OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr I 2019

AGED 40

In LIMERICK PRISON on 27 June 2019.

[Date final report submitted to the Minister for publication: 19 October 2021]

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GLOSSARY

ACO	Assistant Chief Officer
Act	Prisons Act 2007
AGS	An Garda Síochána
CCTV	Close Circuit Television
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
CR	Control Room
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
Office	Office of the Inspector of Prisons
Operational staff	Uniform staff involved in the day-to-day operation of a prison
PAMS	Prisoner Account Management System
P19	Form that is completed when prisoners are reported for alleged breach of disciplined
PHMS	Prisoner Health Management System
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure

PREFACE

The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Minister has requested the Inspector of Prisons to investigate deaths in prison custody. In 2018, clarification was received that the Inspector is also requested to investigate the death of any person which occurs within one month of their temporary release from prison custody. The Office is completely independent of the Irish Prison Service (IPS). The Inspector of Prisons and staff of the OIP are Civil Servants, however, they are independent of the Department of Justice in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations are disseminated in the interest of transparency, and in order to promote best practice in the care of prisoners.

Objectives

The objectives for Inspector of Prisons 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 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 investigative obligation 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.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; 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. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Prisons Act 2007 in relation to accessing healthcare /medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Next of Kin (NoK). This inevitably leads in some instances to a failure to review healthcare/medical records where NoK is unknown, cannot be located, or refuses to provide consent. Mr I's NoK provided consent to access his healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr I was found unresponsive in his cell on the 27 June 2019.

Administration of the Investigation

The OIP was notified of Mr I's passing by email followed by a phone call at 09:38 on the morning of 27 June 2019. Staff of the OIP visited Limerick Prison during the afternoon of 27 June 2019. Prison management provided a briefing and confirmed that CCTV footage for the relevant areas of the prison had been saved. Mr I's cell was viewed and information requirements for the investigation were agreed. Relevant prisoners and staff who were on duty at the time of our visit were interviewed and statements obtained.

All documentation requested was provided promptly by the IPS.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

Representatives from the OIP met with Mr I's parents and partner in May 2019 who raised several queries. These queries and related findings are set out in more detail in the summary of this report. Mr I's family informed the Inspectorate that he was getting on well in Limerick prison, working as a cleaner and was active as a Red Cross listener. They were told that he was a calming influence on other prisoners, that he helped staff and stopped rows between prisoners.

Although this report is for the Minister for Justice it will also inform several interested parties. It is written primarily with Mr I's family in mind. My colleagues and I offer our sincere condolences to them for their sad loss.

Recommendations

There are four recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Irish Prison Service on 14 April 2021 for review, comments and an action plan. A response was received on 24 June 2021.

The IPS accept/part accepted three recommendations. An action plan was provided for the recommendations accepted and part accepted, areas of responsibility and timelines were included. Implementation of the action plan will be monitored in future inspections and or investigations into deaths in custody. The recommendations and the reason for the not-acceptance of one and part-acceptance of another recommendation by the IPS are specified in the following Summary section of the Report.

The IPS did not accept recommendation 3 in relation to the provision of Basic Life Support (BLS) training for Recruit Prison Officers and refresher courses for established staff. The IPS has decided that emergency first aid training is not required as a core competency of new recruits training due to:

1. The time taken to provide training and refresher training and its adverse impact on staffing and provision of other resources
2. The argument of equivalence
3. That nursing care is in the prison at all times

The IPS has cited 3 days as a full first aid course. There are alternatives courses of first aid responder 1 day

and emergency first aid 4 hours. I do not accept that a one day refresher course every two years would disproportionately impact on resources. Preservation of Life is paramount and every possible effort should be made to achieve this. With very limited healthcare resources on duty in prisons at night operational staff with BLS training could provide lifesaving assistance until Paramedics arrive, which can take a considerable period of time depending on the location of the prison.

