Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. K
Midlands Prison
9 June 2022

[Submission Date to Minister: 23 February 2024]

CONTENTS

GLOSSARY

CPR	Cardiopulmonary Resuscitation
GP	General Practice Doctor
IPS	Irish Prison Service
MAM	Multi Agency Meeting
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prison Healthcare Management System
PICLS	Prison In-Reach & Court Liaison Service
PO	Prison Officer
SOP	Standard Operating Procedure

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 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 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 This report is structured paying particular attention to the care that was afforded to Mr. K during his time in prison.

4. Administration of Investigation

4.1 On 9 June 2022, the OIP was notified that Mr. K had passed away in the Midlands Prison. The investigation team attended the prison and met prison management who provided an overview of Mr. K's time in prison. Inspectors also met with persons who had contact with Mr. K 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 Inspector of Prisons role when investigating a death in custody.

5.2 The Investigating team communicated with Mr. K's, NoK, his father. As Mr.K's NoK resided outside of the State, assistance in engaging with the NoK was provided by Mr. K's legal representation and the embassy of the state in which he resides.

5.3 Although this report is for the Minister for Justice, it may inform several interested parties. It is written primarily with Mr. K's NoK in mind.

5.4 The OIP is grateful to Mr. K's father for his contributions to this investigation and we offer our sincere condolences on his loss.

INVESTIGATION

6. Midlands Prison

6.1 Midlands Prison is a closed, medium security prison for adult males. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Laois, Offaly and Westmeath. It has an operational capacity of 875 beds.

6.2 Mr. K was the fifth death of a prisoner from the Midlands Prison in 2022; and the eleventh death in IPS custody that year.

7. Family Concerns

7.1 Mr. K's NoK requested information on who Mr. K engaged with prior to his passing. The NoK informed Mr. K's legal representative that he didn't believe Mr. K would have harmed himself.

8. Background

8.1 Mr. K was a 38 year old remand prisoner when committed to Cloverhill Prison on 30 November 2020. He was transferred to the Midlands Prison on 22 December 2020. This was Mr. K's second period in custody, in May 2020 he had spent a short period of time in custody.

8.2 Mr. K was a remand prisoner with serious charges pending. His trial was due to commence 15 June 2022.

8.3 Mr. K was on the standard level of the Incentivised Regime[1]. Due to the nature of the offences for which Mr. K was on remand he was accommodated in cell 43 on protection landing C3.

8.4 Mr. K shared cell 43 with Prisoner 1.

9. Events of 9 June 2022

9.1 At approximately 11:45 on 9 June 2022 Mr. K received an in-person professional visit from an independent psychologist. This meeting related to his upcoming trial and was organised by his legal team. The meeting concluded at approximately 12:15. Mr. K returned to the C3 landing, where he collected his meal from the servery, returned to and was locked back in his cell with Prisoner 1.

9.2 At approx.14:20 cell 43 was unlocked and Prisoner 1 left the cell to exercise. Prisoner 1 went to the prison outdoor yard along with several other prisoners. Mr. K remained in his cell and the cell door was locked. This was observed by the OIP Investigation team on CCTV footage.

9.3 At approx. 15:30 Prisoner 1 returned to the landing. PO A unlocked cell 43 leaving the door slightly open for Prisoner 1 to enter, PO A did not look into the cell. PO A continued up the landing, unlocking cells for the other prisoners who were returning from exercise.

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

9.4 PO A reported that moments after unlocking cell 43, Prisoner 1 called for him to return to cell 43. PO A immediately returned to cell 43 where he discovered Mr. K with a ligature around his neck. PO A ran to the Class Office to retrieve a Hoffman Knife[2]. PO A alerted PO B before re-entering the cell where he cut the ligature and commenced CPR[3]. PO A's account was corroborated by CCTV footage which showed that at 15:32:48 an officer open cell 43, the prisoner entered the cell at 15:32:51 and exited the cell promptly at 15:33:01 seeking the officers' attention.

9.5 PO B used the Tetra Radio to request immediate medical assistance and then assisted PO A.

9.6 Prisoner 1 was placed in a nearby cell at the opposite end of the C3 landing.

9.7 At approx. 15:34 Nurse Officers A, B and C arrived at cell 43. The Nurse Officers reported finding Mr. K lying on the cell floor with PO A and PO B performing CPR on Mr. K. Nurse Officers immediately took over resuscitation attempts.

