Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Ms. A 2025
Mater Misericordiae University Hospital
while in the custody of
Mountjoy Female Prison
(Dóchas Centre)
1 January 2025
Aged 69

To the Minister: 12 December 2025

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GLOSSARY

HCA	Health Care Assistant
ICU	Intensive Care Unit
IPS	Irish Prison Service
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 is comprised 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 to detail the events leading up to Ms. A's death on 1 January 2025 and the management of the events associated with her death.

4. Administration of Investigation

4.1 On 1 January 2025, the OIP was notified that Ms. A had died that afternoon in the Mater Hospital, Dublin while in the custody of the Mountjoy Female Prison (Dóchas Centre). The investigation team attended the prison on 2 January 2025 and met prison management who provided an overview of Ms. A's time in prison. The investigation team also met with persons who had contact with Ms. A during her time in custody.

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 with Ms. A's NoK, her sister and brother, in writing and by telephone in early 2025. Ms. A's sister did not wish to meet the investigation team in person. The NoK (Ms. A's brother) did provide written consent permitting the investigation team to access Ms. A's prison clinical records. The NoK felt they were well informed on Ms. A's health and time in custody due to the almost daily updates Ms. A had provided.

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 Ms. A's NoK in mind.

5.4 The OIP is grateful to Ms. A's sister and her brother for their contributions to this investigation and we offer our sincere condolences on their loss.

6. Mountjoy Female Prison (Dóchas Centre)

6.1 Mountjoy Female Prison (known as the Dóchas Centre) is a closed, medium security prison for women aged 18 years and over. It is the committal prison for women placed on remand or sentenced from all courts, with the exception of those in the Munster area. It has an operational capacity of 146 beds. On 1 January 2025 (Ms. A's date of death), it accommodated 167 prisoners (representing 114% of its capacity).

6.2 At the time of her death, Ms. A's was the first death of a prisoner from the Dóchas Centre in 2025; and the first death in IPS custody that year.

7. Family Concerns

7.1 Ms. A's NoK did not raise any concerns but did seek reassurance that Ms. A received appropriate medical treatment while in prison custody. In particular, they requested confirmation of the reason for her hospitalisation and if she was being considered for dialysis.

8. Background

8.1 Ms. A was a 69 year-old woman committed to the Dóchas Centre on 26 June 2023. She was serving a sentence of two years and six months. Ms. A's remission date was 10 May 2025. Due to the nature of her offences, Ms. A was classified as a protection prisoner and placed on 'Rule 63'[1] of the Prison Rules 2007 – 2020. She was accommodated in Phoenix House with other women on protection and shared a room with Prisoner 1 since 21 November 2024.

8.2 The OIP was informed that Ms. A had a number of medical conditions on her committal to prison and had regular hospital appointments since October 2023 for these ongoing ailments.

8.3 While Ms. A did not receive any in-person visits during her time in the Dóchas Centre, she did avail of regular phone contact with family members. It was reported by other prisoners that Ms. A was on good terms with the other women accommodated in Phoenix House, especially Prisoner 1 and Prisoner 2.

[1] Rule **63.** (1) of the Prison Rules, 2007 states*: "A prisoner may, either at his or her own request or when the Governor considers it necessary, in so far as is practicable and subject to the maintenance of good order and safe and secure custody, be kept separate from other prisoners who are reasonably likely to cause significant harm to him or her."* (S.I. No. 252/2007 - Prison Rules, 2007)

9. Prisoners' Accounts

9.1 A member of the investigation team met with Prisoner 1, Ms. A's roommate, and Prisoner 2, her former roommate. Prisoner 1 stated that she had shared a cell with Ms. A for approximately one month prior to Ms. A's transfer to hospital. Prisoner 1 described Ms. A as being in extremely poor health, but said that prisoners and staff, including Health Care Assistants (HCAs), had looked after her.

9.2 Prisoner 2 shared a room with Ms. A in Phoenix House for 18 months. She reported a close relationship with Ms. A and provided information about her as a person as well as her health and associated difficulties.

9.3 According to Prisoner 2, mobility issues arising from Ms. A's poor health meant that she could only walk short distances with the aid of a walking frame; she also used a wheelchair. Describing her legs as "*destroyed*", Prisoner 2 stated that she would regularly help apply cream and/or dressings to Ms. A's legs. Prisoner 2 told the investigation team that she realised, with hindsight, that Ms. A's health was deteriorating gradually. In this regard, Prisoner 2 recalled Ms. A making a telephone call to her sister on Christmas Eve 2024 and she reportedly told her "*I'm going downhill*" and expressed gratitude to her siblings for all they had done for her. According to Prisoner 2, the prison staff and healthcare team were excellent to Ms. A. Prisoner 2 stated that she witnessed this high quality of care every day during the 18 months they shared a room together. Concluding her statement, Prisoner 2 described the Governor of the Dóchas Centre as *"excellent"* while also praising the staff of Phoenix House.