The argument of equivalence is without basis. In respect of protection of life under Article 2 ECHR the IPS has a positive duty to provide the measures needed to protect life in many circumstances, particularly those that are foreseeable. In judging foreseeable the questions are, has it happened before and since, and the answer is yes. Would trained people in BLS be in a better position to protect life – the answer is yes. In addition in the Critical Incident Review convened by the Prison Governor following this death, the IPS prison staff asked for BLS training themselves.

The fact that there is a Nurse on duty in a prison does not remove the need for BLS training for all staff. The duty of staff to have training is wider that just being confined to a few and is a core function of prisons as ruled at the European Courts:

Under Article 2, the Court has stressed that this provision enjoins the States not only to refrain from the intentional and unlawful taking of life, but also lays down a positive obligation on the States to take appropriate steps to safeguard the lives of those within their jurisdiction. In the context of prisoners, the Court has previously had occasion to emphasise that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them (*Mustafayev v. Azerbaijan*, 2017, § 53). The obligation to protect the life of individuals in custody implies an obligation for the authorities to provide them with the medical care necessary to safeguard their life (*Jasinskis v. Latvia*, 2010, § 60; *Hilmioğlu v. Turkey* (dec.), 2020, § 70). Given the positive obligation on the State to enact preventive measures to protect the right to life, the Inspectorate is disappointed with the Irish Prison Service response to Recommendation (*3*), which indicates the Irish Prison Service's non-acceptance of the Inspectorate's recommendation to establish such a preventive measure, under the auspices of the Irish State's European Convention on Human Rights Article 2 positive obligations.

I am also concerned at the response provided by the IPS in part-accepting recommendation 2. Preserving a scene where a death occurred, which could potentially be a criminal scene, is critically important pending the arrival of An Garda Síochána. It is the experience of the OIP that there is always a free cell in a prison, such as a Close Supervision Cell, where a vital witness could be accommodated until An Garda Síochána has an opportunity to examine the scene and engage with him/her.

PATRICIA GILHEANEY
INSPECTOR OF PRISONS (CHIEF INSPECTOR)
18 October 2021

SUMMARY

Mr I was forty years old when he was found unresponsive at 07:41 on 27 June 2019 in cell 12, a double cell which he shared with another prisoner, on C3 landing in Limerick prison.

Mr I was committed to Limerick prison on the 19 June 2013 and he had a release date with remission of 17 December 2020.

Mr I engaged positively within the prison and had trained with the Red Cross as a listener[1]. He was an active facilitator in the Alternative to Violence Programme (AVP)[2]. Mr I was highly regarded by both prisoners and staff.

The cell occupied by Mr I was master locked for the night at 19:11 on the 26 June 2019 and subsequently seven checks were conducted on the cell during the night which was in accordance with the IPS Monitoring of Prisoners Policy in place at the time. Assistant Chief Officer (ACO) A checked the cell at 07:38 on the morning of 27 June 2019 and failed to get a response from Mr I and immediately sought assistance.

Nurse Officer A and two other Nurses responded to an emergency call to attend C3 landing. On arrival at the cell at 07:42 Nurses reported that Mr I was non responsive to voice or touch and he was not breathing. Mr I was removed from the top bunk bed, taken from the cell and placed on the C3 landing floor. AED pads were applied and CPR cycles commenced. CPR continued with the support of the paramedics from the national Ambulance Service on their arrival at 08:01 until Dr A pronounced the death of Mr I at 08:44.

The cause of death is a matter for the Coroner.

Mr I had a history of poly substance abuse over many years but to address his addiction he had engaged with the addiction counselling services within the prison. Mr I had been assessed for the Drug Treatment Programme. At the time of his passing he was waiting for a vacancy on the Stabilisation / Drug treatment programme at Mountjoy Prison.

Chief Officer (CO) A informed the Inspectorate that he had been told by a Prisoner that Mr I was smoking heroin in the cell the night before his death.

