Death in Custody Report for Mr. D 2021 Statement on the Redaction of Paragraph 9.1 and 11.12 of the Death in Custody Report

Paragraphs 9.1 and 11.12 of the Death in Custody report for Mr. D 2021 contain a summary of information contained in the Postmortem Examination Report prepared by the State Pathologist for the Coroner. Under the Coroner's Act 1962, as amended, it is the duty of a coroner to hold an inquest in relation to the death of a person who was, at the time of his / her death, in state custody or detention. The postmortem examination report is submitted to the coroner to assist in the death investigation process.

The Minister has, in accordance with section 31 of the Prisons Act 2007, omitted content from paragraphs 9.1 and 11.12 of this Death in Custody report relating to the post mortem examination, on the basis that it would be contrary to the public interest to publish it in this report.

Death in Custody Investigation Report

Mr. D 2021

Midlands Prison

2 August 2021

Aged 59

To the Minister: 19 December 2025

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GLOSSARY

ACO	Assistant Chief Officer
AED	Automatic External Defibrillator
BMI	Body Mass Index
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DVT	Deep Vein Thrombosis
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure

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 for investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the Irish 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 the States obligation 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. D's death in the Midlands Prison on 2 August 2021 and the management of the events associated with his death.

4. Administration of Investigation

4.1 On 2 August 2021, the OIP was notified Mr. D had passed away while in the Midlands Prison. The following day, the investigation team attended the prison and met with staff and senior management.

4.2 Prison Management provided the investigation team with all relevant information in accordance with the standardised checklist of required information.

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 Inspectors met with Mr. D's NoK, his brother, on 7 October 2021. He informed the investigation team that Chaplain A and Chaplain B met with him, in-person, to inform him that Mr. D had passed. The NoK expressed gratitude for the compassion and empathy shown to him by both chaplains.

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. D's NoK in mind.

5.4 The OIP is grateful to Mr. D's brother for his contribution to this investigation and we offer our sincere condolences on his loss.

6. Midlands Prison

6.1 Midlands Prison is a closed, medium security prison for men. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Laois, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. At the time of Mr. D's passing, it had an operational capacity of 875 beds with 820 in custody. It was at 94% capacity.

6.2 At the time of his death, Mr. D's was the first death of a prisoner from Midlands Prison in 2021 and the fourth death in IPS custody that year.

7. Family Concerns

7.1 Mr. D's family requested a summary of the events leading up to his passing, which are detailed throughout this report.

8. Background

8.1 Mr. D was 59 years old when he passed away in Midlands Prison on 2 August 2021. Mr. D was committed to Midlands Prison on 18 October 2018, to serve a five-year sentence with a remission date of 16 February 2022.

8.2 Mr. D was the single occupant of cell 25 on the G1 landing at the time of his death.

8.3 At Mr. D's committal interview with Doctor A, on 23 October 2018, it was noted that Mr. D had factor five Leiden thrombophilia[1]. In addition, Doctor A recorded that Mr. D had been treated for deep vein thrombosis (DVT[2]) and had an ongoing Lymphedema[3] in his left leg. Doctor A noted that Mr. D's blood pressure was elevated and required monitoring. However, neither his systolic nor his diastolic blood pressure readings were recorded in the PHMS on committal.

[1] Factor V Leiden thrombophilia is an inherited blood clotting disorder.
[2] Deep Vein Thrombosis (DVT) – which occurs when a blot cloth forms in one or more veins in the leg causing swelling.
[3] Lymphedema is a long-term condition that causes swelling in the body's tissue, when the lymphatic system is not correctly working.

9. Medical Care

9.1 On 1 July 2021, Doctor B recorded in the Prisoner Healthcare Management System (PHMS) that Mr. D was prescribed Tramadol (pain medication) for a swollen leg, which was viewed as an ongoing secondary issue relating to his previous diagnosis of DVT. Doctor B advised Mr. D that his obesity was "life-threatening" and discussed weight management with him. Doctor B recorded his Body Mass Index (BMI) as being 49.5, but did not record his weight or height on committal. A BMI at this level (morbidly obese) is completely incompatible with Mr. D's recorded weight and height in the IPS Prisoner Information Management System (PIMS) (86kg and 1.6m), ██████████. The PIMS committal entry is clearly inaccurate and the PHMS committal entry is incomplete.

Doctor B also discussed the addictive potential of Tramadol and switched Mr. D's pain medication to Ixprim, a medication for the treatment of moderate to severe pain.

9.2 On 19 July 2021, Doctor B entered in the PHMS that Mr. D had not yet been administered Ixprim and apologised for the error. Doctor B recorded that the medication was then prescribed.

9.3 On 1 August 2021, Nurse A recorded in the PHMS that the antibiotics Augmentin and Flagyl were in Mr. D's medication pack, prescribed by Doctor C. Mr. D was querying why he was in receipt of this medication. Nurse A entered that there was no doctor's note with an explanation and entered "*prescribed in error*". Nurse A requested a new pack of medication from the pharmacy, minus the antibiotics.

