

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner F
in Cork Prison
on 10th May 2013**

***Please note that names have been removed to anonymise this Report**

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Office Ref: 2013/F

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into the circumstances surrounding the death of Prisoner F
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Presented to the Minister for Justice and Equality pursuant to
Part 5 of the Prisons Act 2007

Judge Michael Reilly
Inspector of Prisons

26th August 2014

Preface

Prisoner F was 25 year old man when he died in Cork Prison on 10th May 2013.

I offer my sincere condolences to the deceased's family. As part of my investigation I met with the family and have responded, in this Report, to questions and issues raised by them.

My Report is divided into 10 sections as follows:-

- General Information
- The deceased's interaction with the community based psychiatric services
- The deceased's interaction with the medical services in prison
- The demeanour of the deceased while in prison
- Sequence of events on 10th May 2013
- Concerns of the family
- Addressing the family's concerns
- Findings
- Recommendations
- Matters of concern

I would like to point out that names have been removed to anonymise this Report.

Finally, I would like to thank all those who assisted with this investigation.

Judge Michael Reilly

Inspector of Prisons

26th August 2014

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 25 year old single man. He is survived by his partner, 3 children, parents and siblings. He came from the Munster area. He was committed to Cork Prison on 23rd October 2012. His release date was to be 20th January 2018.
2. It is clear from the deceased's medical file that the deceased had contact with outside psychiatric agencies prior to his committal to prison and with the medical personnel while in prison.
3. The deceased had a history of depression and alcohol misuse.
4. I had unrestricted access to all parts of the Prison, to all records, to prison staff and to prisoners. I also had access to relevant CCTV footage.

The deceased's interaction with the community based psychiatric services

5. The deceased was referred to the Mental Health Services in his local area by his GP – Doctor A. In his referral letter Doctor A describes the deceased as, *inter alia*, having “*a long episode of depression*”, “*being a recluse in his own house for the past year*”, “*sleeping poorly at times*” and having “*no motivation*”.
6. On 25th September 2012 the deceased was assessed by a Consultant Psychiatrist A in his local Mental Health Clinic.
7. During the assessment referred to in paragraph 6 the deceased stated that he had “*lots of things going through my mind. Worrying about things I shouldn't be thinking about*”. He stated that he was “*down and out for the last 3 years. I don't come out of the house really*”. He described his mind as being “*bad enough*”. “*I could be grand one minute and take off very easily the next minute*”. He stated that he was “*easily irritated by nothing major*”. He also reported entertaining thoughts of life not worth living intermittently in the last

2/3 years. He denied any definite plans or final acts. He stated that the closest he came to acting on these thoughts was 3 years previously when he imagined having a rope and having thoughts of hanging himself. He admitted that he did not have the courage to carry it out. He stated that alcohol was a major part of this.

The deceased's interaction with the medical services in prison

8. On 23rd October 2012 the deceased was committed to Cork Prison. A committal interview was conducted by Nurse Officer A. There are no records on the Prisoner Healthcare Medical System (PHMS) that the deceased was assessed by a Nurse or a Doctor on his committal as opposed to the committal interview referred to above.
9. On 1st November 2012 the deceased was transferred from Cork Prison to Portlaoise Prison. He was seen by Chief Nurse Officer A in Portlaoise Prison but there are no records of a committal interview.
10. On 2nd November 2012 the deceased was assessed by Doctor B. During this assessment it was noted that the deceased was currently on medication for depression but that he was *“coping ok, mood appears low but he says it’s ok”*.
11. On 25th November 2012 the deceased was transferred from Portlaoise Prison to Cork Prison. There are no medical notes to indicate that the deceased was seen by any healthcare personnel on transfer.
12. On 10th January 2013 the deceased was transferred from Cork Prison to Portlaoise Prison. The deceased was seen by Nurse Officer B. There are no records of a committal interview.
13. On 11th January 2013 the deceased was assessed by Doctor C. During this assessment it was noted that the deceased had a history of depression but no history of self harming. It was noted that he abused alcohol and ‘recreational’ drugs.