The OIP representatives were present when the Prison Chaplains held a memorial service in the prison yard in memory of Mr I on the evening of his passing. The memorial service was attended by a large number of both prisoners and staff which portrayed the regard in which Mr I was held.

[1] Samaritans Listener Scheme is a service for people who need emotional support in a prison setting. Prisoners act as listeners. Support is offered on a one-to-one basis to ensure confidentiality. The scheme was initiated in Ireland in response to the 1999 report of the National Steering Group on Deaths in Prison

[2] AVP Ireland is a community of volunteers inside and outside prisons who run experiential workshops in conflict resolution and restorative practices. AVP is for anyone who wants to learn to build better relationships, prevent conflict and resolve it when it occurs and who is willing to share his/her skills and experience.

In relation to the queries raised by Mr I's next of kin, our findings are as follows:

Had Mr I anyone to share his problems with, was the Psychology Service available to him?
The prison Chaplaincy Service was available to Mr I. While Mr I was not engaging with the Psychology service at the time of his death, he had engaged with that service early in his sentence.

The family stated that delays in reports being provided to the Parole Board resulted in a delay in the hearing of his case. The hearing scheduled for May 2018 was rescheduled to 24 April 2019. The family stated that the report was only sent in to the Parole Board on 23 April 2019.

The Inspectorate ascertained that Mr I was eligible for a Parole Board Hearing in June 2018. As reports from a number of agencies personnel and the prison governor were outstanding, the meeting did not convene. By September 2018 the Parole Board had received the outstanding reports apart from the Governor's Report. The Parole Board at its meeting in February 2019 made a decision to proceed with Mr I's Review Hearing on 24 April 2019. The Parole Board received the Governor's Report on the day of the hearing. Mr I was offered the opportunity to read the report prior to being interviewed by the members of the Parole Board.

Recommendation 1
In order to prevent unnecessary adjournments of Parole Board hearings IPS staff should ensure that all documentation required by the Parole Board is provided well in advance of a scheduled hearing date.

Mr I wished to transfer to Shelton Abbey open prison in preparation for release and was disappointed that the transfer was not facilitated and wondered if he was kept in Limerick Prison because of his good work with other prisoners. Was he due to transfer to Shelton Abbey the Tuesday after his death?
Prison management confirmed that consideration had been given to Mr I transferring to Shelton Abbey but no date had been confirmed and no arrangements had been made for such a move.

Mr I's partner was of the opinion that he was drug free but had heard he may have died from a heroin overdose. Was there drugs found in his cell?
Reports received from the IPS confirmed there were no prohibited drugs found in Mr I's cell. However, a fellow prisoner informed a member of the prison staff that Mr I smoked heroin the night before his death. The cause of death is a matter for the Coroner.

What occurred between the time Mr I's cellmate tried to wake him and when he was pronounced dead by the Doctor. Was Mr I's cell checked during the night?
The cell was master locked for the night at 19:11 on the 26 June 2019 and subsequently seven checks were conducted on the cell during the night which was in accordance with the IPS Monitoring of Prisoners Policy. ACO A checked the cell at 07:38 on the morning of 27 June 2019, they thought the way Mr I was lying in the bed was unusual and on failing to get a response from Mr I the ACO sought immediate medical assistance. Nursing Staff attended at 07:42 and carried out CPR and were assisted by members of the National Ambulance Service at 08:01. Mr I's death was pronounced by the Doctor at 08:47.

A receipt provided to the NoK showed that Mr I's PAM account was closed at 09:15:01 on 27 June 2019, how could this have happened?
On checking with prison management the Inspectorate was advised that it is standard procedure to secure cash, personal belongings and property as soon as possible following a death.