9.4 On 2 August 2021, Nurse B recorded in the PHMS that Mr. D had been demanding his antibiotics "*as chartered*". Nurse B made a further detailed statement which was provided to the investigation team. In it, Nurse B described how, on 2 August 2021 at 08:00, while he was administering medication to Mr. D, he claimed he was not receiving his antibiotics. Nurse B checked the administration pack – which no longer contained antibiotics – and confirmed that Mr. D's pack was correct. Nurse B informed Mr. D that he would check his prescription and return with same, if required.

9.5 Nurse B stated that he checked the PHMS and confirmed Mr. D had been prescribed antibiotics on 25 July 2021. Nurse B recorded that, at 12:00, he met with Mr. D at the medication dispensary hatch and he was demanding his medication. Nurse B noted that he then provided Mr. D with the antibiotics Augmentin and Flagyl.

9.6 The investigation team's review of the entirety of Mr D's PHMS records did not find an entry submitted by Doctor C. CNO A confirmed to the investigation team, on 16 August 2022, that Doctor C was a locum doctor who had prescribed the antibiotics on 25 July 2021 and had requested a prison doctor review Mr. D on 26 July 2021. CNO A confirmed that Mr. D had not been seen further to this request, and confirmed that the last time Mr. D was reviewed in person, by a prison doctor, was on 19 August 2021 by Doctor B.

10. Events of 2 August 2021

10.1 On 2 August 2021, Officer A reported that Mr. D seemed fine, did not look unwell, and that nothing stood out regarding any of his interactions with him. Officer A stated that Mr. D went to the yard and Officer A reported seeing him at 11:50.

10.2 At 12:28, Officer B took up duty as dinner guard on G Division. Officer B reported receiving a call from an officer in the control room who told her that there was an emergency call on G1. Officer B stated she immediately went to cell 25 on the G1 landing, which had the emergency light on. The investigation team reviewed the cell call record and it recorded an activation for Mr. D's cell (G1 –cell 25) at 12:11:24.

10.3 CCTV footage recorded that Officer B entered the landing at 12:30 before exiting out of sight towards cell 25 at 12:30:19[4]. Officer B opened the cell door observation flap and reported viewing Mr. D standing in his cell. Officer B stated Mr. D had a book in one hand and was pointing to a handwritten note which stated, *"I had a reaction to antibiotics"*. Officer B stated that Mr. D's face was swollen, his tongue appeared swollen, and she could see the tip of his tongue. Officer B told Mr. D she would get him medical assistance.

10.4 Officer B called for nursing staff on her Tetra radio and stated that Nurse C then called her on the G1 Class Office phone. Officer B informed the nurse about the note that Mr D had shown her through the cell door observation flap. Officer B noted that Nurse C arrived on the G1 landing accompanied by Assistant Chief Officer (ACO) A. She stated she spoke with ACO A and noted he did not have the key to the E and G division key room.

10.5 Nurse C confirmed she was in the Surgery accompanied by Nurse D, Nurse B and Nurse E when they received a radio call at 12:24. Nurse C said she ran over to the office phone in the Class Office on G1 landing and spoke with Officer B who told her a prisoner was having an allergic reaction and that his tongue was swelling. Nurse C immediately went to the G1 landing accompanied by Nurse D.

10.6 ACO A made several calls on his Tetra radio in an attempt to gain access to the E and G key room in order to retrieve the keys to Mr. D's cell. Nurse C informed the investigation team that she accompanied ACO A to the G3 landing. There, they met Officer C who handed ACO A the key to the E and G key room. Officer A and Officer C both reported that they both immediately ran to the key room. Nurse C reported that ACO A unlocked the key room and then gave her the master key and she ran to Mr. D's cell and unlocked it, to allow Nurse C and Nurse D to enter.

10.7 Nurse C was viewed on CCTV footage arriving on the G1 landing at 12:36. She went straight to Mr. D's cell, while Nurse D went to the G1 surgery to retrieve emergency medical equipment. Nurse C noted when she arrived at cell 25 the door was locked, she noted ACO A and Officer B were present and they were trying to locate a key.

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[4] There were 5 CCTV cameras covering the area at the time, however, only one was operational. The camera that gave a direct line of sight of the door of Mr G's cell was not operational.

10.8 Nurse C stated she lifted the cell door observation flap and viewed Mr. D, who she described as panicked, holding up a hand-written note which stated he was having an allergic reaction. Nurse C reported viewing Mr. D's tongue, which was swollen, and that Mr. D was having difficulty speaking. She reported that she stayed at the cell door and reassured Mr. D as best she could. The Nurse noted he was distressed and was clearly having difficulty breathing.

10.9 Nurse C stated that Mr. D then laid down, on his bed, onto his side. She called out to him numerous times but received no response. Nurse C shouted down the corridor for the cell keys and continued to attempt to reassure him through the cell door. Nurse C called to Nurse D as she was approaching with the 'Red bag' that Mr. D's tongue was very swollen. She noted Nurse D immediately put a call to control for an ambulance & requested they be informed it was suspected anaphylaxis. Nurse C reported that while waiting outside the cell, for the keys to be located, the medical equipment was prepared for administration.