14. On 9th April 2013 the deceased was seen by Doctor C. It was noted that the deceased was “*feeling quite low*”. It was also noted that the deceased had received letters under his cell door and that there “*seems to be a little element of bullying on landing*”. Doctor C also stated that “*there have been problems with him keeping his cell clean and his hygiene has disimproved*”. Doctor C referred the deceased for a psychiatric review.
15. On 9th April 2013 Chief Nurse Officer A noted on the PHMS - “*if medication is prescribed for (the deceased) to assist with his mental health then this must be under direct observation for at least the time where there is documentation to suggest that the risk of self harm is acceptable (low)*”.
16. On 10th April 2013 Nurse Officer C noted on the PHMS that the deceased’s family “*were in to see him today and they voiced their concerns at his mental state*”. Chief Nurse Officer B was informed about the family’s concerns.
17. On 10th April 2013 the deceased was seen by Chief Nurse Officer B. In the PHMS notes Chief Nurse Officer B noted “*seen in surgery for a nursing assessment of his mental state following yesterday’s consultation with GP*”. The deceased admitted to being a “*heavy drinker*”. The deceased stated that he was diagnosed with depression by his GP three years previously. He stated that he would go to his room and not come out for days. Chief Nurse Officer B stated that his “*eye contact was good at times*”. The deceased “*recognises the link between alcohol and problems in his life. Seems to be able to concentrate on questions but reverts back to initial statement of “I can’t do jail, I need to go to the CMH” frequently*”.
18. During the assessment referred to in paragraph 17 the deceased stated that a note was passed under his cell door saying “*pack your kit and go on the rope*”. Chief Nurse Officer B stated that he saw this note and it did not contain those precise words. The deceased then claimed that prisoners had said this to him. The deceased stated that “*he has thought about it and wants to go to the CMH so that he doesn’t have to hang himself*”. Chief Nurse Officer B’s impressions were that he was “*mildly depressed and that it was associated with former*

alcohol abuse which puts him at moderate risk of suicide". "No evidence of psychosis or irrationality in his thinking. He needs to remain on special obs and be brought his prescribed medication if he does not turn up for it". "He needs to be reviewed by healthcare staff daily".

19. On 12th April 2013 the deceased was seen by the Community Psychiatric Nurse from the Central Mental Hospital In-Reach Team. During this assessment the deceased stated that "*my brain won't allow me to do jail. I think I need to go to Dundrum*". He also stated that his mood was "*bad, very bad*". He stated that he had thoughts of self harm but denied having any plan or intent. The nursing note stated that his "*mood presents as mildly depressed with disturbance to biological features*". "*No indication for psychiatric hospitalisation*".
20. On 23rd April 2013 the deceased was seen by Psychiatrist B from the Central Mental Hospital. During this assessment the deceased stated that he was feeling better now as he was taking a certain medication. The psychiatrist noted that this medication was only started that morning. The deceased also stated that he had "*a bit more life in myself*". He also stated that his mood was improving "*a small bit*". He stated that he didn't feel threatened or at risk in the prison. He stated that he was sleeping badly and his appetite was "*alright*". The psychiatrist outlined the importance of his compliance with the taking of his medication and advised against discontinuing the taking of the medication suddenly without medical supervision. The psychiatrist stated that there was no evidence of psychotic illness and discharged him to the care of the hospital GP. The deceased was continued on the medication already prescribed.
21. On 25th April 2013 the deceased was seen by Doctor D. The doctor increased the medication and continued the deceased on special observation.
22. On 29th April 2013 Chief Nurse Officer B noted on the PHMS that the deceased refused to attend for his medication and he (the deceased) told staff that he no longer wanted medication.

23. On 29th April 2013 the deceased was seen by Doctor D and stated that he was “*having a bad day today...didn’t feel like getting up*”. The doctor noted that the deceased’s “*meds have changed to the night time*” and placed the deceased for review by the psychiatrist the following morning. **There is no note on the PHMS that the deceased was seen by a psychiatrist the following day.**
24. On 29th April 2013 an altercation took place in Portlaoise Prison involving the deceased and other prisoners. He was seen by Nurse Officer C who noted that he was agitated. He was placed on the list to be reviewed by the prison doctor the following day.
25. On 30th April 2013 the deceased was reviewed by Doctor C and it was noted that the deceased was “*doing well on meds*”.
26. On 1st May 2013 the deceased was transferred from Portlaoise Prison to Cork Prison.
27. On 1st May 2013 the deceased was assessed by Nurse Officer D in Cork Prison. It was noted that the deceased “*presented as anxious in manner*” and “*requesting to go to the CMH*”. Nurse Officer D explained to the deceased the referral assessment process for the CMH. The deceased “*denied any specific reason for CMH*”. The deceased denied any thought, plan or intent to self harm. He also denied any thought, plan or intent of suicide.
28. On 2nd May 2013 the deceased was assessed by Doctor E. In his report the doctor states that the deceased’s mood was low and that he had thoughts of self harming. The deceased also stated that he was hearing voices. The doctor continued him on medication and transferred him to the D Unit for medical observation.
29. On 3rd May 2013 the deceased was seen by Psychiatrist C. The psychiatrist stated that the deceased was placed in the HSU. He stated that the deceased

was confused and thought it was Tuesday (it was Friday). The deceased stated that he had thoughts of self harm but *'not now'*.