RECOMMENDATIONS

1. **In order to prevent unnecessary adjournments of Parole Board hearings IPS staff should ensure that all documentation required by the Parole Board is provided well in advance of a scheduled hearing date. [Pg 8]**

   IPS Response: Accepted

2. **Prisoners sharing a cell where a serious incident occurred should not be relocated to a cell with another prisoner as vital evidence could be contaminated or lost. (Pg 12)**

   IPS Response: Part accepted stating:

   "*It is accepted that in most circumstances a prisoner who shared a cell where a serious incident ` occurred should not relocate to another shared cell.*

   However Prison numbers are rising and on any one occasion, there may not be a free cell readily available and while it may be possible on most occasions to relocate prisoners to a single cell, there may be occasions when this is not possible".

   Please see the Office of Inspector of Prisons response in the Preface section of this report.

3. **The Irish Prison Service should consider including Basic Life Support (BLS) training for recruit prison officers during the early part of their training and refresher courses for established staff. [Pg 14]**

   IPS Response: Did not accept stating:

   "*When the IPS developed the current syllabus for Recruit Prison Officer training in 2016, it was decided not to include first responder training in the programme. This was because of the demands this would place on the staffing system for refresher training each year. The initial training takes 3 days to deliver and a further 1 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. Considerations were also based on the principle of equivalency. The response time from the prison healthcare team to a prisoner is likely to be much less that the response time from the HSE to an ambulance call-out. First responder training is however provided to Gym Officers, PSEC Staff and Open Centre staff.*

   With all that being said it should be recognised that a nurse would usually be one of the first people on the scene in these situations. Basic Life Support and First Responder Training is a core element of the skillset of all nurses employed in the prison service".

   Please see the Office of Inspector of Prisons comments in respect of the IPS response to Recommendations 2 and 3 in the Preface section of this report.

4. **In situations where a prisoner has to be removed to the landing to allow for medical intervention privacy screen(s) should be available to protect the privacy of all involved. [Pg 14]**

   Accepted

Limerick Prison

Limerick Prison is a closed, medium security prison for adult males and females. It is the committal prison for males for counties Clare, Limerick and Tipperary and for females for all six Munster counties. It has an operational capacity of 210 males and 28 females. On 27 June 2019 it held 231 males and 36 female prisoners.

Limerick prison has a Visiting Committee whose role is to frequently visit the prison; meet with prisoners, hear their complaints and report to the Minister on matters of concern.

Mr I was the 2nd death of a Limerick prisoner in 2019 and the 9th death in IPS custody that year which met the criteria for investigation by the OIP.

CHAPTER 1: BACKGROUND

Mr I was a sentenced prisoner who was committed to Limerick Prison on the 19 June 2013 and was due for release with remission on the 17 December 2020.

Mr I had undergone training with the Irish Red Cross as a listener and was a very active facilitator in the AVP in the prison. This involved assisting in the resolution of disputes between prisoners which could have otherwise escalated to violence.

Chief Nurse Officer A reported that Mr I had been prescribed a Ventolin Inhaler for respiratory issues associated with smoking. He did not present with any mental health issues and his general health was considered to be good. He had engaged with the psychology service early in his sentence but was not engaging with the service at the time of his passing.

Prison management confirmed that consideration had been given to Mr I's transfer to Shelton Abbey Open Centre but no arrangements had been made for that transfer.

CHAPTER 2: TIME IN CUSTODY

Mr I had been in custody in Limerick prison since the 19 June 2013. He was employed as a cleaner on C3 landing. The reports received indicated that Mr I was well liked and got on well with fellow prisoners and with staff. Mr I had one breach of prison discipline (P19) in the previous six months which was for failing a mandatory drug test in December 2018.

Mr I was on the enhanced level of the Incentivised Regime[3]. He was in receipt of a gratuity of €18.90 per week. There was nothing unusual regarding Mr I's spending pattern in the prison tuck shop and he had a balance of €8.32 in his PAMS account at the time of his passing.

Mr I was actively engaged with Merchants Quay Ireland[4] addiction counselling service in Limerick prison. Mr I had expressed the wish to be drug free when released so that he could have a good family life. He had been assessed for the Drug Treatment Programme in Mountjoy Prison and was awaiting a place to become available on the programme at the time of his passing.

