

**A report by the Inspector of Prisons  
Judge Michael Reilly into the circumstances  
surrounding the death on 15 July 2015 in  
the Mater Hospital Dublin of Prisoner L  
who had recently been in the custody of the  
Dóchas Centre**

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**Office Ref: 2015/L**

**A report by the Inspector of Prisons Judge Michael Reilly  
into the circumstances surrounding the death on 15 July  
2015 in the Mater Hospital Dublin of Prisoner L who had  
recently been in the custody of the Dóchas Centre**

Presented to the Minister for Justice and Equality pursuant to  
Part 5 of the Prisons Act 2007

Judge Michael Reilly  
Inspector of Prisons

30 July 2015

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## **Preface**

Prisoner L was a 43 year old woman at the date of her death.

I did not meet the family of the deceased in the course of my investigation

I wish to offer my condolences to the deceased's family.

Judge Michael Reilly

Inspector of Prisons

30 July 2015

# **Inspector of Prisons Investigation Report**

## **General Information**

1. The deceased was a 43 year old South African woman.
2. The deceased was arrested at Dublin Airport on 14 February 2015, charged with serious charges and appeared before the District Court. She was remanded in custody to the Dóchas Centre. She was further remanded in custody on a number of occasions the most recent being 7 May 2015. She was due to appear in Court on 2 July 2015.
3. When remanded in custody on 14 February the deceased was assessed by the medical staff. She denied any significant medical history and expressed no particular concerns regarding her health.
4. The deceased was reviewed by the prison doctor on 15 February. No issues arose as a result of such review.
5. During April and the first week of May the deceased presented at the prison surgery and was seen by the prison medical staff. Her symptoms initially presented as mild but these escalated and became more serious. For privacy reasons I do not intend disclosing the deceased's medical condition. This does not take from the thrust of this report.
6. On 8 May 2015 the prison doctor referred the deceased to the A&E Department of the Mater Hospital. The deceased was taken to the Mater Hospital on that date and following assessment was admitted to the hospital. The deceased was under prison guard while in hospital.
7. Initially, while in hospital, the deceased was reported to be in a stable condition. She was subsequently diagnosed with a life threatening illness. This condition may have been of long standing origin. However, if the

deceased was aware of this condition she did not mention same to any of the medical professionals either in the prison or in the hospital.

8. The deceased's condition continued to deteriorate. On 31 May she was transferred to the Intensive Care Unit in the hospital as her condition was critical. She was treated intensively but unfortunately her response to treatment was sub-optimal.
9. The deceased's condition remained largely unchanged and she died in the Mater Hospital on 15 July 2015.
10. I did not meet the family of the deceased.
11. At the date of her death the deceased was not in the custody of the Irish Prison Service. As I have stated in paragraph 2 the deceased was due to appear in Court on 2 July. The sitting Judge was made aware of the deceased's serious deteriorating condition. Having heard submissions from both the prosecution and the defence the learned Judge made "No Order". The practical effect of this order was that the prison authorities did not have to maintain a presence in the hospital with the deceased.
12. In view of the fact that the deceased had been referred to hospital by the prison doctor as outlined in paragraph 6 and had not been discharged but had become progressively more ill until she died I decided that I should investigate this death to ensure that the prison authorities had complied with their obligations to the deceased while she was in custody in the Dóchas Centre.

### **Findings**

13. The deceased suffered from a latent undiagnosed illness.
14. The deceased was appropriately and professionally treated by the medical personnel in the Dóchas Centre.

15. It was a correct decision to refer the deceased to the A&E Department of the Mater Hospital on 8 May 2015.
  
16. The cause of death is a matter for the Coroner's Inquest.