



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. K
Cork Prison
14 March 2024

Submitted to the Minister: 24 May 2024

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GLOSSARY

ACO	Assistant Chief Officer
CNO	Chief Nurse Officer
DiC	Death in Custody
HSE	Health Service Executive
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
VPU	Vulnerable Persons Unit

INTRODUCTION

1. Preface

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

2. Objectives

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

3. Methodology

- 3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, next of kin (NoK); analysis of prison records in relation to the deceased's life while in custody; and examination of evidence, such as CCTV footage and phone calls
- 3.2 This report is structured to detail the events leading up to Mr. K's death in prison on 14 March 2024 and management of the events associated with his death.

4. Administration of Investigation

- 4.1 On 14 March 2024, the OIP was notified that Mr. K had passed away while in the custody of Cork Prison. The investigation team attended the prison on the same day, and on the following day, and met with prison management and other persons who could provide an overview of Mr. K's 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 Chief Inspector of Prisons' role when investigating a death in custody.
- 5.2 The Investigating team spoke with Mr. K's sister by phone on 20 March 2024. Members of the investigating team also held an in-person meeting with Mr. K's family, including his mother, sister and aunt on 2 April 2024.
- 5.3 Although this report is for the Minister for Justice, it may also inform several interested parties. It is written primarily with Mr. K's family in mind.
- 5.4 The OIP is grateful to Mr. K's extended family for their contributions to this investigation and we offer our sincere condolences on their sad loss.

INVESTIGATION

6. Cork Prison

- 6.1 Cork Prison is closed, medium security prison for adult males. It is the committal prison for counties Cork, Kerry and Waterford. It has an operational capacity of 296 beds. On 14 March 2024, Cork Prison was overcrowded, housing 325 persons. This represents 110% of its operational capacity.
- 6.2 Mr. K was the third death of a prisoner from the Cork Prison in 2024; and the eleventh death in IPS custody this year.

7. Family Concerns

- 7.1 Mr. K's, family requested information on the events prior to Mr. K's passing, which are outlined in this report.
- 7.2 The family expressed anger that Mr. K had been released from hospital on 13 March 2024 and returned to Cork Prison in what they felt was an extremely short period of time following his transfer to hospital. The family expressed the view that a person in the outside community would not have been released from hospital so quickly, but would rather have been provided with more recovery time and greater health monitoring in a hospital setting. Members of the investigation team explained that the OIP has no remit over the HSE or medical care provided in a public hospital but would record their concern.
- 7.3 The family sought information on what medication Mr. K was prescribed while in the custody of Cork Prison. The OIP confirmed Mr. K was prescribed: Librium, methadone, Epilim and Benerva B1 vitamin tablets. The OIP were informed by the Chief Nurse Officer (CNO) A that Epilim was prescribed by the prison doctor as part of Mr. K's detoxification programme. More detailed information on Mr. K's medication was provided to the NoK privately by the OIP.
- 7.4 The family inquired why Mr. K's partner was listed as his NoK. The investigation team confirmed with prison management that Mr. K had informed the Reception Officer on his committal that his partner was his NoK and he had provided a mobile contact number and an address, which had been recorded on the Prison Information Management System (PIMS). Following Mr. K's passing, the investigation team was informed by Mr. K's family that Mr. K's partner and family agreed that Mr. K's sister should act as NoK and contact person.
- 7.5 Mr. K's family inquired about his personal belongings. The investigation team received confirmation from senior management at Cork Prison that Mr. K's belongings were still in their possession. Mr. K's sister was advised accordingly and was also advised to call or email the prison as they were awaiting contact to finalise arrangements for collection of her brother's personal belongings.

