Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. R
while in the custody of
Cork Prison
on
28 October 2022

Submitted to the Minister: 14 February 2024

CONTENTS

GLOSSARY **3**

INTRODUCTION **4**

1. Preface 4
2. Objectives 4
3. Methodology 4
4. Administration of Investigation 5
5. Family Liaison 5

INVESTIGATION **7**

6. Family Concerns 7
7. Background 8
8. Events of 27 October 2022 8
9. Information Provided by other Occupants of the Holding Cells 10
10. CCTV Footage 10
11. Critical Incident Review Meeting 11
12. Recommendations 12
13. Support Organisations 12

GLOSSARY

A & E	Accident and Emergency
AED	Automated External Defibrillator
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PO	Prison Officer
PSEC	Prison Service Escort Corps

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 time while in custody; and examination of evidence, such as CCTV footage.

3.2 This report is structured to detail the events leading up to Mr. R's death on 28 October 2022 and management of the events associated to his death.

4. Administration of Investigation

4.1 On 28 October 2022 the OIP was notified that Mr. R had passed away in Cork University Hospital, having being found unresponsive in the holding cell at Cork Circuit Court on 27 October 2022 following his sentence to prison custody for two years, with the last six months suspended. The investigation team attended Cork Prison and Cork Courthouse cells on 28 October 2022. The investigation team met prison management who provided an overview of Mr. R's short time in custody. The investigation team also met with persons who had contact with Mr. R while in the courthouse holding cell.

4.2 Prison Management provided the investigation team 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. The investigation team met with Mr. R's family on 7 November 2022.

5.2 The family said that Mr. R was a father of four, the eldest was 12 years of age. Mr. R was described as a very caring person, who prior to COVID-19 had built a successful business with a number of employees and had won an award for his business. The family relayed how drug addiction had adversely impacted his life over the last two years particularly when his business had to cease operation during COVID-19.

5.3 The family stated that they had paid for Mr. R to attend a residential drug rehabilitation centre, but that he had continued to associate with others who had substance misuse issues. The family stated that Mr. R always took responsibility for his actions and was remorseful for the actions which had resulted in his arrest.

5.4 The family stated that the court case weighed heavily on the mind of Mr. R for two years. They relayed how Mr. R was under a curfew and had to be at his address from 23:00 each night. They stated that the effect of An Garda Síochána (AGS) checks, calling to the family address, often late at night, had an adverse impact on his wife and children. Consequently Mr. R moved back to live with his mother. They stated that in addition to the curfew he had to 'sign-on' daily at a Garda station a considerable distance from his home.

5.5 Mr. R's sister informed the investigation team that, on 28 October 2022, she had collected her brother to drive him to court. She described his behaviour as normal. Mr. R's sister stated that Mr. R's sentence came as a huge shock to him and the family as he had expected to receive a suspended sentence. His wife stated that he was due to attend a football match with his child later that day.

5.6 Mr. R's mother felt that imposing a prison sentence was severe stating that her son "*wasn't a criminal, he was an addict*" and should have been placed in an addiction centre. His mother also stated that Mr. R had previously suffered an anxiety attack while in Garda custody and a doctor had to be called.

5.7 The family questions are outlined in **section 6** of this report.

5.8 Although this report is for the Minister for Justice, it may also inform several interested parties. It is written primarily with Mr. R's family in mind.

5.9 The OIP is grateful to Mr. R's wife, mother, sisters and extended family for their contributions to this investigation and we offer our sincere condolences on his loss.

6. Family Concerns

6.1 Mr. R's family asked for the following questions to be considered during our investigation:

1. Why was the family not informed immediately when Mr R was taken to hospital?

   Response: Mr. R had only been in the custody of the IPS for 30 minutes when he was found to be unwell in his cell at 13:15 on 27 October 2022. Mr. R was removed to hospital by ambulance at 14:52. The committal process had not been completed at the time Mr. R became unwell so the next-of-kin contact details were not readily available to the IPS in whose custody he was, at that time.

2. How did a Doctor at A&E get their contact details and why did an IPS official not inform the family?

   Response: The OIP have no remit over the HSE. It was not possible for the OIP to ascertain where the Doctor in A&E got family contact details.