The last two visits Mr I received were from his partner during May 2019 and the last phone call recorded on the prison phone system was to his partner on the 26 April 2019. The family mentioned that they received a telephone call from Mr I at about 22:00 on the 26 June 2019 the night before he passed. This call could only have been made from a contraband mobile phone as his cell was master locked at that time and prison phones were not available in-cell. ACO B reported that a thorough search of Cell 12 had been conducted and nothing prohibited was found. Mr I's disciplinary record showed that he had been disciplined in 2017 for possession of a contraband mobile phone.

[3] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.

[4] Merchants Quay Ireland operates an Addiction Based Counselling Service in 13 prisons across Ireland. Prisoners can benefit from professional addiction counselling through structured assessments and evidence based counselling interventions with clearly defined treatment plans and goals.

CHAPTER 3: POST EVENT

CCTV footage showed Mr I's cell being master locked for the night at 19:11 on the 26 June 2019 and subsequently seven checks were conducted on the cell which was in accordance with the IPS Monitoring of Prisoners Policy in place at the time.

Officer A the Night Guard on C3 and C4 landing reported having one interaction with Mr I and his cell mate Prisoner A during the night between the hours of eleven and midnight. Officer A observed Mr I sitting on a chair reading a book. CCTV footage showed Officer A at Mr I's cell door at 22:51 and again at 23:56. Officer A can be seen conducting the last cell check at 05:52 and recalled that Mr I was lying in his bed asleep. Officer A did not notice anything unusual at the time.

At 07:38 ACO A checked cell 12 and on looking through the viewer noted Mr I, who was in the top bunk, had his back against the wall and his head lying to one side. ACO A stated that he " *felt something wasn't right so I knocked on the door and called Mr I's name to get his attention."* Neither Mr I nor his cellmate responded. ACO A then went to the class office to contact ACO C to come to cell 12 on C3 landing immediately with the keys to unlock the cell. ACO A then contacted the surgery and asked the Nurse to attend C3 landing with the emergency kit. ACO A returned to the door of cell 12 and knocked heavily and eventually Prisoner A, who was in the bottom bunk, bed awoke and responded. ACO A reported asking Prisoner A to rouse Mr I. Prisoner A tried to wake Mr I but got no response. ACO C arrived at 07:41 and unlocked the cell. ACO A stated that Prisoner A was removed to another occupied cell while ACO C tried to wake Mr I. ACO A stated that Nurse Officers A, and B and Agency Nurse C all arrived within a minute or two.

Recommendation 2
Prisoners sharing a cell where a serious incident occurred should not be relocated to a cell with another prisoner as vital evidence could be contaminated or lost.

The CCTV footage showed the Nurse Officers arriving at the cell at 07:41. ACO A reported contacting the Control Room (CR) by radio and requesting an ambulance. At the request of the Nurses, ACO A, ACO C and Nurse Officer B assisted in removing Mr I from the top bunk and placed him on the landing outside the cell. This provided the Nurses with adequate space to administer CPR and use the defibrillator. ACO A stated that when they removed Mr I from his bed he was warm to touch and he was limp as they lifted him. ACO A reported that the Nurses worked hard to resuscitate Mr I with the assistance of four paramedics from the National Ambulance Service following their arrival. CCTV footage showed the ambulance paramedics arrive and consult with the Nurses at 08:01.

ACO C account of events concur with ACO A's. ACO C responded immediately to ACO A's request for assistance and went to C3 with the keys and opened Cell 12. ACO C reported going to the bunk beds, calling Mr I's name and trying to rouse him but got no response. ACO C stated that the Nursing staff arrived and having assessed Mr I asked to have him removed from the top bunk to the landing which ACO C assisted in doing. ACO C also reported assisting the Nurses by holding the oxygen air bag and giving Mr I oxygen as directed by the Nurses until the paramedics arrived and took over care of Mr I. ACO C reported taking over duties from Officer B who was keeping the log book of all persons who attended at the scene and who entered the cell. ACO C reported that Doctor A arrived at about 08:25 and shortly afterwards pronounced the death of Mr I. ACO C stated that all staff then left the area and ACO C remained at the cell until the undertakers removed the remains at 09:40.