8. Background

- 8.1 Mr. K was a 27 year old remand prisoner committed to Cork Prison on 8 March 2024. He was on the standard level of the incentivised regime¹. Mr. K was next due before the courts on 20 March 2024.
- 8.2 Mr. K was accommodated in cell 6 on the Vulnerable Persons Unit (VPU), B1 landing, Cork Prison. Mr. K shared cell 6 with Prisoner 1. Mr. K entered cell 6 on 13 March 2024. Prior to this he shared cell 4 with Prisoner 2 on the A3 landing.
- 8.3 Mr. K and Prisoner 1 were placed on the VPU following two separate incidents. In respect of Mr. K, as outlined below, he had been found unresponsive in his cell on 12 March 2024 and Prisoner 1 had been self-harming. Both prisoners were on “special observations” which meant that prison officers should check the cell every 15 minutes.

9. Events of 12 and 13 March 2024

- 9.1 ACO A reported that, on 12 March 2024, he took charge of A Division at 17:20. Chief Officer A informed ACO A that Mr. K had “*taken a fit during the tea break*”. Officer A attended Mr. K’s cell at 17:25 and described Mr. K as “*drifting in and out of consciousness*”. Officer A assisted Mr. K from the top bunk to bottom bunk to facilitate medical review. ACO A arrived to Mr. K’s cell where Nurse A was assessing Mr. K. Nurse A recorded on the Prison Healthcare Management System (PHMS) that Mr. K was pale, sweating and his eyes appeared to be rolling in his head. Mr. K mentioned suffering withdrawal seizures and stated that he was not feeling well. Mr. K reported that he had a recent history of taking unauthorised medication and up to 100 mls of methadone which he stated he had purchased on the street prior to entering prison. Mr. K was described as becoming alert and orientated after speaking to Nurse A.
- 9.2 Officer B described checking Mr. K’s cell on several occasions between 21:00 on 12 March 2024 and 03:00 on 13 March 2024. ACO A attended Mr. K’s cell and described finding Mr. K as “*very drowsy*” and contacted Nurse B. At approximately 20:45 Nurse B woke Mr. K and assessed him. Nurse B reported that he contacted Doctor 1 regarding Mr. K, who instructed Nurse B to keep regular checks on Mr. K. Nurse B recorded on the PHMS that he walked with Mr. K on the landing at approx. 21:10 and offered him tea which he accepted. Mr. K apologised for causing concern and it is noted in the medical records that he was alert and clear in his communication when the nurse left. Nurse B advised Mr. K to try and get some rest. ACO A reported that Nurse B asked Prisoner 2 to contact staff if he had any further concerns regarding Mr. K’s wellbeing.

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.

- 9.3 At approx. 00:00 (midnight) ACO B took charge of Cork Prison from ACO A. ACO B reported that he was provided with a verbal handover update by ACO A who informed him that Mr. K appeared to be under the influence of drugs and was "*all over the place*" and the night guards² and healthcare staff were checking him on a regular basis.
- 9.4 Nurse B checked on Mr. B at 00:00, 01:00. Officer B during the 02:00 check on 13 March 2024 reported finding Mr. K as "*very incoherent in his cell*" and contacted Nurse B. Nurse B attended the cell and recorded on the PHMS that Mr. K was very drowsy and that he had significant deficiency in his oxygen saturation levels and therefore he had called for an ambulance. ACO B reported that Nurse B informed him that he had called an ambulance for Mr. K as he was unresponsive in his cell. The ambulance arrived at approximately 02:45. Mr. K was placed on a stretcher and removed from the prison to Mercy University hospital at 03:05 under prison officer escort.
- 9.5 ACO B reported that at approx. 04:40 he received a tetra call³ from Officer B who escorted Mr. K to the hospital. Officer B informed ACO B that Mr. K had been assessed and was being discharged from Mercy University hospital. Mr. K arrived back to Cork Prison at approximately 05:25 and was returned to cell 4 on the A3 landing which he shared with Prisoner 2.
- 9.6 Nurse B recorded on the PHMS at 06:47 that, having examined Mr. K, he appeared "*to be in better form/still drowsy but fully responsive*". It was noted from Mr. K's hospital discharge letter that Mr. K had suffered a seizure due to drug withdrawal. Mr. K was removed to the B1 landing at approx. 10:50 and placed in cell 6 on the VPU.
- 9.7 Governor A reported that he had a conversation with Mr. K following his transfer to the VPU. He described Mr. K as appearing relaxed on his bed and asked if he could return to the A3 landing. Mr. K informed the Assistant Governor that he had been given medication in hospital to stop his "*fits*".
- 9.8 The CNO confirmed to the Investigation team that Mr. K was not prescribed additional medication by the hospital doctor. The discharge letter noted that Mr. K suffered withdrawal seizures and that he was to remain on medication prescribed by the prison doctor. The letter also advised "*close observation at prison discretion*". A chest X-ray was taken.
- 9.9 Cork Prison management confirmed that Mr. K's cell was **not** searched for drugs by prison operational or security staff following these incidents and/or prior to Mr. K being placed back in the cell following his return from hospital.