10. Events of 24 December 2024 to 1 January 2025

10.1 The investigation team was informed that Ms. A was transferred to the Mater Hospital Emergency Department on 24 December 2024 due to abnormal blood test results. Ms. A was admitted to the Mater Hospital, as an in-patient, and required immediate surgery. Following surgery, Ms. A was admitted to the Intensive Care Unit (ICU) of the hospital on the same date (24 December 2024).

10.2 Governor A visited Ms. A in the ICU on 25 December 2024, noting Ms. A was under sedation and undergoing dialysis at that time. Ms. A remained in the ICU until 31 December 2024 when she was transferred to the Sacred Heart (cardiology) Ward. The investigation team was informed that Ms. A was due to be fitted with a pacemaker on 7 January 2025.

10.3 The IPS escort officers' last recorded event relating to Ms. A, prior to the day she passed away, was that she made a phone call to her sister on 31 December 2024.

10.4 Chaplain A made a number of visits to Ms. A while she was in hospital.

10.5 At 13:55 on 1 January 2025, Officer A and Officer B were the IPS escort officers with Ms. A in the hospital. Ms. A became unresponsive and Officer A alerted the hospital medical staff who, he reported, responded immediately and attempted to resuscitate Ms. A. Officer A also alerted Chief A, by radio, that Ms. A had gone into cardiac arrest. Chief A telephoned Governor A at 14:10, to inform her of the situation. At the time of the call, medical staff were still in the process of attempting to resuscitate Ms. A.

10.6 At 14:50, Chief A made another call to Governor A to report that Ms. A's death had been pronounced at 14:40 by the medical staff at the Mater Misericordiae University Hospital and that her NoK had been informed by the hospital nursing staff. Governor A attended the hospital and met Ms. A's brother. Governor A also spoke with Officer A and Officer B and offered the relevant IPS staff support services to the officers.

11. Healthcare Records

11.1 The investigation team requested, and received, Ms. A's clinical records from the Dóchas Centre. These records show that Ms. A was referred for, and attended, numerous outpatient clinical appointments spanning the period October 2023 to October 2024. The appointments ranged from Nephrology (kidney-related disorders) and Renal (kidney-related) to Neurosurgery, Dietary and Gastrointestinal consultations, as well as two visits to Accident & Emergency.

11.2 Ms. A attended a Nursing Committal Interview on 26 June 2023 at the Dóchas Centre, conducted by Nurse A. The interview recorded that Ms. A was suffering from a number of pre-existing medical conditions; the most serious of these was noted as "*end-stage renal failure*". In addition, Ms. A had the following ailments or conditions: hypercholesterolemia, diabetes, and osteoporosis (with a history of fractures and extensive spinal surgery). She also suffered from leg ulcers and required a wheelchair. Clearly, upon arrival to prison, Ms. A was in poor health generally, in addition to the aforementioned grave prognosis of end-stage renal failure. In late June 2024, Ms. A was found to be COVID-19 positive while in hospital for hypoglycaemia treatment.

11.3 The medical records examined by the investigation team were detailed and comprehensive. They indicate a high level of care for Ms. A during her time at the Dóchas Centre. For example, in July 2024, the prison healthcare team sent information to the Dóchas Centre kitchen staff to assist them in providing an individualised diet for Ms. A due to her high potassium levels.

11.4 On 1 October 2024, Doctor A recorded on the Prisoner Healthcare Management System (PHMS) that blood tests revealed Ms. A's renal function had deteriorated significantly and a plan was to be put in place to start dialysis in the following weeks.

11.5 On 23 December 2024, Doctor A took a blood sample from Ms. A and ordered tests *"due to a slight deterioration in her presentation."* The results of the blood tests were received on 24 December 2024 and they *"informed her referral to the Mater [Hospital] A&E on the same date"*. It was further reported that while a patient at the hospital, Ms. A underwent a hernia operation.

11.6 Governor A reported that *"based on a local healthcare assessment on the 23 December [2024] and follow-up on the 24 December, [Ms. A] was not considered to be gravely ill and her transfer to hospital did not warrant contacting her next of kin."* The Governor further asserted that Ms. A's condition did not warrant ambulance transfer from the Dóchas Centre to the Mater Misericordiae University Hospital Emergency Department (which is situated directly across from the prison). Ms. A was conveyed to hospital in a prison vehicle.

12. Critical Incident Review Meeting

12.1 On 2 January 2025, a critical incident review meeting[2] was chaired by Governor A and Assistant Governor A. In attendance were; Chief A, Chief B, Chief C, Work Trades Officer A, Integrated Sentence Management Officer A, Work Training Officer B, Staff Support Officer A, Doctor A and Chaplain A. The Minutes were taken by Prison Clerical Officer A.

12.2 The meeting outlined Ms. A's background, sentence details and summarised the events surrounding Ms. A's transfer to hospital and the circumstances of her death. The meeting also detailed Ms. A's medical history and treatment while in the custody of the Dóchas Centre and concluded by noting that IPS support services had been made available to relevant staff.

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

13. Recommendations

13.1 The OIP commends the attentive medical care provided to Ms. A during her time in custody. It makes no recommendations.

14. Support Organisations

14.1 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.