30. On 4th May 2013 the deceased was seen by Psychiatrist C. The deceased would not specify if he was suicidal. The psychiatrist placed him on *"high obs"*.
31. On 7th May 2013 the deceased was seen by Psychiatrist C. It is noted that the deceased had *"fleeting ideas of self harm"*.
32. On 10th May 2013 the deceased was found hanging in his cell.
33. It is noted throughout the deceased's medical file that he often missed his medication, refused to take his medication or had to be constantly reminded to take his medication.

The demeanour of the deceased while in prison

34. While the deceased was imprisoned in Portlaoise Prison he received visits from his family, his partner and his children regularly. During these visits the deceased's partner stated that he (the deceased) was *"very happy in Portlaoise and spoke highly of the prison officers there"*. She stated that the deceased would engage in conversation and would *"always have sweets for the children"*. He would *"talk to them and interact with them during the visits"*. She stated that the deceased appeared *"to be filling his time well and doing things. He was always clean and had clean clothes on during visits"*.
35. Chief Nurse Officer A of Portlaoise Prison has stated that:-

"On April 9th 2013 it was documented by both the nursing staff and doctor in Portlaoise that (the deceased) was struggling to cope mentally. His "Risk" was reassessed and it was felt that there may have been a psychotic illness impacting on (the deceased's) behaviour. (The deceased) was referred on April 9th to the psychiatry team for an assessment and because of a potential non-compliance with taking his

medication; he was placed onto Directly Observed Therapy (DOT). He was initially screened on 12th April by the Community Psychiatric Nurse (CPN) from the Central Mental Hospital (CMH) In-reach Team and seen by the consultant psychiatrist from the CMH on April 24th.

From April 9th, concerns for (the deceased's) mental health were communicated by both the discipline and healthcare staff in Portlaoise; and with the psychiatry assessment not finding evidence of any psychotic illness, (the deceased) was managed as not being adequately adjusted to the prison environment.

On April 29th (the deceased) was involved in an altercation on the Landing of C3 with other prisoners. His "Risk" and management of his mental health needs were reassessed and a care plan was documented that required daily nursing assessments of (the deceased's) behaviour and 15 minutely observations by the discipline staff. It was documented that there was direct taunting of (the deceased) by fellow inmates and that (the deceased) received a letter from one of them that detailed a form of bullying by other prisoners. (The deceased) remained under the close monitoring of the nursing staff until his transfer to Cork Prison on May 1st 2013".

36. On 4th May 2013 the deceased had a visit from his father and one of his sisters in Cork Prison. During this visit the deceased's father and sister became very concerned about the deceased's mental health. The deceased's father stated that "*when they brought (the deceased) in to the room, he stood up and was staring at me*". The deceased's father asked him when he was transferred back to Cork Prison. The deceased's reply was "*Drum*". The deceased's father stated that he knew that it was Dundrum Hospital that the deceased was referring to. The deceased's father stated that his son "*did not look himself*". He stated that the deceased was wearing a red shirt with a white vest. The shirt was open. He stated that the deceased "*looked like he was sleeping rough*". The deceased's father stated that he was worried about the condition that his son was in. He stated that the deceased "*always sat down during*

visits. He would be leaning towards you at the desk in Portlaoise. In Cork Prison (the deceased) was totally different”.