² Prison Officers on duty at night are known as Night Guards

³ TETRA (Terrestrial Trunked Radio) is a professional mobile communication system used within prisons allowing prison operational staff to engage with each other, A Tetra call allows two way communication between two officers..

10. Discovery 14 March 2024

- 10.1 While in the VPU, Mr. K was subject to 15 minute checks by prison officers which continued throughout the night of 13-14 March and into the morning of 14 March 2024. The OIP reviewed the CCTV footage covering this time period as part of its investigation and can confirm that officers checked Mr. K's cell more frequently than 15 minute intervals. Mr. K was checked nine times between 06:01 and a final check at 07:40.
- 10.2 At 07:43:36 Prisoner 1 activated the in cell call bell which alerted staff to cell 6. Officer C arrived at 07:44:05 and reported that Prisoner 1 informed him Mr. K was not breathing. Officer C immediately called for a medical assistance. Nurse C and Nurse D arrived at cell 6 at 07:45:48. Prisoner 1 was relocated to a neighboring cell.
- 10.3 Nurse C recorded on the PHMS that Mr. K was discovered in his bed lying on his back and was not breathing. Nurse C also noted that on further observation it was evident Mr. K had passed as there was no signs of life and rigor mortis was present. No resuscitation was attempted.
- 10.4 Doctor 1 attended cell 6 at 07:45 and pronounced Mr. K dead at 07:58. An Gardaí Síochána arrived at 09:10. Undertakers working on behalf of the Coroner arrived at 11:10, departing the prison with Mr. K's remains 11:30.

At the time of sending this report to the Director General of the Irish Prison Service for a review of factual accuracy, the OIP has yet to learn of the pathologist's finding as regards the likely time of Mr K's death but, given the presence of rigor mortis, it seems probable that he had been dead for some time before his cell mate, Prisoner 1, activated the cell call system and health care staff attended. The Inspectorate will update this section of the report if it receives the relevant information before transmitting this report to the Minister for Justice.

- 10.5 Members of the investigation team met with officers who conducted night checks on Mr. K. These Officers described how they observed Mr. K through the glass panel in the cell door, could see him in bed and had believed Mr. K had been asleep throughout the night.

11. Committal Interviews

- 11.1 Mr. K underwent a Nursing committal interview on 8 March 2024 with Nurse E. It was recorded that Mr. K had no indication that he may deliberately self-harm and that he believed his life was worth living. Mr. K had no history of prescribed methadone treatment in the general community. Mr. K informed the nurse that he was a drug user and would regularly take heroin, street methadone and benzodiazepines. Mr. K was placed on a referral list for addiction counselling.
- 11.2 On 9 March, Doctor 1 assessed Mr. K and recorded on the PHMS that Mr. K had a history of drug and alcohol addiction. Mr. K provided a urine sample which detected the presence of a number of drugs. Mr. K was quoted as describing his mood as "*very sick*". Mr. K reported he had a stab wound to his right thigh. Doctor 1 prescribed medication (section 7.3) including methadone and endorsed the nurse's referral for addiction counselling.

