Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. P
Naas General Hospital
while in the custody
of the Midlands Prison
9 October 2022

Submitted to Minister: 23 October 2024

CONTENTS

GLOSSARY

CNO	Chief Nurse Officer
CO	Chief Officer
DiC	Death In Custody
HCA	Health Care Assistant
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prison Healthcare 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. 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 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 of 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 paying particular focus to the care that was afforded to Mr. P during his time in prison.

4. Administration of Investigation

4.1 On 9 October 2022, the OIP was notified that Mr. P had passed away in Naas General Hospital, where he had been an inpatient since 8 October 2022. On 10 October 2022, the investigation team attended the prison where they were provided with information in relation to Mr. P's time in custody.

4.2 Prison Management provided the investigation team with all relevant documentation 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 Inspectorate of Prisons' role when investigating a death in custody.

5.2 On 17 October 2022 and on 5 October 2023, a member of the investigation team spoke with Mr. P's NoK, his brother, by telephone. He was complimentary of how the IPS had cared for his brother while in custody. However, he did make one comment, which is outlined in **section 7**.

5.3 Although this report is for the Minister for Justice, it may also inform several interested parties. It is written primarily with Mr. P's NoK in mind.

5.4 The OIP is grateful to Mr. P's brother for his contributions to this investigation and we offer our sincere condolences to the family on their loss.

6. Midlands 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, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. At the time of Mr. P's passing, it had an operational capacity of 845.

6.2 Mr. P was the eighth death of a prisoner from the Midlands Prison in 2022 and the sixteenth death in IPS custody which met the criteria for investigation by the OIP.

7. Family Concerns

7.1 Mr. P's brother considered that the prison should have notified the family when Mr. P was hospitalised. The NoK told the investigation team that Mr. P's family was upset that they had not been informed that he had been transferred to hospital.

7.2 Mr. P was removed to Naas General Hospital at 16:00 on 8 October 2022. Prison management informed the investigation team that "*arrangements were being made early the following morning to inform his family*" through the Chaplain's Office.

7.3 In the course of the investigation, the OIP reviewed the Irish Prison Service Protocol *'Chaplaincy and Next of Kin Notificatio*n'. Section 2.3 of the protocol is entitled '*Grave Illness'* and states that *". . . it is imperative that the family (next of kin) be contacted in the quickest way possible, by the Chaplain or by a nominated Officer so that the family have an opportunity to be with their loved one and liaise directly with hospital staff."* The NoK was not notified of Mr. P's removal to hospital at the earliest opportunity. The timeline for the notification of Mr. P's removal to hospital and notification to the NoK is dealt with in **Section 9.**

8. Background

8.1 Mr. P was 79 years old when he passed away while in the custody of the Midlands Prison.

8.2 On 19 June 2019, Mr. P was committed to Mountjoy Men's Prison to serve a six year sentence, with four years suspended, and on the same day he was transferred to the Midlands Prison. The sentence was appealed by the Director of Public Prosecutions and, on 3 February 2020, the original sentence was quashed and Mr. P received a five year sentence which was backdated to 19 June 2019. Mr. P had a remission date of 18 March 2023.

8.3 The investigation team was informed by prison management that, prior to Mr. P entering custody, he had been a resident at a Community Hospital for Older People. Mr. P was suffering from a life-limiting progressive illness and had significant healthcare needs.

8.4 Midlands Prison Chief Nurse Officer (CNO A) stated that an advance care plan was put in place for Mr. P prior to his committal to the Midlands Prison. This was arranged by Midlands Prison nursing staff liaising with the Community Hospital prior to Mr. P's arrival. As part of his prison

care plan, Mr. P had a high-backed orthopedic chair placed in his cell upon committal. Mr. P was supported by HCAs (Health Care Assistants) with his daily personal and hygiene needs. During the investigation, all relevant HCA records were examined and showed that Mr. P did receive HCA daily care and support.

8.5 Due to Mr. P's healthcare needs, his cell was not master locked[1] at night thereby facilitating ease of access by HCAs if required.

8.6 Mr. P's visitor and phone logs for the four months prior to his passing were examined by the investigation team and showed that Mr. P had maintained contact with his brother.