9.8 Nurse Officer A recorded on the Prison Healthcare Management System (PHMS) that on examination of Mr. K no carotid pulse was detected. A defibrillator was attached to Mr. K which advised no shock. Reasons for no shock include that a pulse rate was detected or that there is no pulse detected but not in a shockable rhythm. Nurse Officer A then commenced physical compressions on Mr. K.

9.9 At approx. 15:45 Doctor A arrived at cell 43. Doctor A recorded on the PHMS that he arrived on scene and witnessed nurses providing resuscitation to Mr. K. CPR attempts continued until the arrival of paramedics from the Fire Brigade and Ambulance Services, at 15:52 and 16:10 respectively.

9.10 At approx. 16:11 resuscitation attempts ceased and Doctor A pronounced the death of Mr. K at 16:18 which was recorded on PHMS. The cell was then master locked with PO C detailed to keep a log of any persons entering the cell.

9.11 As is standard procedure members of An Garda Síochána attended the scene; they arrived at 16:54.

9.12 Funeral directors removed Mr. K's remains at approx. 21:55.

[2] Rescue knife

[3] Cardiopulmonary resuscitation is an emergency procedure consisting of chest compressions

10. Interview with Cellmate

10.1 On 10 June 2022 Inspectors met with Prisoner 1 who provided a witness statement.

10.2 Prisoner 1 stated that Mr. K had been his cellmate for the four months prior to his passing. He described Mr. K as an "*easy going*" person who enjoyed art and playing chess. He stated that Mr. K had begun to smoke tobacco on a regular basis during the two weeks prior to his passing. Prior to that he smoked very little.

10.3 On the morning of the 9 June 2022, Prisoner 1 put his name forward for exercise. Prisoner 1 attended the school on the morning of 9 June 2022 returning to the C3 landing at midday. He collected his meal and was locked back in the cell with Mr. K. This account was verified by CCTV footage viewed by the OIP Investigators.

10.4 Prisoner 1 reported watching television with Mr. K while locked in the cell during the meal period. He described Mr. K as being jovial and making a number of humorous comments in relation to the television programmes they watched together. Prisoner 1 described a footrest that Mr. K had constructed by weaving towels and bed linen together into a hammock like formation. He stated that it was secured to both ends of the lower bunk beds. Prisoner 1 stated that this was used as a foot rest while sitting on the lower bunk. He stated Mr. K had this foot rest in his possession since they first became cellmates. Prisoner 1 stated that shortly after 14:00 on 9 June 2022 he was unlocked to attend recreation and, as he was leaving, Mr. K was standing up making coffee.

10.5 Prisoner 1 stated that on return from exercise his cell was unlocked by PO A. As he entered the cell he reported seeing Mr. K suspended by a ligature which he stated was the '*hammock like'* footrest. Prisoner 1 stated that he quickly exited the cell and alerted PO A, he further stated "*I stood with my back to the cell, facing the railings. PO A, runs to the office. I seen prisoners come near my door. I closed the door over. PO A, and another Officer sprinted out of the office shouting on a walkie talkie that a medic was needed on Charlie 3. They ran into my cell. I walked away towards end of landing, I was shocked*." An Garda Síochána confirmed to the OIP Investigators that tightly intertwined bedding and towelling was used as a ligature.

10.6 On review of the Midlands Prisons Standard Operating Procedure (SOP) entitled 'Class Officer In Charge of Landing' it is required at section 5.9 of the SOP that a Class Officer "*should check contents of all cells on a regular basis i.e. lights, bedding, television sets, cell calls, smoke detectors etc ensuring there is no abuse of prison property and remove any prohibited articles and surplus laundry, report any damage caused*." On examination of the documentation received by the OIP there was no evidence that excess laundry was removed.

11. Access to Psychiatry and Psychology Services

11.1 On committal to Cloverhill Prison on 30 November 2020 Mr. K was referred to the Prison in-reach Court Liaison Service (PICLS) team who assist Courts in identifying defendants with major mental illness and try to provide practical solutions to access appropriate mental health care through liaison with community services. Mr. K had regular psychiatric reviews by the PICLS Team while in Cloverhill Prison. Following assessment by the PICLS team it was recorded on the PHMS that there was "*no evidence of mental health disorder under the Mental Health Act 2001*". Following transfer to the Midlands Prison on 22 December 2020 Mr. K was subject to ongoing review by the in-reach psychiatric team. In February 2021 Psychiatric Nurse A recorded that there was "*no evidence of symptoms or major affective or psychotic illness*". On 31 March 2021 Mr. K was seen by Consultant Psychiatrist Doctor B who recorded that there was "*no overt evidence of symptoms of major affective or psychotic illness*". Doctor B also noted that Mr. K was to be reviewed at the Multi Agency Meeting (MAM). In July 2021 Mr. K was seen by both a Psychiatric Doctor and Nurse. Also in July 2021 Mr. K was assessed by a Forensic Community Mental Health Nurse at the Central Mental Hospital who following assessment recorded that Mr. K "*did not impress with active symptoms of a major affective or psychotic illness.*" and recommended that he be discharged to the care of the prison GP.