3. The family heard conflicting reports regarding legal representatives who visited Mr. R after he was sentenced. Did Mr. R's legal team meet with him? Did they meet with him in a cell or professional visiting area?

   Response: This is dealt with in section 8.5 of this report.

4. Was his legal representative present when the medical emergency arose?

   Response: Mr. R's Barrister was not present when Mr. R became ill. The OIP wrote to the barrister seeking assistance with its investigation but did not receive a response.

5. What was the immediate medical response at the courthouse?

   Response: This is covered in Section 8 of this report.

6. The family would like a detailed timeline of events from Mr. R leaving court to his removal to hospital.

   Response: The exact timeline would normally be taken from CCTV footage but unfortunately the footage released to the IPS by the Courts Service did not show clock/time. However, while the exact time cannot be provided it is possible to give the sequence of events from the time Mr. R appeared onto the landing of the holding cell. See sections 8 and 10 of the report.

7. What checks were conducted on Mr. R while in the holding cell?

Response: Mr. R was in the holding cell for approximately 12 minutes before he exited to attend a professional consultation with his legal representative. He was checked by an officer on one occasion during this period. Once locked back in the holding cell, Mr. R was checked by an officer six minutes and 45 seconds later. Following this check the officer departed and returned a further 27 seconds later accompanied by three officers. They then entered the cell. As per their reports (see section 8 of this report), there were immediate concerns about Mr. R's condition.

8. Was CPR[1] provided immediately?

Response: CPR was commenced immediately. See 8.8 and 8.10 of this report.

7. Background

7.1 Mr. R was convicted on 20 June 2022 on drugs charges but was not sentenced until the 27 October 2022. Mr. R presented himself before the Court on 27 October 2022 and had legal representation in court. Mr. R was sentenced to two years with the final six months of the sentence suspended.

7.2 Mr. R was taken into custody in Cork Circuit Court on 27 October 2022 following his sentence. Mr. R was escorted from the court room and placed in courthouse holding cell 7 awaiting his transfer to Cork Prison.

7.3 Shortly after being placed in the courthouse cell Mr. R became unwell. Emergency Services were called and Mr. R was transferred to hospital by ambulance escorted by Prison Service Escort Corps (PSEC) officers.

7.4 Mr. R passed away in Cork University Hospital on 28 October 2022.

7.5 The cause of death is a matter for the Coroner.

8. Events of 27 October 2022

8.1 The Courts Service has responsibility for its facilities which includes security of the premises, maintenance of court cells, CCTV footage etc. At the Circuit Courthouse in Cork members of An Garda Síochána supervise persons in their custody awaiting their appearance before the court. IPS personnel supervise those in prison custody who are (i) awaiting appearance before the Court and those (ii) who have been sentenced to prison custody from the court and are awaiting transfer to prison.

8.2 On the morning of 27 October 2022 Mr. R arrived to court in the company of his sister. Mr. R had been convicted on drugs charges in June 2022 and on 27 October 2022 he was sentenced to two years imprisonment with the final six months suspended. Following sentencing he was escorted from the Court to the holding cells by the prison officers on duty in the Court.

[1] Cardiopulmonary resuscitation – Life saving technique administered to an individual experiencing cardiac arrest.

8.3 Officer A reported that along with Officer B they escorted Mr. R to the holding cells and placed him in cell 7 at approximately 12:45. On examination of the PSEC Class Officer's Daily Journal it was noted that an entry was made that Mr. R had been taken into custody at 12:50.

8.4 Officer C reported that when Mr. R arrived to the holding cell area of the courthouse he conducted a physical search of Mr. R. Officer D stated that he assisted in this search. Officer B reported asking Mr. R to "*hand over his phone and belt*" and these were placed in an envelope and left at the reception desk. Officer D also stated that he had €11 which was left in his possession. Officer C stated that nothing prohibited was found but "*observed that he was under the influence of an intoxicant but coherent and able to converse.*" The investigation team were informed that Mr. R had a 'pat-down' search inside the cell but nothing was found.

8.5 Shortly after being placed in the holding cell Officer D stated that he escorted Mr. R to meet his barrister in the Professional Visiting Box, which was a screened (private) consultation. Officer D stated it was a short meeting of approximately five minutes. On viewing the CCTV footage, which did not display a real-time clock, it detailed that Mr. R was 11 minutes and 58 seconds in his cell when he was removed and was returned to the cell approximately 12 minutes later. The Class Officer's Daily Journal recorded Mr. R attending a consultation at 13:00 and returning to the cell at 13:10. Officer D stated that he had no concerns for Mr. R at this time.