9. Events of 8 and 9 October 2022

9.1 Between 08:25 and 08:35 on 8 October 2022, HCA A assisted Mr. P in getting out of bed and with breakfast. HCA A checked on Mr. P between 09:40 and 09:50 and reported that Mr. P was sitting in his chair, watching television and in good form. Between 12:00 and 12:20, HCA A assisted Mr. P with lunch. After lunch, HCA A then assisted Mr. P getting him into bed (which was reported to be his routine) and the cell was locked. When the cell was unlocked at 14:15, HCA A stated that Mr. P was assisted from the bed to his chair and he "*appeared fine*".

9.2 At approximately 15:15, HCA B was passing Mr P's cell and found him slumped over the arm of his chair and unresponsive. HCA B called HCA C who immediately attended Mr P's cell.

9.3 Officer A was Class Officer in charge of G1 landing on 8 October 2022. Officer A reported that, at approximately 15:15, Mr. P "*took ill"* while being attended to by a HCA. Officer A contacted Nurse Officer (NO) A who attended the cell along with NO B. On the instruction of the nurses, an ambulance was requested.

9.4 NO A reported that Mr. P was unresponsive and that his face was slumped to one side. Assessing that it was a possible stroke, Mr P's care was handed over to the ambulance team on their arrival at approximately 15:45. HCA A assisted the nurses and ambulance paramedics until Mr. P was removed to Naas General Hospital at 16:00, escorted by two prison officers, Officer B and Officer C.

9.5 Officer B reported that hospital staff attended to Mr. P continuously in the Accident and Emergency Department until midnight at which time he was moved to the Intensive Care Unit.

9.6 On 9 October 2022, Officer D and Officer E were assigned escort duty at Naas General Hospital relieving Officers B and C. Officer D reported that, on taking up duty at 07:15, he was informed by a nurse that they hadn't expected Mr. P to make it through the previous night. Officer D reported that, at 08:25, the doctor informed the escort staff that Mr. P had passed away. Officer D reported that he contacted the prison immediately.

9.7 At 08:15, Chaplain A reported that, on arrival to work at 08:15 on 9 October 2022, he went to see Chief Officer A who informed him that Mr. P had been removed to Naas General Hospital the previous day. Chaplain A rang Mr. P's NoK at 08:30 to inform him of the situation and provided him with the number of the hospital.

[1] All cells are double locked (master locked) at night. An officer in charge of a landing cannot unlock a cell at night as the master key is required. The officer in charge of the prison is the only person who holds the master key and who can unlock a master-locked cell at night.

9.8 Chaplain B was notified at approximately 09:00 that Mr. P had passed away and then contacted the NoK to relay the news.

10. Health and Medical care

10.1 Prior to Mr. P's committal into custody, prison nursing staff consulted with the Community Hospital for Older People where he was living to determine his healthcare needs and establish what healthcare assistance Mr. P required. Prison nursing staff were advised that Mr. P was a wheelchair user and he had complex healthcare needs. Consequently, prison healthcare personnel, in consultation with prison management, introduced measures to accommodate Mr. P. This included adapting a cell suitable for habitation by a person with disabilities. A hospital bed, mattress and orthopaedic chair were in place on Mr. P's arrival.

10.2 As stated at **8.4**, due to mobility issues, Mr. P was cared for by HCAs and was provided with support in terms of his daily personal and hygiene needs, including dietary and mobility requirements. While accommodated on G1 landing, Mr. P received round the clock healthcare. The investigation team was also informed that the HCAs had encouraged Mr. P to maintain some level of mobility by encouraging and supporting him to walk the landing using his walking aid.

10.3 On Mr P's medical Committal Assessment Record, the Doctor noted that Mr. P had a bed sore in the buttock area. A pressure relieving cushion for Mr. P was in use on his orthopaedic chair and on, 2 July 2022, NO C recorded on the PHMS (Prisoner Healthcare Medical System) "*Please connect pump to air cushion*".

10.4 It was recorded in the PHMS on 27 July 2022 by NO D that a second pressure sore was evident on the other buttock area and that his pressure-relieving air cushion may not be working. NO D recommended that Mr. P stay in bed for the day as a result.

