Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. R 2024
Midland Regional Hospital, Portlaoise,
while in the custody of
Midlands Prison
21 August 2024
Aged 80

To the Minister: 12 December 2025

CONTENTS

GLOSSARY

A&E	Accident & Emergency
CNO	Chief Nurse Officer
CCTV	Closed-Circuit Television
IPS	Irish Prison Service
ISM	Integrated Sentence Management
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner 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, Home Affairs and Migration 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, Home Affairs and Migration, 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 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. R's death in hospital while in the custody of the Midlands Prison on 21 August 2024 and management of the events associated with his death.

4. Administration of Investigation

4.1 On 21 August 2024, the OIP was notified that Mr. R had passed away in the Midland Regional Hospital, Portlaoise.

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 Inspectorate of Prisons' role when investigating a death in custody.

5.2 The investigation team communicated in writing with Mr. R's NoK, his wife, on 12 November 2024. The letter outlined the role of the Inspectorate in relation to death in custody investigations and enquired if the NoK wished to raise any concerns or seek any clarification regarding the investigation into the death of her late husband. Enclosed with the letter was a 'Consent for Release of Clinical Records Form', along with an explanation that it was required to allow the investigation team to access the late Mr. R's prison clinical records. The NoK was also offered an opportunity to meet with the investigation team if they so wished. The NoK returned the signed consent form but did not raise concerns or queries, nor did they express any wish to meet with the investigation team.

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

5.4 The OIP is grateful to Mr. R's NoK for her consent to allow the investigation team to access her late husband's prison clinical records and we offer our sincere condolences on her loss.

6. Midlands Prison

6.1 Midlands Prison is a closed, medium security prison for adults. It is the committal prison for the counties of Carlow, Kildare, Kilkenny, Laois, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. On 21 August 2024, the date of Mr. R's death, the prison had an operational capacity of 875 beds and was accommodating 966 prisoners. This represents 110% of the total bed capacity.

6.2 At the time of his death, Mr. R's was the sixth death of a prisoner from the Midlands Prison in 2024; and the eighteenth death in IPS custody that year.

7. Background

7.1 On 22 June 2020, Mr. R was convicted at the Central Criminal Court, on a number of charges, and was committed to Cloverhill Prison. On 15 March 2021, he received four concurrent sentences, equating to an 11 year term of imprisonment. On 8 July 2020, Mr. R was transferred to the Midlands Prison. His earliest release date, on remission, would have been 19 September 2028.

7.2 Prior to his transfer to hospital on 12 July 2024, Mr. R was accommodated in cell 16 on the E1 landing of the Midlands Prison.

7.3 Medical documentation reviewed by the investigation team indicated a marked deterioration in Mr. R's health in the months prior to his death. Mr. R had experienced recurring hospital admissions since 2021 and had been attending a heart clinic for cardiology treatment since 2023. Mr. R also suffered from diabetes and hypertension. Mr. R had been hospitalised seven times during 2024 due to his *"multi complex medical issues".*[1] Despite ongoing medical intervention, his condition did not improve.

7.4 Mr. R was 80 years of age when he passed.

8. Prison Healthcare and Hospitalisation

8.1 The records relating to Mr. R's prison health and medical care showed that between May 2024 and his passing on 21 August 2024, he received daily medical attention from the IPS healthcare team at the Midlands Prison.

8.2 Records from Mr. R's Nurse Committal interview, dated 22 June 2020, noted that he had cardiac issues and diabetes. His medical records also noted hypertension.

8.3 In the period leading up to his final hospitalisation in July 2024, Mr. R had three referrals to hospital: 29 May 2024, 2 July 2024, and 12 July 2024. On 12 July 2024, following receipt of abnormal blood results, Doctor A referred Mr. R to the Accident & Emergency (A&E) Department

[1] Quoted from Chief Nursing Officer Report (undated) included in IPS material received by the OIP investigation team.

of the Midland Regional Hospital, Portlaoise. The following day, 13 July 2024, Mr. R was admitted to hospital where he remained, under prison officer escort, until his death on 21 August 2024. The prison records show that the healthcare team at the Midlands Prison was in regular contact with hospital personnel seeking updates on Mr. R's health and wellbeing during this period.

