Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. C
Cloverhill Prison
27 April 2021
Aged 20

Submitted to Minister: 24 April 2024

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GLOSSARY

ACO	Assistant Chief Officer
ADHD	Attention Deficit Hyperactivity Disorder
CCTV	Closed Circuit Television
Class Officer	Prison Officer in charge of a landing
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardio Pulmonary Resuscitation
CSC	Close Supervision Cell
DiC	Death in Custody
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
PIMS	Prisoner Information Management System
PO	Prison Officer
SOC	Safety Observation Cell

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 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. C's death in prison on 27 April 2021 and management of the events associated with his death.

4. Administration of Investigation

4.1 The OIP was notified of Mr. C's death on 27 April 2021 via a telephone call from Governor A. OIP Inspectors attended the prison on 27 April 2021, they viewed the cell of Mr. C, the B exercise yard and requested relevant documentation including CCTV footage to be collated.

4.2 Cloverhill Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of required information.

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 OIP role when investigating a death in custody. The OIP met with Mr. C's mother and her partner on 30 May 2021, the role of the OIP in relation to the investigation of the circumstances surrounding a death in prison custody was explained. At the request of the NoK the OIP again met with Mr. C's mother and his aunt on 31 December 2021.

5.2 Mr. C's mother emailed the OIP with a number of concerns regarding the care of her son while in Cloverhill Prison, these are outlined and replied to in paragraph 15 of this report.

5.3 We are grateful to Mr. C's family for their contributions to this investigation.

6. Cloverhill Prison

6.1 Cloverhill Prison is a closed, medium security prison for adult males, which primarily caters for remand prisoners committed from the Leinster area. It has an occupational capacity of 431 prisoners.

6.2 In the year 2020 Cloverhill Prison had the following recorded seizures; 328 mobile phones, 313 drug seizures and 76 weapons.

6.3 Mr. C was the first death of a prisoner from Cloverhill Prison in 2021; and the third death in IPS custody that year.

7. Family Concerns

7.1 Mr. C's family raised twelve questions with the OIP which have been considered during this investigation and are responded to in section 15 of this report.

8. Background

8.1 On 7 April 2021, Mr. C was committed to Cloverhill Prison on remand awaiting trial on a charge of theft.

8.2 Mr. C's next court hearing was set for 20 May 2021.

8.3 Nurse Officer (NO) A, conducted a committal interview with Mr. C on 7 April 2021.The record on the PHMS (Prisoner Healthcare Management System) noted that Mr. C conversed well, had good eye contact, was alert, coherent and had no thoughts of self-harm. It was also recorded that Mr. C's jaw which had been broken in 2019 had a plate fitted. Mr. C was not on medication or methadone and informed the nurse that he did not use illicit drugs.

8.4 The prison doctor conducted a committal interview with Mr. C on 8 April 2021. The doctor recorded that Mr. C had a past history of ADHD (Attention Deficit Hyperactivity Disorder). The Doctor recorded that Mr C was pleasant and cooperative and his mood was euthymic. When asked Mr C informed the doctor he did not take illicit drugs. It was recorded that Mr C was on "*routine isolation*" as per the IPS COVID-19 Algorithm in place at that time.

8.5 Mr. C was seen by NO B on 8 April 2021 who checked his temperature. It is recorded that Mr. C did not have COVID-19 symptoms but he remained in quarantine in accordance with the IPS Algorithm. Mr. C's temperature was taken every day from 9 to 15 April 2021. The negative result of the swab taken on 14 April 2021 was returned on 15 April 2021 and Mr. C was cleared from quarantine. Mr. C had a toothache on 18 April 2021 for which he was given paracetamol by Nurse C.

8.6 Mr. C was accommodated on the A2 landing on the date of his committal. Mr. C was transferred to a double cell on the B1 landing on 16 April 2021 where he remained until he was placed in a Close Supervision Cell (CSC) on 26 April 2021 following an incident in the exercise yard.