37. The deceased’s father stated that when the visit was finished they were still there when the prison officer took the deceased back in to the Prison. He stated that the officer “*caught him like a child to lead him along*”.
38. Following the visit the deceased’s father and sister requested to see a Governor. As a Governor was not available they met with a Chief Officer. They did not know the identity of this Chief Officer. They outlined their concerns to the Chief and stated that the deceased needed to see a doctor. The Chief Officer told them that he would get someone to see him (the deceased).
39. I have ascertained that the Chief Officer referred to in paragraph 38 was ACO A. ACO A was interviewed as part of my investigation. At interview he stated:-

“In the afternoon of that day approximately between 3 and 4 p.m., I was notified by the officer on the main gate that a person wishes to speak to me. It is a regular occurrence that people visiting would ask to see the Governor and I being the Senior Officer on duty would speak to them. I went to the main gate and I met a man who introduced himself to me as (the father of) a prisoner then in custody in Cork Prison. (The father) expressed his concerns to me about the general well being of his son...whom I knew to be in the High Dependency Unit – Medical Unit. (The Father) stated that during his visit with (his son), which had just finished he felt he was distant and would not speak to him or his daughter who was very upset and also concerned about (the deceased’s) condition. (The father) also said that (the deceased) was dishevelled - looked unkempt. Both (the family members) spoke about a doctor for (the deceased) and I explained to them that (the deceased) was in the Medical Unit under the care of the medical staff and was seeing the doctor on a daily basis. I assured them that (the deceased) was receiving the best medical care that the prison could provide. I

also told both.....that I would speak to the medical staff about their concerns and that I would also visit (the deceased) as part of my rounds. I spoke to both of the (family members) for about 10 minutes and they left the prison then.

I immediately contacted the Surgery unit and spoke to a member of staff there – who I don't remember at this stage about (the deceased's) condition. They informed me that they were fully aware of (the deceased's) condition and were treating him appropriately. Later that evening approximately around 6 pm, I visited (the deceased) in his cell in D Wing. I spoke to him. He was in bed. I told him his father and sister were concerned about him. He did not reply to me or speak to me. I did not pursue this any further with (the deceased) as he was not communicating and I then left the cell. I spoke to the staff on duty about the concerns of (the deceased's) father and sister.”

40. The deceased's family were so concerned about the deceased's mental health that, on returning from their visit with the deceased, they contacted their solicitor in Dublin.

41. On 8th May 2013 the deceased had a screened visit with his partner and children. During this visit the deceased's partner became very concerned about the deceased's mental and physical health. In an interview with the deceased's partner she stated that the deceased “*looked very pale*” and had “*dark circles around his eyes*”. “*He had lost an enormous amount of weight, he looked like he had not showered in days, hair standing out, unshaven, teeth yellow and he had prison clothes on him*”. When she spoke to the deceased she was “*shocked*” and stated that she could not believe the change in him since she saw him last (over two weeks previous). She stated that the deceased did not speak to their children and that “*he appeared sleepy as if he was not there, just blank*”. She asked the deceased what was wrong with him but he did not reply. The deceased then stated that he needed to go to Dundrum. The deceased's partner stated that “*his voice was low and he had difficulty talking*”.

42. Following the visit outlined in paragraph 41 above the deceased's partner was so concerned that when she left the visit she requested to see a Governor.
43. Chief Officer A met the deceased's partner as a Governor was not available. The deceased's partner outlined her concerns to Chief Officer A. Chief Officer A told her that he would talk to the deceased and that he would make sure that everything was ok with him. The deceased's partner was due to meet Chief Officer A the following week at her next visit with the deceased.
44. As part of my investigation Chief Officer A was interviewed. He recalled being on duty in Cork Prison on the afternoon of 8th May 2013 and was aware that the deceased had a visit from his partner and their two children. This visit took place between 2.15pm and 2.45pm. On completion of the visit the deceased's partner requested a meeting with the Governor. The Chief Officer met the deceased's partner as a representative of the Governor at the main gate. He was told that she was worried about her partner's health – particularly his mental health. He stated that she explained that the deceased spoke very little during the visit and that she was worried about this. The Chief Officer stated that he tried to reassure her and told her that he would talk to the deceased that evening. The Chief Officer went on to recount that during his rounds of the prison that evening at approximately 6.40pm he visited the D Unit and spoke to the deceased in his cell – Cell 2 on D1. He stated that the deceased said that he wanted to be transferred to the CMH or to an open prison. He stated that he advised the deceased that he had met his partner that evening and that she was concerned about him. He advised the deceased to take all the medical advice and co-operate with the medical team. He remembered the deceased as being communicative but not fully lucid in his thinking. His overall impression of the deceased was of a person not in danger of taking his own life.
45. Before the deceased's partner left the prison she went to lodge money into his prison account as the deceased stated that he had no money. When she went to lodge the money into his account she noticed that he had a considerable

amount of money in his account. The deceased's partner stated that "*this confused and worried me as it showed (the deceased's) confusion*".