Nurse Officer A reported receiving an emergency call from ACO A to attend C3 landing at approximately 07:45. On arrival Nurse Officer A reported that Mr I was non responsive to voice or touch and on inspection noted that he had no palpable radial pulse or carotid pulse, that he was not

breathing, his pupils were fixed and dilated, his peripheries were cold but central areas were warm to the touch and rigor mortis had not set in. Nurse Officer A stated that once Mr I was laid on C3 landing floor, AED pads were applied and CPR cycles were commenced. Nurse Officer B's account concurred with Nurse Officer A stating that on arrival in the cell an assessment took place of Mr I and due to his presentation CPR was commenced.

Agency Nurse C reported being called by radio to attend an incident on C3 landing at approximately 07:45. On arrival the Nurse reported finding Mr I unresponsive, no pulse, not breathing, mottled in colour but he felt warm to the touch.

Nurse Officer A, Nurse Officer B and Agency Nurse C in their statements reported that the ambulance crew arrived at approximately 08:05 and set up the equipment necessary for continued cardiac monitoring and an automated chest compression device was utilised. At 08:25 Doctor A arrived at the landing and consulted with the Nurses and Paramedics. CPR continued until Mr I's death was pronounced by Doctor A at 08:44.

CCTV footage showed two members of An Garda Síochána (AGS) arrive at the scene at 09:02.

At 09:40 the remains of Mr I was removed for post-mortem examination.

Assistant Governor A informed the Chaplaincy of Mr I's passing and Chaplain A went directly to Mr I's parent's house to inform them of his passing. Chaplain A spoke to Mr I's father and then drove him to Mr I's mother's place of work and drove them back to their home.

Chaplain B went straight to the prison and spent time with the prisoners on the C wing. Chaplain B was asked by the prisoners if they could arrange prayers in the yard that evening. The Chaplaincy received clearance from prison management and arranged a memorial service at 18:00. There was a large attendance comprising prisoners, prison staff and representatives of the OIP.

Chaplain B was notified of the death of Mr I at 09:23. They were disappointed that they were not notified of the incident earlier in the morning as they would have attended the cell to pray and anoint Mr I.

Critical Incident Review

A critical incident meeting was held at 11:30 on the 27 June 2019. The purpose of the critical incident meeting was to establish the facts and provide an opportunity to share views in relation to how the situation was managed, identify any additional support that could have assisted or learning for future similar instances.

The meeting was attended by six staff.

Assistant Governor A chaired the meeting and thanked all the medical personnel and operational staff especially ACO A for their efforts to save Mr I's life. A plan was put in place for saving CCTV footage, taking of statements and collating of medical personal data.

Internal review into Mr I's passing

An internal review into Mr I's passing was held on 26 August 2019.

The following considerations/recommendations emerged from the internal review:

Defibrillator/CPR training for staff – It was considered that a defibrillator would be of immense benefit, particularly at night. CPR training for operational staff.

Technology – A full body scanner similar to those used in the airports would be beneficial to detect contraband concealed in the person and prevent it from entering the prison.

Screens – Portable privacy screens should be purchased to place around medical and emergency personnel responding to an incident in a communal area and to preserve the dignity of injured/deceased person(s).

Recommendation 3
T**he Irish Prison Service should consider including Basic Life Support (BLS) training for recruit prison officers during the early part of their training and refresher first aid courses for established staff.**

Recommendation 4
In situation where a prisoner has to be removed to the landing to allow for medical intervention privacy screen(s) should be available to protect the privacy of all involved.