Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. E
Cloverhill Prison
12 August 2021

[Submission Date to Minister 23 February 2024]

CONNTENTS

GLOSSARY

AED	Automated External Defibrillator
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons

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 for 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 help to fulfil the obligations of the State 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 The structure of this report details the events leading up to Mr. E's death in prison on 12 August 2021 and management of the events associated with his death.

4. Administration of Investigation

4.1 The OIP was notified of Mr. E's death on 12 August 2021. On 13 August 2021, Investigators from the OIP team attended Cloverhill Prison. Governor A provided the investigation team with all relevant information in accordance with the standardised checklist of required information.

4.2 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 Inspector of Prisons role when investigating a death in custody.

5.2 The investigation team met with Mr. E's NoK, on 3 September 2021 and 14 September 2021. The concerns raised by Mr. E's NoK are covered in section 7 of this report.

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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. Cloverhill Prison has an occupational capacity of 433 prisoners.

6.2 Mr. E was the second death of a prisoner in Cloverhill Prison in 2021 and the fifth death in IPS custody that year.

7. Family Concerns

7.1 Mr. E's NoK, raised the following concerns/questions:

1. What were the circumstances of our son's death?

   Response: The circumstances of Mr. E's death are outlined in this report.

2. Notification of the death of our son should have been in person and not over the telephone.

   Response: This is addressed in section 11 of the report.

7.2 Mr. E's father stated that he received the devastating news over the phone that his son was found *"unresponsive"*. It was early morning around 09:00 on 12 August 2021 when the phone call was received and Mr. E's father was not long awake. Mr. E's father stated that he initially thought the call was a hoax but then the caller stated that Mr. E had *"passed"*. The NoK expressed the view that news of this nature should be given in person.

7.3 The investigation team were informed by Mr. E's mother that she was driving on the morning of 12 August 2021 and missed a number of calls. She later realised that these were from Cloverhill Prison, but she had already been informed by Mr. E's father (her ex-husband) at approximately 09:45 of their son's passing.

7.4 Mr. E's mother stated that she became very distressed on receiving the news of her son's passing. Mr. E's mother was thankful she had missed the phone calls from the prison as the shock of hearing that her son had passed could, she stated, have been the cause of an accident. She stated that her ex-husband had asked her to park up before he gave her the bad news and she was unable to drive home.

8. Background

8.1 Mr. E was 34 years old when he passed away in Cloverhill Prison.

8.2 Mr. E was a remand prisoner having been committed to Cloverhill Prison on 14 May 2021 on drug charges. He was awaiting trial which was listed for hearing on 24 August 2021.

8.3 At the time of his death, Mr. E was accommodated in cell 7 on the B2 landing and was sharing a cell with two others, Prisoner 1 and Prisoner 2.

9. Events of 11 August 2022

9.1 During the afternoon of 11 August 2022, between 14:15 and 16:00, prisoners on B2 landing were granted access to B yard. Mr. E, Prisoner 1 and Prisoner 2 all went to the yard for exercise. Prisoner 1 advised the investigation team that he acquired three contraband tablets in the yard, he had taken one while in the yard and two when he returned to his cell. Prisoner 1 stated he had not taken tablets for years. The CCTV footage covering the exercise yard was of very poor quality and was not saved in consecutive clips.

9.2 Prisoner 2 stated that, on returning to cell 7, Mr. E informed him that he (Mr. E) had acquired five to 10 tablets, known as "*zimos*"[1], in the yard from another prisoner. The investigation team was informed that Mr. E told Prisoner 2 that he had already consumed four "*zimos*" while in the yard.

9.3 Prisoner 2 stated that after tea, at approximately 17:30, Mr. E and Prisoner 1 were joined in cell 7 by two other prisoners, Prisoner 3 and Prisoner 4 to play cards. Both Prisoner 3 and Prisoner 4 confirmed attending cell 7 to play cards and drink tea. They also confirmed that Mr. E informed them that he had taken tablets while in the yard earlier in the afternoon. Prisoner 2 and Prisoner 3 stated that Mr. E was in good form and was talking about his son.

9.4 Prisoner 2 stated that he left the cell and returned to B yard for evening exercise returning to the cell at 19:00 as Prisoner 3 and Prisoner 4 went back to their cell. All cells were master locked for the night at about 19:20.