Sequence of events on 10th May 2013

46. In paragraphs 47 to 55, I outline the sequence of events leading up to the death of the deceased on 10th May 2013. As there are no CCTV cameras in the D Unit of Cork Prison I am unable to verify the sequence of events outlined below. However, from my investigation, from my contact with Prison Officers and prisoners and from my perusal of documentation I have pieced together the sequence of events.
47. At 9.25am there is a note on the PHMS to the effect that the deceased was seen by Doctor E. The PHMS note states that the deceased had "*no complaints this am*".
48. At approximately 9.51am the deceased was seen by a Governor. The Governor stated that the deceased "*made no requests*".
49. At approximately 12.00 noon Officer A gave the deceased his dinner and stated that there was "*nothing unusual to report*".
50. At approximately 12.40pm Officer B – the Dinner Guard - took charge of the D Unit. This fact can be corroborated by CCTV footage harvested from a camera situated in the hall outside the D Unit which clearly shows Officer B entering the Unit.
51. Officer B has stated that on taking charge of the D Unit he checked all prisoners. In his statement he goes on to state that "*on one occasion while checking on (the deceased) he was looking for matches which I got from (Prisoner 1) who was in the next door. On the other occasion while being checked the deceased was looking for a phone call which I told him to ask the Class Officer at 2 o'clock. The last time I checked the deceased was approx 1.55pm and the deceased was sitting in his bed at that stage*".

52. The account given by Officer B in paragraph 51 of the deceased looking for matches is corroborated by Prisoner 1 who has stated that *“at about 2.30 or 1.30 I was just getting my first bit of sleep when (the deceased) knocked on my wall asking for a match. I did not reply to him so he got an officer to come to my door.....I gave the officer two matches and told (the deceased) not to knock me again”*.
53. Officer C, who had returned to the Unit, stated that at 2.05pm he checked on the deceased and observed him walking around the cell.
54. Officer A stated that at approximately 2.10pm he observed the deceased on his bed.
55. Officer C stated that approximately 2.20pm he checked the deceased and found him hanging from a ligature attached to the television unit on the wall of his cell. ACO B who was in charge of the D Unit was immediately called to attend the scene.
56. I cannot independently verify the accuracy of the events referred to in paragraphs 53 to 55 as there were no CCTV cameras.
57. Officer C and Officer D released the deceased from the ligature point.
58. Once ACO B arrived at the scene he immediately called for medical assistance, stating that he had a medical emergency in D Unit.
59. At approximately 2.25pm Chief Officer A, Medical Orderly A and Chief Nurse Officer C arrived at the cell. Medical Orderly A and Chief Nurse Officer C removed the ligature from around the deceased's neck and commenced CPR while Chief Officer A called for an ambulance.
60. At approximately 2.35pm Chief Nurse Officer C discontinued CPR as no pulse could be found.

61. At approximately 2.40pm the ambulance crew arrived at the scene and confirmed the death.
62. The deceased was removed from the Prison at approximately 6.20pm.
63. Throughout his time in Cork Prison the deceased was classified as a special observations prisoner. As such, under Standard Operating Procedures, he should have been checked every 15 minutes. This requirement is especially relevant having regard to the observation of Psychiatrist C as referred to in paragraph 30 and to the deceased's fragile medical condition. A journal is maintained for each cell which includes, *inter alia*, a section to be completed of checks made of prisoners by officers. This section is divided into 15 minute sections i.e. 2.00, 2.15, 2.30, 2.45, 3.00 etc. The officer must then tick a box to the effect that the deceased is awake, asleep, distressed etc. In the case of the deceased's journal all of the times are appropriately ticked. However the journals for all other prisoners in the Unit for the time that the deceased was accommodated there have been similarly ticked for the exact same times. As there are no CCTV cameras in the D Division I have been unable to verify the accuracy of the entries in the journal and if the necessary checks took place.

Concerns of the family

64. A member of my team and I met with the family on two separate occasions. Their concerns expressed were as follows:-
 - (a) Why was the deceased transferred from Portlaoise Prison to Cork Prison?
 - (b) Why wasn't he watched in his cell?
 - (c) Why was he denied a phone call in Cork Prison?
 - (d) Why was he denied access to the tuck shop?
 - (e) Why was he on his own in the cell?
 - (f) Why wasn't he seen by a Doctor and Psychiatrist?
 - (g) Was his medication reviewed for its strength or lack of strength?