8.7 Mr. C was 20 years old when his death was pronounced in Cloverhill Prison on 27 April 2021.

9. Events of 24 and 25 April 2021

9.1 On Saturday 24 April 2021 Officer A was in charge of B1 landing where Mr. C was accommodated. During the afternoon prisoners on B1 went to the exercise yard and Officer A became aware that "*prohibited articles were being thrown into the prison grounds from outside*." Officer A reported that Mr. C "*was identified as throwing an object at the yard netting in order to retrieve prohibited articles*."

9.2 Officer B was supervising prisoners while they were taking rubbish to the bins and also reported observing Mr. C throwing an object at the yard netting. Officer B stated that he shouted at Mr. C to stop but he (Mr. C) continued throwing an object at the overhead netting.

9.3 Mr. C was issued with a P19[1] disciplinary report by Officer A and Officer C for throwing an object at the overhead yard netting.

9.4 Mr. C went to the exercise yard again during the afternoon of 25 April 2021. Officer A reported that prohibited articles were thrown over the perimeter wall onto the netting that covers B exercise yard. A second P19 disciplinary report form was served on Mr. C by Officer C for again throwing an object at the overhead netting and for trying to retrieve contraband.

9.5 Officer C in his report stated that Mr. C "*just accepted*" the P19's and was described as being "*quiet and calm as normal. He didn't appear to be under the influence of any drugs on either occasion*".

10. Events of 26 April 2021

10.1 During the afternoon of 26 April 2021 prisoners on B1 landing were granted access to B yard for outdoor exercise.

10.2 Officer C was in charge of the B Hub[2] during the afternoon of 26 April 2021 and was accompanied in the Hub by ACO A and Officer D when they observed Mr. C throwing an object at the overhead netting.

10.3 Officer E was detailed in charge of the B Hub for the reserve period (from 17:00 to 20:00) on 26 April 2021. Officer E observed Mr C "t*rying to retrieve contraband from the net…*" Officer E reported the matter to ACO A who attended the Hub and observed Mr. C retrieving contraband and arranged for Mr. C to be removed from the yard. Officer E's account of events was corroborated by ACO A. ACO A stated that he directed Mr. C to leave the yard but he did not

[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.

[2] Viewing Hub where the office in charge of the exercise yard is located. This Hub has a glass front and sides so that prisoners can be observed while exercising.

comply. ACO A reported the incident to Chief Officer (CO) B and directed Officer D to escort Mr. C from the yard to the Reception area to be searched.

10.4 The CCTV footage viewed by the OIP captured a prisoner throwing a drinks bottle at the overhead netting. Mr. C can be seen observing this incident from the rear of a large group of prisoners. At 17:56 the prisoner who was throwing the object at the netting was removed from the yard by officers. The group of prisoners then dispersed and walked around the yard in smaller groups.

10.5 A few moments later a group of prisoners gathered near Mr. C. The CCTV footage viewed showed two prisoners, who were identified to the OIP as Prisoner 1 and Prisoner 2, pointing up and down. Prisoner 2 had removed his top and was wearing shorts, he tensed his upper body, stood in front of Mr. C, pointed his finger at Mr. C a number of times and appeared to be making demands of Mr. C. Prisoner 2 was pointing at the ground and then pointed up towards the overhead netting. The body language of these prisoners appeared aggressive/intimidating in nature. These prisoners appeared to be giving direction to Mr. C to throw a drinks bottle at the overhead netting and to pick up items which fell from the netting. At this point some prisoners walked away.

10.6 Mr. C took a few steps back from Prisoner 2 and by his body language he appeared to be uncomfortable with this interaction. Mr. C was younger and physically smaller than Prisoner 1 and Prisoner 2. The investigation team was informed by COA that Prisoner 1 and 2 were well known "*high profile*" prisoners who were on remand, their charges were for serious offences.

10.7 After some hesitation Mr. C picked up the drinks bottle and began throwing the bottle at the overhead netting. Mr. C threw the bottle at the netting over 20 times. On eight occasions Mr. C bent down and picked up items which had fallen to the ground from the netting.

10.8 At 18:02 Mr. C could be seen to begin distributing something to fellow prisoners. Mr. C then sat on a nearby bench and was looking at something in his hand. Prisoner 1 and Prisoner 2 approached Mr. C and spoke to him before Mr. C appeared to hand something to Prisoner 1 and Prisoner 2. Mr. C, Prisoner 1 and Prisoner 2 then began to circle the yard together. At 18:16 Mr. C entered the yard toilet. Prisoner 1 and Prisoner 2 remained outside the toilet waiting for Mr. C to emerge.