12. Prisoner 1

- 12.1 On 14 March 2024, the OIP investigation team attended Cork Prison to speak to Prisoner 1 to obtain his account of events leading to the death of Mr. K. Upon arriving on the VPU Division at approx. 15:35, the investigation team encountered a live medical emergency and were informed that Prisoner 1 had just been discovered unresponsive in cell 7. Consequently, it was not possible or appropriate to attempt to interview him on that day.
- 12.2 Prisoner 1 was revived by the prison healthcare team before departing to Mercy University hospital by ambulance. The investigation team were informed that Mr. K was treated in hospital and returned to Cork Prison in the early hours of 15 March 2024. Upon his return to Cork Prison, Prisoner 1 was placed into cell 6 on the VPU, the same cell where his cell mate, Mr. K, had passed in his presence the previous day.
- 12.3 On 15 March 2024, a member of the OIP investigation team again met with Prisoner 1 at Cork Prison. Prisoner 1 professed to be greatly affected by the passing of Mr. K. He presented as very distressed at being placed back in the same cell where his cell mate, Mr. K, had passed away. Prisoner 1 reported that Mr. K had taken his prescribed methadone in the afternoon of 13 March 2024 and that he didn't appear well when he returned to their cell.
- 12.4 Prisoner 1 said that, in the "early hours" of 14 March 2024, he observed that Mr. K was making strange noises, talking to himself and his eyes were rolling in his head. However, there is no evidence that Prisoner 1 activated the cell call system at that moment.
- He also stated that, later that same morning, he had checked Mr. K's pulse and found none, and he then activated the cell call system (as mentioned above, this was at 07:43:36).
- Prisoner 1 said that believed it was possible Mr. K had access to heroin and other drugs but he was reluctant to discuss this further.
- 12.5 Prisoner 1 admitted that he himself had taken benzodiazepines and "*whatever else I had*" prior to being transferred to hospital on 14 March 2024. He declined to provide information on how he came into possession of these drugs.
- 12.6 A member of the inspection team spoke to prison management regarding Prisoner 1's cell allocation, expressing concern about the insensitivity shown in returning him to the location where his cell mate had died. The OIP was informed that Prisoner 1 was moved shortly afterwards to a different cell on the VPU.
- 12.7 The following day, 16 March 2024, the OIP was informed that Prisoner 1 had again been discovered unresponsive. Healthcare staff administered first aid until the arrival of the emergency services. At approx. 13:33 Prisoner 1 departed to Mercy University Hospital. He returned to Cork Prison at 16.18 on the same day.
- 12.8 On completing the first check of Prisoner 1 following his return from hospital, was once again found unresponsive. Healthcare staff administered first aid until the arrival of the emergency services. Prisoner 1 was taken to the Mercy University Hospital departing Cork Prison at approximately 17:33. Prisoner 1 returned to Cork Prison at approximately 20.20 on 16 March 2024.

- 12.9 On 18 March 2024 at approximately 16:00 Prisoner 1 was once again discovered unresponsive in his cell. The OIP were informed that healthcare staff responded quickly and managed to revive Prisoner 1. A decision was taken by the Healthcare team that Prisoner 1 did not require hospital treatment on this occasion.
- 12.10 On 2 April 2024 the OIP investigation team again met with Prisoner 1 at Cork Prison. Prisoner 1 reported that he no longer had access to drugs as they were now “*all gone*”, indicating they had been consumed. The investigation team found him to be extremely anxious but much more alert in his engagement as compared with 15 March 2024.
- 12.11 Cork Prison Management subsequently advised the Inspectorate that they had secured a bed for Prisoner 1 in a community psychiatric intensive care unit. Prisoner 1 was transferred for treatment to this facility on 11 April 2024.

13. Prisoner 2

- 13.1 On 14 March 2024 Prisoner 2 met with the investigation team at Cork Prison. He informed the investigation team that he had a good friendship with Mr. K as he had known him prior to prison. They shared cell 4 on the A3 landing.
- 13.2 Prisoner 2 reported that when Mr. K came to Cork Prison on 8 March 2024, he was “*sick*” due to drug withdrawal. Prisoner 2 believed Mr. K may have been in possession of heroin since his committal to prison on 8 March 2024 but stated Mr. K would not openly discuss this with him as he himself was not a drug user.
- 13.3 It was reported that in the early hours of 13 March 2024 Prisoner 2 was awoken by Mr. K. He described Mr. K as making groaning noises and that his eyes appeared to roll in his head. He immediately alerted staff and Mr. K was treated by medical staff before being transferred to hospital.
- 13.4 Prisoner 2 said that he was shocked that Mr. K had returned to prison so quickly following his transfer to hospital. Prisoner 2 expressed the view that Mr. K ought to have been able to stay in hospital for a longer period of time and did not believe he was fully alert or aware of what had happened. Prisoner 2 stated that he was deeply saddened when told by prison staff that Mr. K’s had passed.