- (h) When he asked for help why wasn't he given it? He mentioned the CMH on several occasions.
- (i) The deceased's partner stated that on her last visit to Cork Prison her visit with the deceased was screened. Why was this visit screened?
- (j) The family were told about the deceased's death over the phone. Why were they not notified in person?

Addressing the family's concerns

65. In paragraph 64, I outlined the concerns expressed to me by the family. In paragraph 66, I endeavour to address such concerns. I adopt the same numbering sequence as in paragraph 64.
66. (a) The deceased was transferred from Portlaoise Prison to Cork Prison following his involvement in an incident in Portlaoise Prison on 29th April 2013 for which he received punishment following a P19 hearing.
- (b) When a prisoner is placed on special observation he/she should be checked every 15/20 minutes. The deceased was accommodated on D Wing and was classed as being on special observation. According to prison records the deceased was checked every 15/20 minutes. I cannot verify this as there is no CCTV footage in the relevant area.
- (c) Prison management stated that the deceased was only denied evening recreation following his involvement in the incident in Portlaoise Prison. The deceased was not denied any telephone calls.
- (d) Prison management stated that the deceased had access to the tuck shop.
- (e) International best practice is to have all prisoners in single cell accommodation.
- (f) The deceased was seen on 6 occasions by the Prison Doctor and on 3 occasions by the Psychiatrist between the date of his transfer to Cork Prison – 1st May 2013 and the date of his death – 10th May 2013. He had considerable contact with the medical and psychiatric services in Portlaoise Prison between 23rd October 2012 and 1st May 2013 as outlined in this Report.

- (g) The deceased's medication was increased on 25th April 2013 as referred in paragraph 21. His medication was reviewed on 28th April 2013 and 2nd May 2013 but was not changed.
- (h) The deceased's contact with the Psychiatric Services is documented in this Report which shows considerable involvement with the deceased by the Psychiatric Services.
- (i) It is normal prison policy that prisoners held in the Medical Support Unit of Cork Prison receive visits in the screened visiting box.
- (j) I cannot account for this except to say that in situations such as this it is imperative that members of a deceased's family are informed of a death as quickly as possible. I address this in my recommendations.

Findings

- 67. The deceased suffered from depression and the results of the abuse of alcohol.
- 68. On a number of occasions in prison the deceased displayed suicidal thoughts which were documented.
- 69. The deceased was 'looking for help'.
- 70. The deceased had considerable contact with the Psychiatric Services both in the community and in prison as documented in this Report.
- 71. The medical view was that the deceased did not require hospitalisation.
- 72. The deceased was a special observation prisoner – a requirement that he be checked every 15/20 minutes.
- 73. There was no CCTV in the D Division.
- 74. I am not in a position to say if the deceased was checked every 15/20 minutes while he was in Cork Prison due to my finding at paragraph 73.

75. The deceased's medical care while in prison was well documented in both prisons.
76. The concerns of the family were taken seriously.
77. While the cause of death is a matter for the Coroner's Inquest I understand it to be (a) Asphyxia and (b) suspensions by a ligature.

Recommendations

1. Adequate CCTV should be installed in all relevant areas of working prisons.
2. Prison management must be sensitive to the feelings of family members, in times of crisis, when delivering critical information.

Matters of concern

1. Over the past number of years I have drawn the attention of the management of Cork Prison to the fact that there were and are no CCTV cameras in the D Division.
2. The physical characteristics of the D Division in Cork Prison have been well documented in the past. It accommodates prisoners who are on punishment and vulnerable prisoners. The perception is that prisoners who are accommodated in the D Division, whether they are vulnerable prisoners or not, are on punishment. This Unit is at the back of the prison and totally isolated from the main prison. It is small. Cells do have in-cell sanitation. It has its own yard and a small gym. However, prisoners do not enjoy any of the other facilities enjoyed by the prison population as a whole. On many of my visits over the years cells were filthy and cold. Prisoners in this Unit rarely interact with other prisoners and for the most part have nothing to do and are locked up for up to 23 hours a day. This is a forbidding place for vulnerable prisoners. **It is not fit for purpose even for prisoners on punishment but it should certainly not be used for vulnerable prisoners such as in the instant case.** I am aware that a new prison is under construction in Cork at the moment. However, there have been, are and will be vulnerable prisoners

in Cork Prison who have and will require accommodation in a form of High Support Unit in the existing prison. These are prisoners that the healthcare team direct should be placed in such a Unit. Therefore, appropriate cells for this purpose must be identified in the existing prison **as a matter of urgency** which are fit for purpose and are accessible to the healthcare professionals.