10.5 On 8 August 2022, it was recorded by NO A that the air cushion was not working and that HCA A was to contact the supplier to order a new air cushion.

10.6 On 9 August 2022, NO A recorded that the new air cushion had been ordered and the CNO A confirmed to the investigation team that this was delivered on 9 August 2022.

10.7 On 4 October 2022, NO E recorded in the PHMS that there was a strong smell from Mr. P's cell, "*inmate has a strong smell from his cell?? UTI*." The HCA tested Mr P's urine, which was "*positive for leuocytes and nitrates*". It is recorded in the PHMS by NO E that they; "*Informed Dr. [A] of same, states she will px OABX*".

10.8 The investigation team reviewed Mr. P's medications chart, which had no record of an antibiotic being administered to Mr. P from 4 October 2022 to the time of his transfer to hospital on 8 October 2022.

10.9 The HCA notes of 5, 6 and 7 October 2022 recorded Mr. P "*was in good form".*

10.10 It also found that Doctor A had retrospectively entered the following note on Mr P's record on 10 October 2022 *"Note in retrospect for "04 10 2022"*, *Reviewed in his own cell HCA advised for MSU[2] for C&S[3]"*.

10.11 Given that Doctor A's retrospective note made no reference to the prescription of an antibiotic, the investigation team made further enquiries and CNO A advised that Doctor A had stated that "*they were not clinically indicated as per guidelines for the management of UTI's in the elderly*".

10.12 Doctor A advised that they "*initially considered to start Mr. P on antibiotics for query UTI" following* the review which Dr. A completed on 4 October 2022 (and noted retrospectively after Mr P's death). However, they informed the Investigation team that, subsequently, they made a decision not to prescribe the antibiotic for the following reasons:

- "*Urine dipstick for older adults > 65 year of age who are frail and who are suspected of having an asymptomatic urinary bacteraemia is not reliable;*
- *The patient was double incontinent; and*
- *Urine harvested from the pad is contaminated with the mixed growth bacteria from the pad and can give false positive results".*

10.13 Doctor A also stated that "*urine samples known as mid-stream urine for culture and sensitivity should be sent to the laboratory*" for these patients. There was no evidence in the PHMS that the urine samples were sent for analysis. Dr. A confirmed that the "MSU or C&S had not been sent to the laboratory prior to Mr. P's passing.

11. Critical Incident Review Meeting

11.1 Governor A convened a Critical Incident Review Meeting[4] at 10:00 on 10 October 2022. Attendees included operational staff, healthcare personnel and Chaplain B. The meeting focused on Mr. P's time in custody, including medical/healthcare provided and the events related to 8 October 2022.

11.2 CO B confirmed at the meeting that no doctor was on-site in the prison over the weekend of 8 and 9 October 2022.

11.3 Chaplain B informed the meeting that, on arrival to work on 9 October 2022 he contacted the escort officers at the hospital for an update and then rang Mr. P's NoK and advised him of his brother's passing.

11.4 It was recorded that Chaplain B would remain in contact with the NoK to provide assistance or support.

[2] Mid-stream specimen of urine.
[3] Culture and sensitivity.
[4] 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. Recommendations

12.1 The Office of the Inspector of Prisons has made four recommendations:

1. The IPS should comply fully with its own protocol in relation to the notification of family (NoK) in cases of grave illness; by ensuring that family (NoK) is notified at the earliest opportunity when their relative becomes seriously ill and is hospitalised. A similar recommendation previously made in the case of Mr. I 2018 was accepted by the IPS.

2. Where medical aids/equipment essential for the prevention of pressure sores are not working correctly or require replacement, these concerns should be communicated to the Chief Nurse Officer for immediate action. A second pressure sore might have been prevented had a pressure cushion been replaced in a timely way when concerns were first highlighted. It is of concern that Mr. P was left for 13 days without a functioning pressure cushion after a second pressure sore was identified.

3. Where it is recorded in PHMS that an antibiotic is to be prescribed for a Urinary Tract Infection or any other infection an updated entry should be made if the doctor subsequently decides that an antibiotic is contraindicated.

4. All urine and other samples taken should be sent to the laboratory for analysis on the date the sample is taken, thereby ensuring that treatment, if required, will commence at the earliest opportunity.

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.