11 The investigation team reviewed CCTV of 14 November 2024 for the event that occurred on the C1 landing. At 17:28:22, Mr. Z was observed in the company of four other prisoners. Prisoner 2 was standing next to Mr. Z who was standing with his arms folded. At 17:28:49, one of the group raised his hand and waved at another person off camera. At 17:28:51, Mr. Z dropped his hands by his side as he and the group look in the direction of the person off camera. One second later, Mr. Z drew back his right hand, made a fist and punched Prisoner 2 on the left side of his jaw/neck area. Prisoner 2 then fell to the floor. Immediately afterwards, Mr. Z was observed holding up both hands, palm open, and he took a step towards Prisoner 2. It is at this point, 17:28:54, Prisoner 3 was observed stepping in to restrain Mr. Z and then moved him down the landing.
- 9.12 On 16 November 2024, members of the investigation team met with Prisoner 2. Prisoner 2 described how both he and Mr. Z had become friends while in prison together and had both been a great support to each other. Prisoner 2 described how Mr. Z had returned from a football session earlier that day and informed him he had been involved in an altercation. He reported that Mr. Z returned to his cell, head in his hands, and was extremely agitated. Prisoner 2 recalled how he made Mr. Z a coffee and got him tobacco and attempted to reassure him. Later, Prisoner

2 described how he had called over to Mr. Z's cell at around 17:30 to organise a card game and that the group of prisoners had been chatting on the landing.

- 9.13 Prisoner 2 described receiving the punch from Mr. Z as a flash, he recalled being struck by Mr. Z in the jaw and neck area and then finding himself on the ground. He stated that he had no memory of what occurred immediately after, other than being aware of the fact that Mr. Z had punched him. Later, at approximately 18:50 while on the landing, Prisoner 2 reported feeling shaken but expressed that Mr. Z's behaviour had been out of character. Prisoner 2 approached Mr. Z's cell, where Mr. Z remained locked back following the incident. Looking through the cell door viewing flap he observed that Mr. Z had his head in his hands and described him by stating that he, "*wasn't with it*". Prisoner 2 recalled that he tried to reassure Mr. Z and expressed his belief that Mr. Z was not fully aware of what he had done. Prisoner 2 reported that medical staff had checked on Mr. Z and that this reassured him.

10. Events of 15 November 2024

- 10.1 On 15 November 2024, Officer C reported that he was on duty on the C1 landing of the Progression Unit. At approximately 09:15, ACO C requested Officer C to leave Mr. Z in his cell after the rest of the cells were unlocked, as Governor A was attending to carry out Mr. Z's P19 disciplinary hearing.
- 10.2 Officer C stated that at approximately 10:30, Governor A attended the Class Office on the C1 landing. There, Governor A conducted the hearing with Officer C and Mr. Z present. Mr. Z's P19 hearing report recorded that during the hearing Mr. Z stated, "*I have insomnia and cannot remember what happened. It's not right what's going on in my head. Can I see a medic.*" Afterwards, Officer C reported returning Mr. Z back to his cell. Officer C was on duty when he facilitated a visit to Mr. Z's cell for the Chief Nurse Officer (CNO A) and Doctor C.
- 10.3 At the request of Governor A, Doctor C conducted a review of Mr. Z in his cell with CNO A, which was recorded in the PHMS. Doctor C provided background in the entry which stated that Mr. Z "*has been previously seen by psychology but I can't find any diagnosis*". Mr. Z informed him that he was previously in the Central Mental Hospital and had been transferred from there to Tallaght University Hospital.
- 10.4 Doctor C noted how Mr. Z presented and documented that Mr. Z felt his mind was racing and that he had insomnia for the last four days. Mr. Z reported that he could not remember the event from the previous day and that "*I hit my mate for nothing, I just hit him*". Doctor C recorded that Mr. Z denied taking drugs and that Mr. Z had no thoughts of self-harm or suicide and no obvious signs of psychosis. Doctor C's documented plan was that Mr. Z was to be referred to psychology and be prescribed 10mgs of Olanzapine³ until he received a psychology assessment.
- 10.5 Officer C reported that at approximately 11:00, he was requested by ACO C to inform Mr. Z that he was to pack his belongings as he was being relocated to Mountjoy's Main Prison. At approximately 11:45, Officer C stated that he escorted Mr. Z to the main prison to ACO D at the B1 Class Office at 11:55.