10.9 At approximately 18:18, when Mr. C had emerged from the toilet, ACO A instructed Mr. C to leave the yard. Mr. C did not comply. At 18:20 ACO A directed Officers C and D to enter the B yard and escort Mr. C to Reception. Mr. C accompanied the officers voluntarily.

11. Prison Reception Area

11.1 At 18:23 Mr. C entered the reception area escorted by Officers C and D. On arrival at Reception Mr. C handed up a small amount of contraband to Officer C which he removed from his pocket.

11.2 Mr. C was searched by Officers C and D. Mr. C was searched using a handheld metal detector commonly referred to as the "wand". Mr. C was also instructed to sit on the Boss Chair[3]. The search indicated that Mr. C had a metallic item concealed on his person. Mr. C removed his jumper and the officers checked this for an indication of any metallic item(s) using the wand. As there was nothing concealed in the jumper Officers C and D returned the jumper to Mr. C.

11.3 Officer C reported that while searching Mr. C he *"admitted that he had stuff inside him."* Mr. C informed Officer C that he had a phone and drugs which had been retrieved from the overhead netting. Officer C stated that Mr. C was given an opportunity "*to get rid of it by going to the toilet",* Officer F was nearby and reported hearing Mr. C stating "*I'll flush it*". Officer C waited outside the holding cell and stated they heard something "s*ounding metallic being flushed. Mr. C came out of the toilet saying he had got rid of whatever he had*."

11.4 Mr. C was searched for the second time and on this occasion there was no indication that a metallic item was concealed on his person.

11.5 ACO A and CO B discussed the situation and CO B directed that Mr. C be placed in a Close Supervision Cell (CSC) on the D2 landing. A CSC is provided for under Rule 63 of the Prison Rules 2007-2020. A CSC is used to accommodate prisoners who are vulnerable or are disruptive and need to be separated from other prisoners to maintain a safe and secure environment[4].

11.6 Mr. C was escorted to D2 landing by Officer D and G shortly after 18:50 and placed into CSC 4. ACO B reported that he informed Mr. C that he was placed in a CSC as the search indicated a metallic item was concealed on his person and staff believed this may have been a mobile phone. ACO B stated that he provided Mr. C with another opportunity to hand over any concealed contraband. The investigation team were informed by the officers that Mr. C stated that he was not in possession of contraband.

11.7 Mr. C's clothing was removed and he was provided with refractory clothing[5] when placed in the CSC. Mr. C was provided with a meal and was locked back for the night.

11.8 While in the CSC Mr. C was checked every 15 minutes in line with the IPS Standard Operating Procedure in operation at the time. In addition to the mandatory 15 minute checks, the officer conducted an additional four checks on Mr. C's cell when the general check of D2 landing was conducted.

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[3] The Boss Chair contains a flat metal detector, which is fixed to the seat and scans the person's body cavities, in what is described as a non-intrusive manner.

[4] Prison Rule 2007-2020. Rule 63(1) provides that "*A prisoner may, either at his or her own request or when the Governor considers it necessary, in so far as is practicable and subject to the maintenance of good order and safe and secure custody, be kept separate from other prisoners who are reasonably likely to cause significant harm to him or her".*

[5] Anti-ligature clothing placed on a patient where there is serious risk of self-harm.

12. Events of 27 April 2021

12.1 Officers H and I conducted 15 minute checks throughout the night and into the morning of 27 April 2021. Between 21:00 on 26 April 2021 and 02:00 on 27 April 2021, Mr. C made a number of general requests such as seeking assistance with the in-cell television, looking for tobacco and asking for the TV to be turned off when he wanted to sleep. Officer I stated that after 02:00 Mr. C "*appeared to be asleep during all of my checks*" and recorded in the journal that Mr. C was asleep from 02:00 onwards.

12.2 Officers J and G began a staggered unlock of D2 landing for breakfast at 08:30. At 08:49 Officer J opened Mr. C's cell but received no response from Mr. C when called. The Officers immediately requested the assistance of NO D who was dispensing medication nearby on D2 landing.

