Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. N 2024
at Tallaght Hospital while
in the Custody of
Cloverhill Prison
6 May 2024
Aged 79

To the Minister: 19 December 2025

CONTENTS

GLOSSARY

CCTV	Closed Circuit Television
CIRM	Critical Incident Review Meeting
CPR	Cardiopulmonary Resuscitation
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 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 paying particular focus to the care that was afforded to Mr. N during his brief time in prison and management of the events associated with his death on 6 May 2024 at Tallaght Hospital.

4. Administration of Investigation

4.1 On 6 May 2024, the OIP was notified that Mr. N had passed away at Tallaght Hospital, Dublin, while in the custody of Cloverhill Prison. The investigation team attended the prison on 7 May 2024 and met prison management who provided an overview of Mr. N's time in prison. They met with fellow prisoners who had contact with Mr. N to determine the chain of events that led to his death.

4.2 Prison Management provided the investigation team 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 A member of the investigation team met with Mr. N's NoK on 21 May 2024 and obtained consent for the OIP to access Mr. N's medical records.

5.3 Although this report is for the Minister for Justice, Home Affairs and Migration, it may also inform several interested parties.

INVESTIGATION

6. Cloverhill Prison

6.1 Cloverhill Prison is a closed, medium security prison for men, which primarily caters for remand prisoners committed from the Leinster area. It has an operational capacity of 431. At the time of Mr. N's death, the population of Cloverhill Prison was 479 (111% of its capacity).

6.2 At the time of his death, Mr. N's was the second death of a prisoner from Cloverhill Prison in 2024; and the fourteenth death in IPS custody that year.

7. Family Concerns

7.1 Mr. N's NoK did not raise any concerns or questions regarding Mr. N's passing.

8. Background

8.1 Mr. N was 79 years old when he was committed to Cloverhill Prison on 3 May 2024, three days before he died. Mr. N was on the standard level of the incentivised regime[1].

8.2 Mr. N was accommodated in cell 9 on the C2 landing, which was a three-person cell. Mr N occupied the bottom bunk in the cell, shared with two other prisoners; Prisoner 1and Prisoner 2 who provided the investigation team with accounts of their interactions with Mr. N during the brief time they shared a cell from 3 May to 6 May 2024.

9. Events of 5 and 6 May 2024

9.1 As per standard routine, Mr. N was locked back for the night in his shared cell at 19:17 on 5 May 2024. On the morning of 6 May 2024, Officer A commenced duty as an early start officer for the C Landing. He was rostered to start work at 08:00 but he took up his duties 30 minutes early, at 07:30, and relieved the Night Guard.

9.2 Officer A stated that there was a cell-call activation from cell 9 shortly after he took up duty at 07:30 on 6 May 2024. On his arrival at cell 9 he was made aware, by Mr. N's cellmates, that Mr. N was ill and had been vomiting. Officer A reported this matter to the Class Officer, Officer B, at 08:01 when Officer B commenced his duty on the landing. Officer B then informed Nurse A of Mr. N's condition.

9.3 Nurse A assessed Mr. N at 08:30 and noted, in a retrospective entry on the Prisoner Healthcare Management System (PHMS) at 16:47 on 6 May 2024, that an officer from the C2 landing had reported to her that Mr. N had been vomiting. Nurse A placed Mr. N on the doctor's referral list as "urgent" for review that morning.

[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.

9.4 At 10:13, Mr. N was escorted to the prison surgery by Officer C and was assessed by Doctor A. Doctor A referred Mr. N to the Accident and Emergency Department of Tallaght Hospital, as a precaution due to him vomiting. Doctor A recalled that nothing in Mr. N's presentation or vital signs indicated that he required immediate transfer to hospital.