8.6 Officer D reported checking on Mr. R a short time later. When he looked through the viewing panel of the cell door he saw Mr. R walking around the cell and Mr. R did not respond to the officer. The footage showed an officer at the cell door six minutes and 40 seconds following Mr. R's return from his legal consultation, the officer appeared to be speaking to Mr. R through the door having raised the viewing flap. Officer D sought the assistance of another officer to enter the cell; the CCTV corroborated this account of events. On entering the cell Officer D reported placing Mr. R in a seated position on the bench before departing the cell. Officer D stated that Mr. R almost immediately leaned forward towards the floor from his seated position.

8.7 Officer A stated that at approximately 13:15 along with other Officers they went to the cell of Mr. R after hearing noises from the cell. Officer A stated that Mr. R was walking around the cell in a distressed manner. Officer D reported that on entering the cell Mr. R was "*very agitated and his arms were waving in the air*." Officer D stated that they "*took hold of his right arm to prevent staff from being injured*" along with calming and reassuring Mr. R. Officer E reported taking hold of Mr. R's left arm and stated that after a few minutes he calmed down and was placed in a seated position. Officer F reported seeing Mr. R in a "*confused state."* Officer A reported they removed his shoes and socks before leaving the cell. Officer E stated "*I noticed that he [Mr. R] was unsteady on his feet, his arms were swinging and his shirt was on the floor. He was shouting and muttering to himself*."

8.8 Officer A reported that at approximately 13:30 while conducting a cell check, she discovered Mr. R on the cell floor. Officer A stated "*immediately it became apparent that the prisoner was in difficulty as he was foaming from the mouth and bleeding from the nose*." Mr. R was placed in the recovery position and his pulse was checked. Officer A further reported that Mr. R was non responsive and had a weak pulse. Officer A stated they commenced CPR. Officer C stated that he asked the Garda on duty to call an ambulance. The investigation team were informed that Officer A and Officer B were First Responders and commenced CPR. Officer B went to the gate to ensure that the ambulance would not be delayed entering the court building.

8.9 Officer E corroborated the report of Officer A and Officer B.

8.10 Officer G reported that at approximately 13:25 he attended the holding cell area during the court recess and discovered Mr. R lying on the floor who appeared to be breathing poorly, he stated that Mr. R "*was having some form of fit/seizure.*" Officer G stated that Officer H, Officer B and Officer I began to administer first aid and CPR. An Officer went to the Control Room to retrieve the Automated External Defibrillator (AED). The Officer attached the AED to Mr. R which advised no shock. A "*no shock*" message from the AED indicates either; there is a pulse present, a pulse has been regained or the person is pulseless but is not in a shockable rhythm. Paramedics took over the care of Mr. R on arrival and Mr. R was removed to hospital by ambulance.

8.11 Officer G reported driving to the hospital behind the ambulance. Immediately upon arrival at the hospital Mr. R was admitted to the Resuscitation Unit.

9. Information Provided by other Occupants of the Holding Cells

9.1 Prisoner 1 who was in a nearby holding cell in the courthouse informed the investigation team that he saw Mr. R being brought to a nearby cell and described Mr. R as appearing "fine". Prisoner 1 further detailed that "*about a half hour later after he was placed in the cell I could hear him pacing up and down and kicking the wall. He was rambling and not making much sense. It was like he was on drugs*." Prisoner 1 stated that he heard officers ask Mr. R in the cell what was wrong but Mr. R did not respond.

9.2 Prisoner 1 was taken to court and on his return stated that he saw Mr. R on the floor outside the cell with medical personnel and prison officers trying to revive him.

9.3 Prisoner 2 was accompanied in the cell by two others. Prisoner 2 reported hearing a person in another cell shouting. Prisoner 2 stated that Officers responded quickly and asked him what was wrong but he kept shouting and "*seemed to be oblivious to the officers and their questions"*. Prisoner 2 stated that he could see through a crack in the door and it was not long before Gardaí and paramedics arrived to the cell and they started "*pumping his chest*".