³ Olanzapine is used in the treatment of bipolar disorder and schizophrenia.

- 10.6 ACO D stated that at 11:40 he received a call from Officer D who informed him that Mr. Z had arrived on the B1 landing. ACO D reported to the Class Office on B1 and met with Officer D and Officer E and observed them conducting a protection assessment interview with Mr. Z. When the interview concluded, he spoke with Mr. Z who then requested to start a methadone programme. ACO D liaised with the nursing staff to arrange an assessment.
- 10.7 Officer D stated, in her report, that when the protection assessment concluded, Mr. Z was assigned into the blue protection group on the B1 landing. This was one of a number of smaller groups of “protection” prisoners in place at the time. Only members of the same “protection” group were allowed to associate with each other when out of their cells. Officer D recorded that she then escorted Mr. Z to his cell (22) and provided him with cutlery before he collected his dinner from the servery. Officer D reported that a nurse called to Mr. Z’s cell at 12:00 to obtain a urine sample for drug testing based on his methadone programme request. The investigation team confirmed the urine drug test returned a negative result for illicit substances.
- 10.8 Officer E reported that at approximately 12:20, he conducted a cell check of the landing with Officer D and that during this check he observed Mr. Z unpacking his belongings in his cell. The investigation team reviewed CCTV for Mr. Z’s landing and observed an officer conducting a cell check on Mr. Z at 12:16:34, stopping at the cell and looking through the viewing flap before moving on.
- 10.9 The events which happened next were documented in a report compiled by ACO E. ACO E recorded that Officer F was the Dinner Guard on duty on B1. At 12:35, Officer F conducted a cell check of Mr. Z and on observing Mr. Z, he called a “*Code Red*”⁴ on his TETRA⁵ radio. Officer F withdrew the keys and unlocked the cell. The investigation team observed Officer F, on CCTV, conducting a cell check at 12:42:10. He was then seen running up the landing while speaking into his Tetra Radio at 12:42:14. Entry into the cell was noted by the investigation team as occurring at 12:43:08.
- 10.10 ACO D recorded in his statement that he responded to the code red at 12:40 and that on entering the cell, he observed Mr. Z as “*prone and unresponsive*”. ACO E’s report detailed that Work Training Officer (WTO) A, who also responded, removed a ligature from around Mr. Z’s neck. ACO D stated that CNO A and Nurse B arrived soon after he had entered the cell and began the delivery of CPR⁶. The ligature was made from plastic bags that had been provided to Mr. Z for packing his belongings when he was transferred from the Progression Unit to the main prison.
- 10.11 CNO A recorded in the PHMS that he received a call for medical assistance at approximately 12:40 and in the company of Nurse B, he attended the B1 landing. CNO A noted that on entering the landing he observed Mr. Z in a “*supine position head to his left side*”. CNO A detected no pulse and commenced CPR. CNO A stated that Nurse B retrieved the (Automated External

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

⁵ Terrestrial Trunked Radio (TETRA) is a digital encrypted radio handset system used by IPS officers to communicate with each other securely.

⁶ CPR or Cardiopulmonary Resuscitation is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest.

Defibrillator) AED and once applied to Mr. Z, no “*rhythm*”⁷ was detected. The delivery of CPR is reported, by CNO A, as continuing for another nine to ten minutes.