9.5 Prisoner 2 stated that he saw four liters of "*hooch*" in cell 7 which is illicit alcohol made by prisoners – he stated that he hadn't seen the "*hooch*" in the cell earlier. The investigation team was informed by Prisoner 2 that all three of them consumed about two liters of hooch between them. Prisoner 1 reported that the hooch *"had quite an effect.*"

9.6 At 23:30 both Prisoner 2 and Prisoner 1 noticed that Mr. E was slurring his speech. Prisoner 2 recalled placing Mr. E in a chair near the air vents as he believed cool air would help sober him up. Prisoner 1 stated that he decided to sit up all night to try to make sure Mr. E was okay.

10. Events of 12 August 2022

10.1 At 03:30 Prisoner 2 woke and noticed Mr. E was still sitting in the chair and told Mr. E to go into bed. Prisoner 2 reported helping Mr. E to the in cell toilet and he threw up. Prisoner 2 stated that he gave Mr. E his lower bunk bed as he was concerned Mr. E would fall from the top bunk. Prisoner 2 informed the investigation team that he placed Mr. E in the recovery position on the

[1] "*Zimos*" is an abbreviation commonly used for Zimovane, a form of strong sleeping tablet, of which the active ingredient is Zopiclone. The investigation team has not gathered any direct evidence, other than the oral statements of the prisoners concerned, as to the precise pharmacological content of any medication that they, or Mr E, may have consumed.

lower bunk. Prisoner 1 stated that he placed his mattress on the floor beside the lower bunk to prevent Mr. E from hitting the ground should he fall from the bunk bed.

10.2 Prisoner 1 stated that he agreed to stay awake throughout the remainder of the night to monitor Mr. E and he watched television to stay awake. Prisoner 1 reported that Mr. E was snoring loudly, but stated that this was not unusual for Mr. E.

10.3 Prisoner 2 reported waking at 05:30 and joked with Prisoner 1 that he was watching a children's television show. Prisoner 1 and Prisoner 2 then both fell asleep believing that Mr. E was okay as he had not thrown up since 03:30.

10.4 Prisoner 2 woke to use the toilet around 07:00 and noticed soiled bed clothes on the lower bunk and realised that Mr. E had been ill again. Prisoner 2 stated that this was 07:03 and he knew the time as he (Prisoner 2) turned on the TV for more light and saw the time on the BBC TV news.

10.5 Prisoner 2 reported that Mr. E was making a gargling type sound but unresponsive when called. Prisoner 2 informed the investigation team that he had received first aid training from the Red Cross and began CPR[2] on Mr. E. Prisoner 1 stated that he hit the in cell call system button to alert staff that they needed assistance, he also reported striking the cell door and shouting to other prisoners to make noise to get the attention of officers.

10.6 Prisoner 5 occupied Cell 8 on B2 landing and reported hearing someone "*banging on a door*" on Thursday morning. Prisoner 6 was accommodated in Cell 6 and reported that at approximately 07:05 he "*could hear people trying to revive another perso*n" and then "*they started to bang the door"*. Prisoner 6 realised it was serious so he activated the cell call. Prisoner 6 heard "s*taff and the nurse arrive about 07:10*".

10.7 When the investigation team attended the prison on 13 August 2021 they checked the time shown on the CCTV footage panel against the current time and found that the footage was two minutes faster. On checking the cell call footage it was noted that the cell light outside Cell 7 was activated at 07:10 (actual time was 07:08). Officer A responded, looked into the cell through the viewing hatch, turned off the cell call light from outside the cell door and ran from the cell, this was 07:13:36 (actual time 07:11:36).

10.8 The cell call light activated in Cell 7 again at 07:15:16 (actual time 07:13:16) and a cell call light was activated in Cell 6 at 07:16:43 (actual time 07:14:43).

10.9 ACO A stated that shortly after taking up duty she was informed that there was a prisoner sick in Cell 7 on B2 landing. ACO A stated that she immediately made her way to B Division and asked Officer B and Officer C to accompany her to the cell. On opening the cell door she described seeing two prisoners in a panic, with Prisoner 2 reporting that "w*e can't wake him up*" and Prisoner 1 adding that "*he's after getting sick and we can't wake him*". ACO A called for a nurse over the radio and asked Prisoner 1 to assist in lifting Mr. E off the bed and onto the floor. NO A arrived to the cell and took over the care of Mr. E. The footage viewed by the investigation team showed the ACO accompanied by two staff open the cell at 07:16:08 (actual time 07:14:08). The ACO also called for an ambulance. Prisoner 1 and Prisoner 2 exited the cell and were placed in another nearby cell.

[2] Cardiopulmonary resuscitation – life saving technique for those suffering from cardiac arrest.