14. CCTV Footage

- 14.1 As part of the investigation, Inspectors reviewed CCTV footage of Mr. K and the response to his medical emergency on 14 March 2024. Checks were conducted at 15 minute intervals and on occasions more frequently. The footage reviewed supported the accounts provided by the Healthcare and Operational staff of their involvement with Mr. K and their response to the medical emergencies.
- 14.2 The investigation team reviewed CCTV of both Mr. K’s return to prison from hospital on 13 March 2024. It was clear Mr. K was not fully alert and at times, he appeared unsteady on his feet before being placed in cell 4 on the A3 landing.

15. Phone calls

- 15.1 The investigation team also listened to a number of the recorded phone calls Mr. K made while in custody. Mr. K can be described as animated throughout all conversations, with the exception his final phone call to his partner at 18:01 on 13 March 2024.
- 15.2 During his final phone call made from the prison Mr. K was at times incoherent with a very slow pace of speech. Mr. K himself described his speech as “*blurry*” when speaking to his partner. Mr. K informed his partner that he had a fit and had been in hospital and that his cellmate Prisoner 2 had informed him that he thought he was dead prior to departing to hospital.
- 15.3 When asked by his partner what had happened Mr. K responded “..... *a lot of drugs*”. It is clear from the conversation that Mr. K did not know exactly why he had been in hospital and asked his partner to make contact with his mother to ask her to contact Cork Prison to find out what had happened. Mr. K threatened to self-harm if he did not find out what happened to him while in hospital.

16. Critical Incident Meeting

- 16.1 On 14 March 2024 a critical incident meeting⁴ was held, Chaired by Governor A. In attendance were Chief Officer B, Chief Nurse Officer A, Nurse Officer C, Nurse Officer D, Chaplain A and Officer C.
- 16.2 Officer C reported how he became aware of the incident when the cell call system was activated. Upon attending cell 6 Prisoner 1 informed him that Mr. K was not breathing. Officer A reported calling for assistance over the Tetra radio which he stated was responded to immediately.
- 16.3 Nurse Officer C and Nurse Officer D outlined what they encountered upon their arrival at cell 6. Nurse Officer C reported that he verbally informed the doctor of the incident.
- 16.4 Chief Officer B commended all involved for their rapid response and professionalism throughout the incident.
- 16.5 Governor A confirmed that following Mr. K’s return from hospital on 13 March 2024 he wasn’t reviewed by a doctor as there was no doctor on duty.
- 16.6 No recommendations were recorded at the conclusion of the critical incident meeting.

⁴ Staff meeting held following the death of a prisoner.