9.5 Mr. N was collected from the C2 Landing at 14:18 by three officers (Officers D, E & F), in order to escort Mr. N to Tallaght Hospital. Officer F recalled that Mr. N, *"appeared to be a rather frail old man".* Officer D stated that when he first saw Mr. N on the afternoon of 6 May 2024 *"he appeared very frail."*

9.6 Upon seeing how infirm Mr. N was, and after observing his lack of mobility, the officers decided to use a wheelchair to assist transferring Mr. N from the landing to the prison van. Officer F retrieved a wheelchair and transferred Mr. N to the prison Reception area.

9.7 En route to Reception, it was noticed that Mr. N had soiled himself and his clothing. Mr. N was offered the opportunity to shower and change his clothing, which he accepted. Mr. N was then conveyed to an IPS prisoner van. Mr. N required assistance to get into the rear cell section of the prison van. The escort left the prison at 15:11 for the nine kilometre journey to Tallaght Hospital.

9.8 The IPS van used to convey Mr. N to Tallaght Hospital was a small Peugeot Expert prisoner transport vehicle. The van had two individual cell compartments at the rear, with plexiglass type clear windows facing from the rear towards the front of the vehicle. The van was fitted with an observer seat for a prison officer, which faced backwards towards the two cell compartments. There were CCTV cameras in the van but the system did not record footage; it only provided "live" or "real-time" CCTV coverage of the cell sections by means of a monitor located on the dashboard of the van. The investigation team inspected the vehicle in question and confirmed that the rear of the vehicle could be observed from the front of the van if officers had turned their heads around to look through the plexiglass panel.

9.9 On the journey to Tallaght Hospital, all three officers were seated in the front three seats of the vehicle. The officers, excluding the driver, claimed that they regularly monitored Mr. N throughout the journey, by looking back towards the cell compartments. However, the rear-facing prison officer observer seat that directly faced the cell compartments was left unoccupied

9.10 Upon arrival at the hospital, the escorting officers went to assist Mr. N from the vehicle when they noticed that he was in a distressed state and had vomited a black/brown substance. Officers reported that Mr. N was sitting on the floor of the cell leaning against the internal cell wall. He had vomit on his chest and was groaning. His face was pale but according to Officer E, Mr. N had been pale prior to being transported to hospital. The officers, assisted by a member of Dublin Fire Brigade who happened to be passing, immediately brought Mr. N into the hospital Reception area.

9.11 A hospital doctor, who was in the Reception area, noticed Mr. N's condition and directed that he be brought immediately through to the resuscitation area. Officer E recollected, in a statement to the investigation team, that the doctor informed him that Mr. N appeared to be suffering a cardiac arrest.

9.12 The resusicitation team began performing cardiopulmonary resuscitation (CPR) on Mr. N but the efforts were unsuccessful and he was pronounced dead by a hospital doctor at 16:00. Officer D rang Chief Officer A to inform him of Mr. N's passing.

10. Accounts of Prisoner 1 and Prisoner 2

10.1 Prisoner 1 stated that he had only been moved to cell 9, from another cell, on the Sunday afternoon, 5 May 2024. He recalled perceiving Mr. N as *"poorly, weak and feeble. He had a hernia".* On the Sunday night, Prisoner 1stated that Mr. N began *"projectile vomiting and he had diarrhoea".* Mr. N refused to allow his cellmates to call for assistance. However, the next morning after persistence from Prisoner 1 and Prisoner 2, Mr. N acceded and allowed them to seek medical assistance for him. Prisoner 1 recalled that at that point, Mr. N's *"breathing was very bad"* but when he returned to the cell, after seeing the medical staff, *"he was more calm."* He recalled that Mr. N was taken from the cell in the afternoon to go to hospital.

10.2 Prisoner 2 provided a detailed account of his time with Mr. N in cell 9. He recalled that he only met Mr. N for the first time on Sunday afternoon, 5 May 2024. Mr. N was already in cell 9 with Prisoner 1 when Prisoner 2 joined them. Prisoner 2 recalled that throughout the night of Sunday into Monday morning, Mr. N had diarrhoea and was vomiting and that he *"looked very sick".* Prisoner 2 reported that Mr. N's hernia was so large that it was obvious to anyone that met him.