10. CCTV Footage

10.1 The contract for the CCTV system operated in Cork Courthouse was awarded by the Courts Service and neither the IPS nor the OIP have direct access to the footage recorded. In this case BAM FM, Ireland's Facilities Manager at Anglesea Street Courthouse, Cork, informed the Governor of PSEC, Governor A, that BAM were engaged by the Courts Service and were "*contractually not allowed give information to anyone only the Courts Service*" as their client and there was a Service Level Agreement "*on how and who we share information.*" The Facilities Manager directed Governor A to the Courts Service as the IPS was "*a third party user of the building*".

10.2 The release of footage requested by the IPS was dealt with under the Courts Service CCTV Policy.

10.3 Article 5.1(b) of the General Data Protection Regulation states that personal data shall be collected for specified, explicit and legitimate purposes and not further processed in any way incompatible with those purposes. The Data Protection and Freedom of Information Officer of the Courts Service informed Governor A that the purposes for the processing of video footage via CCTV are for the security of their premises and the health and safety of both staff and the public.

10.4 Under the Courts Service Policy when investigating a crime, An Garda Síochána or another law enforcement agency such as the Garda Ombudsman may view CCTV footage. Governor A was informed that the IPS entitlement was limited to accessing video footage showing IPS staff. All images of third parties were redacted.

10.5 The footage provided to the IPS and viewed by the OIP in the course of our investigation was heavily pixilated. It was presented in 'clips' and excluded the time of recording consequently it was of limited investigative value.

10.6 The OIP wishes to recall that it is foreseen that, in future, its monitoring mandate under the Inspection of Places of Detention Bill will extend to monitoring detention in Courts Service premises. The Inspectorate intends to engage constructively with the Courts Service in order to ensure that, in future, it will be provided in a timely manner with the full information necessary to perform all of its statutory functions.

11. Critical Incident Review Meeting

11.1 On 28 October 2022 a critical incident review meeting[2] was held by Governor B at Cork Prison. In attendance were Assistant Governor A, PSEC, Acting Chief Officer A, Cork Prison, Officer D, Cork Prison, Officer J, PSEC, Officer G, PSEC, Officer C, PSEC, Officer B PSEC and Officer E PSEC.

11.2 Officer J reported being in-charge at Cork Courthouse when Mr. R was sentenced and he "*seemed ok.*" Mr. R was escorted from the court room to the holding cell. He informed the meeting that Mr. R was again removed from the cell for a short period to meet his barrister.

11.3 Officer J reported that staff commenced CPR and continued until paramedics arrived.

11.4 Those present at the Critical Incident Review Meeting acknowledged the efforts of Officer B, Officer H, Officer A and Officer I in performing CPR until they handed over to the paramedics.

11.5 It was recorded that a Critical Incident Support Meeting for staff was scheduled for staff on 1 November 2022.

11.6 A recommendation of the meeting was that First Responder Training be made available to all PSEC staff and the importance of First Aid Training for all IPS staff.

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

12. Recommendations

There are three recommendations in this report:

1. First Responder Training and First Aid Training should be provided to all IPS staff who have direct contact with prisoners, including PSEC staff. The OIP has previously made a similar recommendation in Mr. I 2019. The recommendation was not accepted by the IPS, they stated: "*This was because of the demands this would place on the staffing system for refresher training each year. The initial training takes three days to deliver and a further one day refresher is required every two years thereafter. The drain on resources from the requirement to provide refresher training would seriously impact on staffing and the provision of other resources."*

2. The IPS hold responsibility for persons in their custody who are temporarily accommodated in courthouse holding cells. The IPS should have access to view and obtain CCTV footage at an early stage of an investigation into a serious incident involving a person in the custody of the IPS. It is recommended that the IPS engage with the Courts Service as a matter of urgency to gain access to CCTV footage. If necessary, amendments should be made to the Courts Service CCTV policy to facilitate this.

3. A record should be maintained of all items taken possession of in a 'Personal Belongings Record' to be completed by the Reception Officer at the Courthouse. A similar recommendation was made in Mr. X 2021. The recommendation was not accepted by the IPS, they stated that: "*Resources are not available to conduct this task at court level.*" The OIP recommends that the IPS reconsider their position as it is very important to ensure that a new committal has nothing in their possession which could cause themselves or others harm.

13. Support Organisations

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