17. National Warning

- 17.1 The Chief Inspector of Prisons had acute concerns about the circumstances surrounding the death of Mr. K and the repeated hospitalisations of his cellmate, Prisoner 1. Consequently, on 14 March 2024, he contacted the Director General of the Irish Prison Service and the OIP requested further information about recent apparent overdoses in prisons in Ireland. The Inspectorate was informed by the IPS that there had been a total of six overdoses across the prison estate between 11 March and 14 March 2024. Two of those related to Mr. K and Prisoner 1. The other four related to prisoners in a Dublin prison.
- 17.2 All four prisoners in Dublin had attended hospital and made a full recovery. The time spent by the four Dublin based prisoners in hospital varied. The shortest attendance being six hours and the longest 24 hours.
- 17.3 On the evening of 15 March 2024, the IPS in association with the HSE issued press releases confirming that a number of drug overdoses had occurred in Irish prisons which were suspected to be linked to the presence of Nitazene⁵.
- 17.4 The IPS informed the OIP that it had immediately commenced an information campaign for prisoners on the life threatening dangers of consuming drugs that could contain Nitazine, in particular drugs that may contain synthetic opioids.
- 17.5 During its investigation and inspection activities over the following days, the OIP observed that posters conveying this message were displayed prominently in prisons.
- 17.6 The IPS is to be commended for the rapidity and effectiveness of its reaction to the discovery of the apparent presence of Nitazine in Irish prisons. Had it not reacted so swiftly and decisively, the lives of other prisoners could have been placed in jeopardy.
- 17.7 Nonetheless, the events leading up to the death of Mr. K and the very similar pattern evident in the events surrounding the repeated hospitalisations of his cellmate, Prisoner 1, demonstrate that there is room for improvement in the handling of cases of this kind, both by the IPS and the HSE.
- 17.8 More generally, this case highlights the difficulties experienced by the IPS in effectively monitoring people living in prisons who may have been internally secreting drugs. It seems clear that relying upon the cell mates of such persons (if, as in the case of Mr. K, they are held in shared accommodation) to raise an alarm is not an adequate safeguard. Nor is visual observation by prison staff from outside cells always sufficient to detect a risk to life.

The following recommendations emphasise the vital role that should be played by health care staff in such monitoring, including at night. Consideration should also be given to the potential of remote monitoring of vital signs technology to assist them in that task.

⁵ Nitazene is a very strong and potentially deadly synthetic opioid.

18. Recommendations

The OIP has made eight recommendations:

- 18.1 The OIP welcomes the IPS Drugs Strategy 2023 – 2026. In keeping with the objectives set out in that Strategy, it recommends that, in all cases where a prisoner is removed from his/her cell following a suspected overdose, a **thorough** search of the cell should immediately be conducted, in order to ascertain if any drugs remain hidden there. This search should be fully documented and information regarding the nature of any drugs found should be communicated to the prison's healthcare team and, if the prisoner concerned remains hospitalised, to the hospital concerned. This requirement should be set out in an Irish Prison Service Standard Operating Procedure (SOP).
- 18.2 Where a prisoner is removed from a cell following a suspected overdose, the prisoner concerned should never be returned to the same cell unless a thorough search of that cell has been conducted and fully documented.
- 18.3 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 have been 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.⁶
- 18.4 If it is deemed necessary to isolate a person from the general prison population because of a suspicion that that they have internally secreted drugs or other items of contraband, they should be subject to health care, 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.

In this regard, the Inspectorate endorses the view of the Council of Europe's European Committee for the Prevention of Torture (CPT) that the most effective approach would be to do away with the current differentiation between a CSC and a SOC and instead focus on the reasons for the placement of a prisoner in one of these cells⁷.

- 18.5 In order to enhance the effectiveness of the health care monitoring of such persons, the Inspectorate recommends that the IPS explore the potential of employing remote monitoring of vital signs technology in prisons in Ireland.

⁶ 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, which apply *mutatis mutandis* in relation to the death of Mr. K 2024:

- 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.

⁷ See document CPT/Inf (2020) 37, at paragraph 61 - <https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-7th-periodic-visit-report-on-ireland>

- 18.6 In the event that a prisoner dies in a multiple-occupancy cell, all the other occupants of that cell should be immediately relocated to different cell. Prisoners should never be obliged to remain in, or be returned to, a cell in which they have witnessed a death. This should be made clear to Prison Governors by the Director General of the Irish Prison Service.
- 18.7 All prisoners who attend hospital following a serious incident, such as a suspected drug overdose, should be medically reviewed by a prison doctor on their return to prison or at the earliest opportunity thereafter.
- 18.8 It is frequently deemed necessary to remove a person from prison to hospital for medical intervention. The OIP recommends that protocols be established between the IPS and HSE to ensure that medical treatment and adequate aftercare is provided to prisoners before they are returned to a prison setting.

Implementation of this recommendation will require close cooperation between the Department of Justice and the Department of Health.

19. Support Organisations

- 19.1 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.