12.3 NO D responded immediately making her way a short distance to CSC 4. NO D reported finding Mr. C lying on his bed with his legs crossed, right hand behind his head and left hand on his chest. NO D checked Mr. C's vital signs and reported that he had no carotid pulse, was cold and rigor mortis had set in. At 08:50 NO D radioed Chief Nurse Officer (CNO) A informing her that a prisoner had passed on the D2 landing.

12.4 At 08:51 CNO A arrived at CSC 4. On arrival CNO A completed a pulse check on Mr. C and determined that CPR was not to be commenced as Mr. C met two of the six criteria for non-commencement of CPR.

12.5 At 09:30, Doctor A attended the cell and pronounced the death of Mr. C.

12.6 At 10:15 members of An Garda Síochána arrived at Mr. C's cell.

12.7 At 11:55 staff with the Dublin Coroner's Office arrived and took charge of Mr. C's remains.

13. Critical Incident Review meeting

13.1 A critical incident review meeting took place on 30 April 2021 with nine staff in attendance including Governor B, Doctor A and CNO A. Attendees were provided with a brief overview of Mr. C's time in Cloverhill Prison and the events prior to the death of Mr. C.

13.2 Governor B stated it was his experience a CSC should be used where there is a suspicion that a prisoner may be concealing a mobile phone. However, if there was a possibility that "*metallic pieces"* were used to conceal drugs in the person a Safety Observation Cell (SOC)[6] should be used. SOC cells are used for prisoners who require frequent observation for medical reasons or because they are a danger to themselves or others. A prisoner placed in a SOC by the Governor must be examined by the prison doctor as soon as practicable after he has been accommodated in the SOC. He would also be subject to 15 minute checks by operational staff and frequent observation by nursing staff and at least daily and as frequently as the doctor believes it necessary.

13.3 Doctor A concurred with the views expressed by Governor B. CNO A suggested that Rule 102 of the Prison Rules could be utilised in such circumstances, stating that in Cloverhill prisoners are checked every hour under this Rule.

[6] Rule 64 of the Prison Rules 2007-2020

13.4 Governor B undertook to raise the matter with IPS Headquarters with a view to having the CSC and SOC policies reviewed to cover situations where there is a suspicion of drugs being concealed in the person using metallic items.

13.5 Governor B confirmed that he made the recommendation to IPS HQ. At the time of writing this report the policies in question had not been reviewed.

14. CCTV Review - Wheatfield Prison

14.1 The investigation team reviewed CCTV footage from Wheatfield Prison which covered part of the perimeters of Wheatfield Prison and the south walls of Cloverhill Prison for the period 17:47 to 17:51 on 26 April 2022. The footage covered an area of external wasteland. The footage showed a hooded male enter the wasteland where he began to slingshot items over the prison wall into the B yard of Cloverhill Prison.

14.2 Over a three minute period the male was observed on the footage repeatedly picking items from a plastic bag and using a slingshot to propel the items over the prison wall. It is estimated it is over 100 metres from the wasteland to Cloverhill Prison yard. The footage showed the male leaving the area in a dark coloured hatchback motor vehicle.

14.3 The Governors of both Wheatfield and Cloverhill Prisons confirmed that they are in regular contact with An Garda Síochána regarding contraband entering their prisons over perimeter walls. Senior management at IPS Headquarters advised that a number of 'sting' operations have been arranged by An Garda Síochána and several arrests have been made.

15. Family Questions including OIP Response

15.1 Mr. C's family asked the Office of Inspector of Prisons twelve questions listed and responded to hereunder.

1. **Is there a risk assessment carried out on everyone entering the Prison?**

   Response: A doctor and separately a nurse conduct committal interviews with all prisoners on their committal to a prison. Both the Nurse and the Doctor record details of their committal interview and assessment on PHMS. The Governor of the prison also meets with a new committal and conducts a Governor's committal interview. A note of the Governors interview is recorded on the Prisoner Information Management System (PIMS).

2. **Do they have a medical examination – would Mr. C have been put on any medication?**

   Response: A physical examination is not routinely conducted by a doctor on committal. The engagement with the doctor was a consultation, the details of which are provided at section 8.3.