10.3 When Prisoner 2 asked Mr. N how he was feeling, Mr. N replied that he was *"alright"* although Prisoner 2 felt that Mr. N *"looked shaken".* Prisoner 2 then stated that Mr. N defecated on himself.

10.4 Prisoner 2 further declared that on two separate occasions during the day, he called for assistance from cell 9 due to Mr. N soiling himself and vomiting. Prisoner 2 stated that he told an officer, *"the man [Mr. N] is badly sick in here, he needs to be seen by a doctor."* Prisoner 2 further recollected that Mr. N was given paracetemol at teatime but did not take the medication.

10.5 On the Monday morning, 6 May 2024, Prisoner 2 stated that Mr. N *"was vomiting more and sneezing and I said to the officer that he must be taken to the hospital".* At that point, Prisoner 2 reported that he was told by the prison officer that the doctor was on his way and that Mr. N would be taken to hospital.

11. Engagement with Healthcare personnel

11.1 On 3 May 2024, Mr. N was medically assessed by a nurse as part of the committal procedure. It was noted on Mr. N's PHMS record that he reported stomach pain on arrival but no diarrhoea or vomiting. However, there was no mention in the nurse's assessment of any visible hernia.

11.2 On 5 May 2024, Doctor A medically assessed Mr. N. Doctor A recorded that Mr. N had a large inguinal hernia. Mr. N declined a referral to the hospital at that time in respect of the hernia. Doctor A recorded that Mr. N was aware of the attendant "*risks of strangulation*" arising from potential complications from the hernia. Doctor A concluded the consultation by advising Mr. N to talk to prison staff if he had any problems.

11.3 On the morning of 6 May 2024, at the request of Nurse A, Mr. N was examined by Prison Doctor A at 10:13. Doctor A assessed that Mr. N should attend Tallaght Hospital. Doctor A prepared an IPS referral form for Tallaght Hospital. In completing the clinical information section of the form, Doctor A noted that Mr. N had a "*massive*" inguinal hernia which he stated was increasing in size. It was also noted that Mr. N reported bouts of vomiting in recent days combined with an absence of bowel movements.

11.4 The investigation team met and interviewed Doctor A to gather some more detail and background information regarding their medical assessments of Mr. N. Doctor A informed the investigation team that in the course of his initial committal assessment of Mr. N, he checked all his vitals which were considered stable. Mr. N's inguinal hernia was extremely obvious, described as "*massive*", but considering his age, he was otherwise not of any immediate concern and of reasonable health for a 79 year old man. Mr. N had informed Doctor A that he had the hernia for the past 12 years and had declined any surgical intervention. Mr. N refused to be placed on a referral list for treatment. According to Doctor A, Mr. N had no other complaints regarding his health and was not taking any medication.

11.5 Doctor A described Mr. N's engagement as open and courteous. Doctor. A stated that Mr. N was physically able and did not need any assistance with walking or climbing onto the medical bed for assessment.

11.6 Doctor A recalled having previous interactions with Mr N as had been "*in and out of prison over the years"*. Doctor A reported that he assessed Mr. N on 6 May 2024 as Mr. N. had been put on the prison's "*GP List*" that morning by the nurse. Mr. N was on the list as an officer had become aware that Mr. N had been sick in his cell.

11.7 After examining Mr. N, Doctor A advised that he should go to hospital "*as a precaution*" due to his vomiting, coupled with his hernia, which according to Doctor A can cause complications with blood flow or bowels twisting, which could have poisoned Mr. N. Doctor A stated that vomit could have been an indication of a number of issues, but as Mr. N was not in severe pain, he did not believe it was urgent. Doctor A stated that if Mr. N's bowels had fallen into his scrotum or twisted, due to the hernia, he would have been in "*severe pain*" and this would have required urgent hospital admission. Mr. N's vitals, nil complaints and nil pain, did not indicate the need for urgent transfer to hospital.