10.10 NO A reported that on entering Cell 7 on B2 she found Mr. E unresponsive and cold to the touch. Mr. E had no pulse detected and there was dry blood visible on his face and on the bed clothes. NO A checked his airway, breathing and circulation then commenced CPR. Oxygen was also administered while CPR continued with two officers in rotation. An Automated External Defibrillator machine was applied (AED)[3] and NO A reported following its instructions. NO B corroborated NO A's account and reported bringing the emergency bag to the cell and assisting with CPR until the emergency services arrived.

10.11 ACO B arrived for duty at 07:15 and heard the "*code red alert*" being called. ACO 2 immediately responded and attended Cell 7 on the B2 landing, CO A also responded. ACO B contacted the main gate to advise them of the situation and to notify all Governors and Chief Officers of the incident as they arrived to work. Officer D waited at the main gate to meet members of the emergency services and to ensure they got to the cell promptly.

10.12 At approximately 07:38 (actual time 07:36) Dublin Fire Brigade personnel entered Cell 7, taking over resuscitation efforts. Two National Ambulance Service personnel arrived approximately 10 minutes later and assisted with CPR efforts.

10.13 CO A reported being informed at 08:05 that paramedics had ceased resuscitation attempts on Mr. E.

10.14 At 09:05 Doctor A pronounced Mr. E deceased.

10.15 At 09:25 Garda Inspector A, Detective Sergeant A, Garda A and Scenes of Crime Garda B attended Cell 7. At 11:05, funeral directors working on behalf of the Coroner's Office arrived and removed Mr. E's remains from Cloverhill Prison.

11. Next of Kin Notification

11.1 Chaplain A stated that he rang Mr. E's parents on 12 August 2021 to let them know the sad news of Mr. E's passing. Chaplain A stated that he spoke to Mr. E's father but his three calls to Mr. E's mother went unanswered. Chaplain A reported leaving a voicemail for Mr. E's mother requesting a return phone call as he had *"important information to tell her"*. Mr. E's mother and the Chaplain spoke at approximately 11:00 on 12 August 2021.

11.2 The IPS has a protocol entitled *"Chaplaincy and Next of Kin Notification"*. The protocol states that the chaplain will "*endeavour to make contact with the family by telephone"*, if it is not possible for the chaplain to attend the home of the deceased family in person.

11.3 Governor A informed the investigation team that it was not possible for the chaplain to attend the home of the NoK in person due to the health risks which were associated with COVID-19 and restrictions in place within the IPS at the time. Governor A stated that it was the practice to contact families of a deceased by telephone at that time.

[3] Used to help those experiencing sudden cardiac arrest.

12. Critical Incident Review Meeting

12.1 A critical incident review meeting took place on 12 August 2021. Attendees were provided with a brief overview of Mr. E's time in Cloverhill Prison along with the sequence of events that took place on 12 August 2021. The following sub-sections of this section of the OIP's report are based on the minutes of that meeting, which were reviewed by the investigation team.

12.2 Governor B acknowledged that Mr. E's passing was the second in Cloverhill Prison during 2021 in which contraband appeared to have been a factor.

12.3 The CNO suggested launching an anti-drugs campaign within the prison. The possibility of using the in cell television channel to provide anti-drug awareness and distributing information leaflets to prisoners was discussed.

12.4 The CNO raised concerns at the length of the waiting list for drug counselling, advising that on the morning of 12 August 2021 an additional 18 prisoners had been added to the list. The CNO queried if an anti–drug group discussion with prisoners would be beneficial. Governor B held a group discussion with prisoners; however, it was felt that the discussion had little effect as some of the prisoners who had participated in that discussion had proceeded to attempt to retrieve contraband from the yard.

12.5 Concerns regarding the cessation of First Aid training for operational staff due to the shortage of nursing staff were raised at the meeting by the healthcare representatives.

12.6 There were three Actions recorded as emanating from the Critical Incident Review Meeting:

1. A review to take place of security measures to tackle drugs entering prison yards.
2. A more intensive anti-drugs campaign to inform prisoners of the dangers of drug consumption.
3. Request that the IPS consider providing Officers with CPR training.

13. Recommendations

13. 1 The Office of the Inspector of Prisons has made two recommendations:

1. The IPS 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.

2. The IPS 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.[2] [3]

[2] 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.
[3] Also a recommendation in the OIP report into the circumstances surrounding the death of Mr I 2020.

13.2 These recommendations are also made in the Inspectorate's report into the death of Mr. C 2021.

14. Support Organisations

14.1 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.