8.4 On 17 July 2024, Nurse A recorded on the Prisoner Healthcare Management System (PHMS) that she had telephoned the hospital for an update on Mr. R's condition and was informed that he was *"recovering slowly and no plans for discharge yet".* The records show that Mr. R's condition remained generally stable (but serious) until the afternoon of 3 August 2024. A clinical assessment, performed on 3 August 2024, determined that Mr. R's health had deteriorated and he was moved to the critical care suite in the hospital. Hospital staff advised the prison escorts that Mr. R's NoK needed to be contacted and this was actioned by the prison chaplain.

8.5 Mr. R's condition began to improve slightly from 3 August 2024. By 9 August 2024, it was recorded on the PHMS that the hospital staff informed Nurse A that Mr. R was getting out of bed with the help of a physiotherapist, he was eating and drinking, and they were hoping "*to discharge him back to the prison as soon as he is well enough*."

8.6 On 13 August 2024, Chief Nurse Officer (CNO) A and Nurse B attended the hospital, "*to access [Mr. R] and his requirements if returning to our care".* It was noted by the nurses that Mr. R was unable to stand or move unassisted and had swelling to his ankles, legs and stomach. He was also in a state of confusion and had difficulty speaking. It was recorded on the PHMS that Mr. R would require *"full nursing care",* an air mattress, a hospital bed, as well as a continuous supply of oxygen therapy if he returned to prison. It was also noted that Mr. R had been recorded by the hospital as having a "*Do Not Resuscitate*" (DNR) status.

8.7 Mr. R's condition remained stable but serious until he again deteriorated on 17 and 18 August 2024 (as noted on the PHMS by Nurse C. A hospital doctor apprised Mr. R's NoK of his declining health.

8.8 Mr. R was pronounced dead at 07:00 on 21 August 2024 at the Midland Regional Hospital, Portlaoise. The medical staff at the hospital had been alerted at 06:15 that morning, by prison escort staff, about Mr. R's *"declining health".* At 06:30, the hospital personnel contacted Assistant Governor A to advise him of Mr. R's state of health. Chaplain A informed Mr. R's NoK that he had died.

8.9 CNO A, in a report to the Governor following Mr. R's death, stated that Mr. R was given daily assistance by healthcare assistants as well as being seen four times per day by a nurse prior to his hospitalisation. She also stated that Mr. R had been seen, as required, by Doctor A or the doctor on call and that Mr. R *"continued to attend medical appointments as required up to his last hospitalisation".* CNO A stated that Mr. R was in the *"end stage of Congestive Cardiac Failure, Chronic Kidney Disease and [was] an insulin dependent diabetic".* The prison healthcare records support this account.

9. Critical Incident Review Meeting

9.1 On 22 August 2024, a critical incident review meeting[2] (CIRM) was chaired by Governor B. In attendance were: Governor A, Chief A, IPS HQ representative A, Integrated Sentence Management (ISM) Officer A, Chaplain A and Chaplain B, Doctor A, CNO A, Psychologist A and Minute Taker A.

9.2 An overview of Mr. R's time in the custody of the Midlands Prison was provided, which included his declining health prior to hospitalisation and the ongoing contact with hospital staff during his time as an in-patient. It was noted that the standard hospital in-patient journal was maintained and recorded relevant events of Mr. R's stay at the hospital.

9.3 The meeting was informed that Chaplain A made contact with Mr. R's NoK to offer condolences and support.

9.4 ISM Officer A informed the meeting that he had little contact with Mr. R, noting the last such meeting was in March 2024. It was also noted that the psychology service had no recent engagement with Mr. R.

9.5 No recommendations were recorded at the conclusion of the critical incident review meeting.

10. Recommendations

10.1 The OIP makes no recommendation in this report.

11. Support Organisations

11.1 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] Staff meeting held following the death of a prisoner. The purpose of the meeting is to review the circumstances and activities surrounding an incident, identify learnings, commend good practice and recommend changes, if required, to prevent a similar occurrence.