11.8 Although the medical referral form for Mr. N was marked "*urgent*" by Doctor A, the officers were not aware of this as the 'Application for Hospital Order' form, which is the document the officers had access to, made no reference or mention of urgency. When the investigation team met subsequently with Doctor A, he confirmed that Mr. N's transfer was routine and not urgent.

11.9 The OIP investigation team obtained relevant medical records covering Mr. N's previous incarceration at the Midlands Prison earlier in 2024 (January to April). These records made no reference to Mr. N's hernia but the doctor did note the following: *"I noted he was a bit SOB [short of breath] COPD [Chronic Obstructive Pulmonary Disease] Patient declined any intervention, inhalaer [sic] at this time. Reassured".* No other significant medical issue was recorded as having been raised by either Mr. N or the medical team at the Midlands Prison during Mr. N's time at the prison in 2024.

12. CCTV Footage

12.1 As part of the investigation, the investigation team reviewed CCTV footage from the Cloverhill Prison CCTV system covering key moments of the final hours of Mr. N's time in the prison.

12.2 The investigation team reviewed CCTV from the early morning of 6 May 2024 (including the point at which Mr. N was seen emerging from his cell) until later that day when Mr. N was placed in the rear cell section of the IPS van. It was clear that Mr. N was alert (although clearly infirm and having mobility issues); he appeared unsteady on his feet before being placed in a wheelchair to convey him to the van at approximately 14:30.

12.3 It is worth noting that CCTV footage at 08:22 shows Mr. N smiling and chatting with an officer outside his cell and he appeared alert and not in any visible distress – this remains the case throughout the CCTV footage showing Mr. N's movements in Cloverhill Prison (including from the point that Mr. N. departs his cell on the morning at 08:22 until he was assisted into the prison van later in the afternoon at 15:10). However, Mr. N's frailty and reduced mobility is obvious from the CCTV footage. Prison staff were clearly mindful of this and treated Mr. N with dignity and care while preparing him for transport to hospital and while assisting him into the prison van.

13. Critical Incident Review Meeting

13.1 On 6 May 2024, a critical incident review meeting[2] (CIRM) was chaired by Governor A. In attendance were Chief Officer B, Chief Officer C, Doctor A, Doctor , Doctor C, Chief Nurse Officer A, Officer D, Officer F, Nurse B and Clerical Officer A (minute taker).

13.2 The attendees at the CIRM outlined, in detail, the sequence of events covering the period from Mr. N's committal to Cloverhill Prison until his passing at Tallaght Hospital. Further related items, such as NoK and external stakeholder notifications, were also discussed.

13.3 Chief Officer B commended the compassion and dignity shown to Mr. D by the officers.

[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.

13.4 The meeting suggested that access to medical notes and consent issues needed to be examined to ensure a smoother handover of medical information in the future.

13.5 A further suggestion, which was discussed at the meeting, related to NoK issues; it was proposed that an "Emergency contact" telephone number be taken upon committal and that this number be called to confirm that the recipient would be happy to receive an emergency call.

14. Recommendations

The OIP has made three recommendations:

1. Nurse Officers should ensure, when completing Nursing Committal Forms, that all fields are completed and that any obvious physical abnormalities are noted on the Nursing Committal Form. Forms should be completed at the time of the Nursing Committal interview with retrospective entries made only when absolutely unavoidable.

2. In the event of a prisoner declining or refusing medical attention or a medical hospital referral, a declaration to that effect should be signed and dated by the prisoner, counter signed by the clinician, and the form retained with their medical records. A refusal to sign should be recorded by the prison doctor/nurse on PHMS.

3. One officer should always be present in the rear of the cellular vehicle at all times while a prisoner(s) is being transported (as per the IPS Escort Policy). This will make it easier for continuous visual monitoring of a prisoner in transit.

15. Support Organisations

15.1 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.