- 10.12 The investigation team reviewed CCTV and observed two prison personnel running up the B1 landing carrying a green medical bag. Both entered Mr. Z’s cell at 12:44:21. At 12:44:59, one staff member was observed leaving the cell and running up the landing. She returned at 12:45:25 carrying another bag while being followed by two other staff members, one of which was carrying the prison emergency medical red bag.
- 10.13 Nurse B recorded in her PHMS entry that the delivery of CPR continued until the arrival of the Dublin Fire Brigade (DFB), who then took control of the delivery of emergency care to Mr. Z. The investigation team’s review of CCTV confirmed the arrival of the DFB to Mr. Z’s cell at 12:53:47. At 12:58:58, a National Ambulance Service (NAS) paramedic was observed entering Mr. Z’ cell, quickly followed by two other NAS personnel who arrived with an ambulance trolley and equipment. At 13:04:26, Mr. Z was removed from the cell by the responding emergency services and placed on the trolley on the landing, where the delivery of CPR continued while an AED remained attached to Mr. Z.
- 10.14 At 13:16:18, the responding emergency services of NAS and DFB were observed leaving the B1 landing with Mr. Z on the ambulance trolley. CNO A recorded in his PHMS entry at 14:08 that Mr. Z was transported to hospital for further evaluation. At 14:16, CNO A recorded that he had contact with the Mater Hospital and was advised that three more cycles of CPR had been delivered to Mr. Z; however, his death was pronounced at 13:32.

11. Critical Incident Review Meeting

- 11.1 On 20 November 2024, a critical incident review meeting⁸ (CIRM) was held by Governor B. In attendance were Chief A, Chief B, Chief C, ACO D, ACO F, WTO A, WTO B, CNO A, Nurse B, Nurse C, Officer E, Officer F, Prison Officer Association (POA) representative A, Psychologist B, Psychiatric Nurse B, Psychiatric Nurse C, Head of Risk Assurance and Compliance for the IPS, Chaplain B and Service Support Officer (SO) A.
- 11.2 Governor B outlined the purpose of the meeting, which was to review the events around Mr. Z’s death on 15 November 2024, the procedures that were followed, and identify any lessons to learn. A full timeline of events was then discussed at the meeting.
- 11.3 Psychologist B stated that the Psychology Service and the Probation Service had last met with Mr. Z in 2023 and noted that no risks or distress were identified.
- 11.4 It is recorded in the minutes of the CIRM that Psychiatric Nurse B and Psychiatric Nurse C outlined that Mr. Z was not on their caseload and they had only been made aware of him on the morning of the 15 November 2024.

⁷ A no shock message from the AED can mean that the person has a pulse, regained a pulse, or the victim is pulseless but is not in a shockable rhythm.

⁸ 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.

- 11.5 Chaplain B confirmed that he had spoken with Mr. Z's NoK (parents) and his sister. Chaplain B stated that he had arranged to meet with the family prior to the funeral and to keep in contact with them.
- 11.6 Chief B stated that the initial Code Red was not heard by the Nurses. CNO A and Nurse B confirmed this at the CIRM and it was noted that the initial radio transmission was not received at the nurse's station. When they responded, they only did so with a green medical bag which did not have an AED. This resulted in a delay of just over one minute before the AED became available. CNO A and Nurse B recorded that the floor of Mr. Z's cell was covered in washing up liquid, as was Mr. Z's body, which made it extremely difficult to perform CPR. In response, they placed blankets on the floor to provide some stability.
- 11.7 Governor B commended all for their outstanding and difficult work and for following protocol and procedures. Head of Risk Assurance and Compliance for the IPS also acknowledged the traumatic event and requested confirmation on what time Mr. Z's cell was last checked. This was recorded in the CIRM as 12:21.
- 11.8 No recommendations were recorded at the conclusion of the CIRM.

12. Recommendations

- 12.1 The Office of the Inspector of Prisons makes the following three recommendations:
1. Following violent incidents and observed confused or agitated behaviour, the Irish Prison Service should introduce a formal escalation and risk assessment process. This process should ensure that any sudden or repeated changes in a prisoner's behaviour are reviewed and recorded. These reviews should inform all decisions regarding relocation from a progression or open unit to a closed prison, cell placement, and the issuing of items that may present a safety risk.
 2. The Irish Prison Service should ensure that all incidents of violent or unusual behaviour are consistently documented and communicated to relevant staff. This information should be considered in risk assessments and operational decision making to ensure that critical behaviours are not overlooked in management reviews.
 3. Considering that senior prison and healthcare staff stated at the CIRM that the initial Code Red transmission was not received, the OIP recommends that the Irish Prison Service conduct a technical and operational review of the TETRA radio system in Mountjoy Prison to identify any coverage gaps equipment failures or procedural weaknesses and ensure that emergency calls are reliably received by healthcare and operational staff.

13. Support Organisations

- 13.1 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.