3. **How did Mr. C spend his day before his death – were there any incidents involving him, did he behave any differently from normal. Was he in different company than usual?**

   Response: This is covered in section 10 of the report.

4. **Did Mr. C share a cell with anyone?**

   Response: Mr. C shared a cell with Prisoner 3. Prisoner 3 had no involvement in the events that took place in the prison yard. He described Mr. C as *"a nice young lad"* and that he *"got on with him very well"*. Prisoner 3 reported that he warned Mr. C against making efforts to retrieve contraband in the yard.

5. **How often are prisoners checked during the night?**

   Response: Mr. C was checked every 15 minutes throughout the night as he was accommodated in a CSC.

6. **If Mr. C had difficulties during the night and was unwell and needed help what is the procedure for letting someone know? What medical care is available during the night?**

   Response: Mr. C had access to an in-cell alarm button which would immediately ring in the Class Office and activate a flashing light outside the cell door. There was no evidence that Mr. C sought assistance. There were no concerns for Mr. C's health when he was being placed in the CSC. Mr. C's last request was to turn off the TV as he wished to sleep. If the need arose for healthcare assistance Cloverhill Prison had nursing staff on duty all night.

7. **What was the regime of looking after Mr. C and was it followed?**

   Response: Mr. C was on the standard level of the incentivised regime[7]. Mr. C was offered daily out of cell time on completion of his quarantine period on 16 April 2021. Details of his engagement with healthcare staff and yard exercise is outlined in this report.

8. **How long was Mr. C dead before his body was found?**

   Response: This question is more appropriate for the Coroner's Inquest.

9. **Was he dead when he was found and if he was not dead how long did it take for the medical staff to turn up? Were there delays?**

   Response: This is addressed in section 12 of this report.

10. **If the cause of death is drugs – how could he get them whilst in prison and supposedly being monitored by the staff, what controls are in place to keep them safe?**

    Response: The cause of death is a matter for the Coroner. Section 10 provides details on how some contraband entered the prison.

11. **What controls have been introduced because of other deaths? Were those controls adhered to?**

    Response: The OIP recommends improvements, where appropriate, in death in custody investigation reports. The IPS provides an Action Plan outlining how they propose to address the areas for improvement. The implementation of these actions are reviewed by the OIP during prison inspections. The OIP also obtains a self-assessment report on implementation of their Action bi-annually. The self-assessment reports from the IPS on recommendations made in the OIP Inspection reports are published on our website www.oip.ie Irish Prison Service self-assessment reports on the Investigation recommendations will be published shortly.

[7] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and quality of behaviour

12. **How often are reviews carried out and are they carried out independently and are they published?**

Response: The Office of the Inspector of Prisons is independent in its function. The IPS Action Plans in response to the death in custody recommendations are published on the Office of the Inspector of Prisons website www.oip.ie under Deaths in Custody. Our reports are laid before the Houses of Oireachtas by the Minister for Justice who publishes the reports on the Department of Justice website. Implementation of the committed actions by the IPS to address shortcomings identified by the OIP are checked during prison inspections and through a bi-annual self-assessment by the IPS.

16. Recommendations

The Office of the Inspectorate of Prisons has made 5 recommendations:

1. 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[8].

2. 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.

3. 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 isolated in a Safety Observation Cell (SOC) under medical supervision, not in a Close Supervision Cell (CSC) under security observation.

4. 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.

5. The Irish Prison Service should intensify its engagement with other relevant stakeholders, including An Garda Síochána, to develop a multi-agency written strategy to counter contraband entering a prison. This strategy should examine the use of technology, architectural disruptions, as well as how to prevent exploitation and coercion being used as a means to bring drugs and other contraband into a prison.[9] [10]

[8] This is also a recommendation in the OIP report into the circumstances surrounding the death of Mr I 2020.

[9] Consider the potential of the non-punishment principle of the Council of Europe Convention for Human Trafficking and working in partnership with An Garda Síochána to identify those who exploit and coerce those who are forced to take drugs into a prison.

[10] Also a recommendation in the OIP report into the circumstances surrounding the death of Mr I 2020

17. Support Organisations

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.