Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. F
Portlaoise General Hospital
In Custody of Midland Prison
12th August 2021

Date submitted to the Minister: 19 May 2022
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GLOSSARY

OIP	Office of the Inspector of Prisons
IPS	Irish Prison Service
CO	Chief Officer
PO	Prison Officer
PGH	Portlaoise General Hospital
NoK	Next of Kin
NO	Nurse Officer
The Act	Prison Act 2007
Committed	Ordered to Prison by a Court
Remission	Release with Reduction in Sentence

INTRODUCTION

1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established by the Department of Justice under the Prisons Act 2007 (the Act). Since 2012, the Minister has instructed the Inspector of Prisons to investigate 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 carry out regular inspection of prisons.The Office is independent of the Irish Prison Service (IPS). The Inspector of Prisons and staff of the OIP are independent of the Department of Justice in the performance of statutory functions.

1.2 The OIP can 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 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;
- Assist the Coroner's investigation and the States 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; and
- Identify areas that may be pivotal in achieving or obstructing progress of the Department of Justice 2021 to 2023 Strategy Statement to create a 'Safe, Fair and Inclusive Ireland' (Goals 2 and 3).

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 to detail the events leading up to Mr. F's death and the events that followed.

4. Administration of Investigation

4.1 The OIP was notified of Mr. F's death on 12 August 2021. A standardised checklist of information requirements from the IPS to assist an investigation is used in all cases. The Prison Governor and IPS provided the OIP with all relevant information requested.

4.2 This report was provided to the Irish Prison Service on 25 April 2022 for their review and any comments.

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 Although this report is submitted to the Minister for Justice, it will also inform several interested parties and for public transparency. It is written with Mr. F's family in mind.

5.3 The Office of the Inspector of Prisons offer our sincere condolences to the family of Mr. F for their loss.

INVESTIGATION OVERVIEW

6. Summary

6.1 Mr. F was 79 years old when he passed away in Portlaoise General Hospital (PGH).

6.2 Mr. F was committed to Mountjoy Prison on 30 July 2021. He was in ill-health prior to his committal and was transferred from Mountjoy to the Midlands Prisons on 31 July 2021 for accommodation that was more suitable for his needs.

6.3 On 12 August 2021, following being transferred to hospital Mr. F passed away.

7. Recommendation(s)

7.1 There are no recommendations in this case.

8. Midland Prison

8.1 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 845 beds.

8.2 Mr. F was the second death of a prisoner in the custody of Midlands Prison in 2021 and the sixth in IPS custody which met the criteria for investigation by the OIP in that year.

FINDINGS

9. Family Concern

9.1 Mr. F's brother, as NoK, did not raise any concerns with the OIP or the IPS.

10. Background

10.1 Mr. F was 79 years old when he passed away in Portlaoise General Hospital.

10.2 Mr. F was in ill-health prior to his committal and required support for his daily routine. He had a high health care package in the community and this was communicated to the prison healthcare team prior to his committal into prison.

10.3 On 31 July 2021 Mr. F was transferred to the Midlands Prison as accommodation was more suited to his needs. He was quarantined[1] in a single cell and received 24 hour care from a healthcare team.

10.4 Mr. F was placed on the standard level of the Incentivised Regime[2] as a new committal.

10.5 On 12 August 2021 healthcare assistants realised Mr. F was feeling unwell and alerted a prison nurse. At approximately 14:00, Mr. F was examined by Nurse Officer A who then requested an ambulance for emergency discharge to hospital. At approximately 15:15, Mr. F was taken by ambulance to PGH under escort of prison officers A and B.

10.6 Hospital staff examined Mr. F and returned a very poor prognosis. The hospital contacted Mr. F's Nok. The Prison Chaplain attended PGH to visit Mr. F.

10.7 At 20:18hrs on 12 August 2021 Mr. F died.

11. Critical Incident Review

11.1 The following day 13 August 2021, a Critical Incident meeting[3] took place where Chief Officer A was assigned to examine the circumstances from an operational perspective, while the Chief Nurse Officer A was instructed to review healthcare measures provided.

11.2 All procedures appear to have been properly followed.

12. Closing

12.1 Midland Prison provided Mr. F with a 24 hour care assistance package from his arrival as he was in very poor health. In total, he served 13 days before his removal to hospital and subsequent death.

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[1] For COVID restrictions.

[2] There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level. All prisoners enter the system at standard regime level and have the opportunity to become eligible for the enhanced regime status once they have met the required criteria for the preceding two months. Incentivised regimes (irishprisons.ie).

[3] This meeting is between prison management and all prison staff who were involved in the incident of who may have relevant information. These are conducted to identify good practice, potential shortcomings and to address any welfare needs. In this case no issues of concern were raised or identified.

12.2 Prison facilities are not designed or equipped to accommodate detainees with serious health and mobility issues. Mr F was transferred to a cell in the Midlands Prison where his care was managed insofar as practicable. On all the information provided, it appears Mr. F was provided with dignity and respect by those caring for him during his short period in detention.

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.