11.2 Mr. K continued to be discussed at the MAMs and, on 4 November 2021, the CNO reported that there were no concerns regarding Mr. K. In November 2021 Mr. K was discussed with the psychology waiting list team and was assigned to Psychologist A. On 1 December 2021, Mr. K met with Psychologist B. It is recorded that Mr. K presented as cautious and unsure of whether or not to engage with the psychology service. Mr. K declined to sign a confidentiality and consent form which he was asked to take with him and consider signing. One week later Mr. K then declined to attend a follow up assessment with the psychologist.

11.3 A third appointment was offered to Mr. K by Psychologist A. Mr. K again declined the opportunity to attend. As Mr. K had declined to attend two appointments and in line with the Psychology Service policy entitled '*IPS Protocol Management of Psychology Care Pathway Referral to Discharge',* his referral to psychology was closed. A final letter was issued to Mr. K informing him of the closure and if he wished to engage with psychology in the future a consultation would be arranged.

12. CCTV Footage

12.1 As part of the investigation, OIP Inspectors reviewed CCTV footage of the C3 landing. The accounts of officers were corroborated by the footage. CCTV captured PO A unlocking cell 43 at 15:32:48. Prisoner 1 entered cell 43 at 15:32:51. Prisoner 1 exited his cell at 15:33:01 and appeared to be shouting towards PO A who was nearby on the landing. PO A ran towards Cell 43 at 15:33:03. He enters Cell 43 at 15:33:07 and exited almost immediately and ran to the Class Office. PO A and PO B ran towards Cell 43 and entered at 15:33:12. Prisoner 1 remained on the landing and could be seen holding his head in his hands and communicating with the prisoners on the C3 landing, all appeared to be in a state of shock.

12.2 Three Nurse Officers A, B and C arrived at cell 43 at 15:34:22, one nurse was carrying a red medical emergency bag. Doctor A entered cell 43 at 15:46:00. Members of Dublin Fire Brigade arrived and entered cell 43 at 15:52:50. Three members of the National Ambulance Service arrived at 16:10:17 with a wheeled stretcher and waited on landing outside cell 43. By 16:11:00 it is evident that the resuscitation attempts had ceased as medical staff and paramedics were viewed in conversation on the landing as they begin to pack away medical supplies. At 16:21:23 Dublin Fire Brigade and National Ambulance Service paramedics departed the C3 landing.

13. Critical Incident Meeting

13.1 At 10:00 on 10 June 2022 a Critical Incident Meeting[4] was held by Governor A and Governor B. In attendance were CO A, Doctor A, CNO, Chaplain A, Chaplain B and Psychologist A.

13.2 An overview of Mr. K's time in custody and timeline of events were recorded in the minutes of the meeting.

13.3 Chaplain A stated that Mr. K's NoK was informed of his passing on 9 June 2022 and the chaplain committed to remain in contact to provide support.

13.4 Doctor A stated that Mr. K's had denied having any thoughts of self-harm following his meeting with an independent Psychologist on 9 June 2022.

13.5 No recommendations were recorded at the conclusion of the critical incident meeting.

[4] Staff meeting held following the death of a prisoner.

14. Recommendations

The OIP has made three recommendations:

14.1 A Class Officer in the Midlands Prisons in charge of a prison landing should follow the existing Midlands Prison Standard Operating Procedures as required in SOP entitled *'Class Officer In Charge of Landing'* and maintain a written record on date and time of checks undertaken and outcomes.

14.2 When conducting routine checks of cells, prison officers should be especially attentive to the presence of non-standard items, such as "hammock" type footrests, that could be deployed as ligatures. If detected, such items should be immediately confiscated and a clear written record kept of their confiscation, indicating the cell location and the name of the prisoner concerned.

14.3 In the interest of uniformity of procedure across all prisons it is recommended that Irish Prison Service Headquarters develop a centralised Standard Operating Procedure outlining the duties and responsibilities attaching to the role of Class Officer, including the need to maintain a written record on date and time of checks undertaken and outcomes.

15. Support Organisations

15.1 Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie.