



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. H
on
8 April 2023
while on
Temporary Release
from Cork Prison

Submitted to the Minister: 14 February 2024

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GLOSSARY

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| ACO | Assistant Chief Officer |
| AG | Assistant Governor |
| CNO | Chief Nurse Officer |
| CO | Chief Officer |
| DIC | Death in Custody |
| FTR | Full Temporary Release |
| IPS | Irish Prison Service |
| NoK | Next of Kin |
| OIP | Office of the Inspector of Prisons |
| TR | Temporary Release |
| VPU | Vulnerable Persons Unit |

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. Our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations can be disseminated in the interest of public transparency, to promote best practice in the care of prisoners.

2. Objectives

- 2.1 The objectives of 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; and
 - Assist the Coroner's investigation and contribute to meeting the State's obligations 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.

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. H's death in the Mercy University Hospital Cork on 8 April 2023.

4. Administration of Investigation

- 4.1 On 8 April 2023, Governor A notified the OIP by email that Mr. H had passed away at the Mercy Hospital Cork.
- 4.2 Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of information required.
- 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 The OIP investigation team was informed by Assistant Governor (AG) A that unsuccessful attempts were made to contact Mr. H's NoK both at the time of his admission to hospital on 21 March 2023 and on the date of his passing on 8 April 2023. Garda A of Anglesea Street Garda Station Cork made contact with Mr. H's brother following his passing. The OIP was informed that the NoK resided outside of the jurisdiction.
- 5.3 The OIP investigation team made several attempts to contact Mr. H's NoK, his brother, without success. The Inspectorate subsequently learnt that the NoK with whom the IPS engaged had himself died. The OIP were unable to contact any other family members.
- 5.4 Although this report is for the Minister for Justice, it may also inform several interested parties.

INVESTIGATION

6. Cork Prison

- 6.1 Cork Prison is closed, medium security prison for adult males. It is the committal prison for counties Cork, Kerry and Waterford. It has an operational capacity of 296 beds.
- 6.2 Mr. H was the first death of a prisoner from Cork Prison in 2023; and the eighth death in IPS custody that year.

7. Background

- 7.1 Mr. H was aged 52 years when he passed away on 8 April 2023 in the Mercy University Hospital Cork. Mr. H was on Full Temporary Release (FTR) from Cork prison at the time of his passing.
- 7.2 Mr. H was committed to Cork Prison on 20 February 2023. Mr. H had an eight month sentence with a remission date of 19 August 2023.
- 7.3 Mr. H was on the standard level of the Incentivised Regime¹. Prior to his admission to hospital on 21 March 2023. Mr. H was accommodated in cell 9, a single cell, on the Vulnerable Persons Unit (VPU), B1 landing.
- 7.4 On 28 March 2023 Mr. H was discussed at the Cork Prison Multi-Disciplinary meeting² which was attended by Governor A, Chief Nurse Officer (CNO) A, Prison Doctor A, Prison Chaplain A, Chief Officer A, Integrated Sentence Management (ISM) Officer A, Resettlement staff and other prison based support services. Those present were advised that Mr. H had been admitted to hospital and was terminally ill.
- 7.5 On 5 April 2023, Governor A made an application to IPS HQ recommending that Mr. H be approved Temporary Release. Assistant Principal Officer A Operations Directorate approved Mr. H's Full Temporary Release (FTR) on 5 April 2023. Mr. H's TR was subject to the following conditions:
- be of good behaviour;
 - do not convey messages in in/out of a prison;
 - keep the peace;
 - shall be of sober habits;
 - shall not enter pub, club or other licensed premises or off-licence premises;
 - shall reside at the Mercy Hospital; Cork;
 - agree not change address from the Mercy Hospital without a new TR form.

¹ 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.

² A meeting where all relevant services within the prison meet and discuss individual cases.

- 7.6 On 6 April 2023 AG A and Acting Chief Officer A visited Mr. H in the Mercy University Hospital and informed him that he was granted FTR. Acting Chief Officer A noted that Mr. H appeared tired but understood that he had been granted FTR.
- 7.7 Examination of relevant records showed that Mr. H did not have any visits or phone calls while in the custody of Cork Prison.

8. Medical Care

- 8.1 The Office of the Attorney General has informed the IPS and OIP that the provisions of the Prisons Act 2007 cannot be relied upon to access healthcare/medical records of deceased prisoners in relation to investigations of deaths in custody. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from next-of-kin. This leads in some instances to a failure to review healthcare/medical records such as in circumstances where the next-of-kin cannot be located. Mr. H's next-of-kin, his brother, resided outside of Ireland and a few months following the death of Mr. H's his brother also died. Consequently, consent for the Inspectorate to access Mr. H's healthcare/medical records for the purposes of this investigation was not obtained and the investigation was undertaken without access to pertinent medical/healthcare records.
- 8.2 Healthcare personnel informed the OIP that Mr. H was known to them and two weeks after Mr. H's committal his health began to deteriorate and he was referred to the Emergency Department at the Mercy University Hospital. The operational records showed that Mr. H attended Mercy University Hospital on 15 March 2023 and was discharged on the same date back to the custody of Cork Prison.
- 8.3 Assistant Governor A reported that Doctor B, took a blood sample from Mr. H on 20 March 2023. On receipt of the results on 21 March 2023, Mr. H was admitted to hospital. Mr H remained in the Mercy University Hospital until the date of his passing on 8 April 2023.
- 8.4 On 7 April 2023 AG A reported that along with the Prison Chaplain A they visited Mr. H in hospital. AG A recorded that that he was informed by the hospital nursing staff that Mr. H 'was *starting on a syringe driven morphine pump*'. AG A asked the hospital staff to contact him in the event of Mr H's condition deteriorating, so that a member of the prison staff could be with him in his final moments.
- 8.5 On 8 April 2024 Assistant Governor A was contacted by the Mercy University Hospital and informed that Mr. H's condition deteriorated very rapidly and that he had passed away very quickly.
- 8.6 Assistant Governor A's intention to arrange a member of staff to be with Mr. H during his final hours is to be commended given that Mr. H was on FTR and not officially in the custody of the prison at the time. Sadly Mr. H's condition rapidly deteriorated and he passed before arrangements could be made for a staff member to attend the hospital. Following the notification of the death of Mr. H Chaplain A attended the hospital.

9. Recommendations

There are no recommendations arising from this report.

10. Support Organisations

- 10.1 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