Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. G
Midlands Prison
17 April 2022

To the Minister: 18 December 2023

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GLOSSARY

DiC	Death in Custody
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PIMS	Prisoner Information Management System

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 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 help to fulfil the obligations of the State 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'.

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 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. In this case the family was estranged and consent from the NoK to review healthcare/medical records was not received.

3.3 This report is structured to detail the events and actions of prison staff while Mr. G was in their care.

4. Administration of Investigation

4.1 On Sunday 17 April 2022, the OIP was notified that Mr. G had passed away while in the custody of the Midlands Prison. On Monday 18 April 2022, the investigation team attended the prison and discussed with prison management Mr. G's time in custody with a particular focus on his health care.

4.2 Midlands Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of required information.

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 Inspectors communicated with Mr. G's NoK by telephone on 19 August 2022. The NoK did not wish to meet the OIP. The investigation team respected the family's wishes.

5.3 Although this report is for the Minister for Justice, it will also inform several interested parties.

6. Midland Prison

6.1 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.

6.2 Mr. G was the second death of a prisoner from Midlands Prison in 2022 and the seventh death in IPS custody this year.

7. Family Concerns

7.1 The NoK confirmed that they did not wish to raise any concerns or questions.

8. Background

8.1 Mr. G was 73 years of age when he died in Midlands Prison. On Friday 7 July 2017, Mr. G was sentenced to 10 years in prison on sexual assault charges and was committed to Mountjoy Prison. He had a remission date of 4 January 2025.

8.2 Three days following committal, on 10 July 2017, Mr. G was transferred to the Midlands Prison. Mr. G was accommodated on G1 landing in cell 32 and was on the standard level of the Incentivised Regime[1].

8.3 Mr. G's Visitor and Phone log were examined by the OIP which showed that Mr. G had no contact with family or friends for the six months prior to his passing.

8.4 The Prison Service was unable to contact the NoK when Mr. G's health deteriorated and/or following his passing.

8.5 The IPS paid for the funeral expenses.

9. Healthcare

9.1 As stated at 3.2 the OIP had no access to healthcare records. However, reports from healthcare personnel and operations staff along with the examination of non-healthcare records provided the OIP with the following information in relation to the healthcare of Mr. G.

9.2 The OIP were informed that a few years prior to Mr. G's committal to prison he had undergone cardiac surgery.

9.3 In August 2019, Mr. G was transferred to the Midlands Regional Hospital Portlaoise having suffered a heart attack. The OIP were informed by healthcare personnel that Mr. G's heart function declined which adversely impacted on his kidney function resulting in hospital appointments.

[1] 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).

9.4 The OIP examined the prisoner movement history recorded on the Prisoner Information Management System (PIMS) which showed that Mr. G attended the hospital radiology department, consultant cardiologist and also attended the hospital for diabetic retina screening. In addition, the PIMS recorded that Mr. G attended the Emergency Department on a number of occasions.

9.5 In early 2022, the OIP was advised that Mr. G's health began to decline further resulting in his admission to Portlaoise General Hospital on 4 March 2022 and returning to the prison on 6 March 2022. Mr. G was again admitted on 27 March 2022, returning to Midlands Prison on 31 March 2022. The OIP was informed that Mr. G was in heart failure and the community palliative care team were contacted in relation to the management of his end of life care. Health Care Assistants were engaged by the IPS to support Mr. G with his basic hygiene needs.

9.6 Chief Nurse Officer A confirmed in her report that following a medical review of Mr. G he was moved on 14 April 2022 to cell 6 on G 1 landing which had a hospital bed and air mattress. As Mr. G's health deteriorated Healthcare personnel and Operation staff reported that Mr. G's cell was not master-locked at night; this allowed Healthcare Assistants and healthcare staff access the cell during the hours of lock back.

9.7 On 17 April 2022, Mr. G passed away in the presence of two nurses and a Healthcare Assistant.

9.8 Doctor A pronounced Mr. G deceased at 18:09.

10. Next of Kin

10.1 When Mr. G's health deteriorated Prison Chaplain A made efforts to contact his NoK, his brother, and voice messages were left but no return call was received from the NoK. Following the passing of Mr. G the Chaplain was provided with a telephone number for his sister who was then contacted. Mr. G's sister informed the Chaplain that she had no contact with her brother.

10.2 A retired Chaplain was also contacted by Chaplain A to ascertain if she had any information which would assist in contacting the recorded NoK. Chaplain B confirmed that she had, during her time in the prison, spoken to the NoK whom she always found to return her call and was helpful but advised Chaplain A that the NoK also had health issues. Mr. G had informed Chaplain B that he had paid his funeral expenses. However, she did not have any further details.

10.3 The IPS made contact with solicitors with whom Mr. G engaged during his time in custody. These Solicitors confirmed that they did not represent Mr. G regarding any funeral arrangements or probate matters.

10.4 Governor A confirmed that the IPS covered the entire cost of the funeral.

10.5 On 27 June 2022 Governor A spoke to the NoK, who informed the governor that he had significant health problems and only returned to his home having spent three months in hospital.

10.6 The NoK requested confirmation in writing of the death of his brother (Mr. G) in order to reclaim money which had been prepaid to a funeral director by Mr. G. The OIP were informed that the Midlands Chaplains engaged with NoK in relation to this matter.

11. Critical Incident Review

11.1 On Wednesday 20 April 2022, a Critical Incident Review meeting[2] took place and no recommendations emanated from that meeting.

12. Recommendations

12.1 The Office of the Inspector of Prisons has no recommendations.

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.

[2] 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.