10.10 Nurse C stated that the cell door was opened at 12.38[5] by ACO A and she immediately entered with Nurse D. Nurse D administered the first dose of Epinephrine from an EpiPen (treatment for anaphylaxis shock) into Mr. D's right upper thigh. She noted that when Nurse D assessed Mr. D, he had no pulse. Nurse D then they proceeded to move Mr. D onto his back and commenced Cardiopulmonary resuscitation (CPR). She stated no airway was possible due to the swelling of Mr. D's throat and that 15 Litres of oxygen were applied via a non-rebreather mask.

10.11 Nurse C stated that Officer A and Officer C arrived on the scene and assisted ACO A in moving Mr. D to the floor to enable effective CPR. She further stated that they changed to bag-valve-mask once assistance arrived and rounds of compressions were continued by Nurse D, ACO A and Officer A.

10.12 Nurse B and Nurse E arrived on the scene and Nurse B applied an AED (Automated External Defibrillator) to Mr D's chest while CPR continued. She stated "*no shock*" was advised by the AED. A "*no shock*" message can mean one of three things: the person has a pulse, the person has now regained a pulse, or the person is pulseless but is not in a "shockable" rhythm (i.e. not ventricular fibrillation).

10.13 At 12:43, a second EpiPen was administered by Nurse B. In his statement, Nurse B recalled how the second use of the EpiPen had no effect. Nurse B described how Mr. D had no pulse and he was cyanosed[6]. Nurse D recorded that as there was no doctor on site in the prison and with the obvious conclusion that no sign of life was present, he consulted with the other nurses present and asked if they agreed to cease the delivery of CPR. Nurse D recorded that all agreed and recorded this decision at 12:52. At 14:58, Doctor A attended Mr D's cell and pronounced Mr. D's death at 14:59.

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[5] Governor A noted in the reports of staff there were a number of variances in the times recorded which was due to individuals' watches not being synchronised.

[6] Cyanosis is a blue/purple colouring of the skin which represents a low level of oxygen in the blood.

11. Access to the Internal Keys Office

11.1 The internal Keys Office is a secure office near the centre of the prison. The keys for all areas of the prison are held in the Keys Office and are recorded in a journal by the officer in charge of the keys. Details such as to whom a key is allocated to and by whom returned it, are noted in the journal. The officer in charge of the Keys Office controls who can enter the Keys Office.

11.2 The investigation team met with Chief A who advised that, on 2 August 2021, there was no "*set procedure*" in relation to the keys on E & G wings during staffing breaks. He explained that when E and G wings were locked back for dinner, the keys for those wings are normally taken by the ACO at the E and G key room to the internal Keys Office. The ACO Dinner Guard on E and G Wings collected the keys from the internal key room as they took up dinner guard duty. Chief A explained that the E and G key room did not have a dinner guard as that post was 'cut' as a 'cost saving' measure during the IPS transformation process.

11.3 Officer C was present in the key room on the E and G landings and had been working through lunch on 2 August 2021. The investigation team were informed that he was not occupying an official post during lunch but wanted to attend to do 'paperwork'. Officer C locked the E and G key room and went to the staff team room on the G3 landing before the Dinner Guard, ACO A, arrived on the E and G landings. Officer C was not in possession of a Tetra radio at that time.

11.4 ACO B was in charge of the G division on 2 August 2021. He noted that at approximately 12:20/12:25, Dinner Guard Officer B reported for duty and staff were then dismissed for their break. ACO B stated that Officer C, who had the keys of the E and G key room, had informed him that he was remaining in situ on the landing as he wished to catch up on prisoner booking visits. ACO B stated that Officer C mentioned that he would go for a break at some stage. ACO B said he understood that Officer C would retain the keys in his possession.

11.5 ACO B stated he then went to the gym in the main prison. Shortly after arriving at the gym, ACO C asked him if he knew where the keys were for the E and G key room. ACO B stated that he informed ACO C that they were with Officer C in the E and G key room.

11.6 ACO A was detailed as ACO Dinner Guard for E and G Divisions. The ACO noted that, at approximately 12:30, he called to the ACO's Office and checked in with ACO C (who was dinner guard in the main prison) and then went to the internal Keys Office to collect the key for the E and G key room. He said he spoke to the Officer there and discovered the keys were not there. ACO A said he then continued to the E and G divisions and expected to collect the keys on the way over or at the E and G key room which is located in the centre circle between the E and G Divisions on the ground floor.

11.7 ACO A stated he was entering the E and G connecting corridor when he heard a request on his Tetra radio for a Nurse to attend the G1 landing. ACO A stated he called G Dinner Guard Officer B privately to enquire what the nature of the problem was and he informed him there was a prisoner in distress. The ACO said he continued over to the E and G key room and found it was locked and there was no one there. He said he did not know who had the key and he needed access to get the Master Key to unlock Mr. D's cell.

11.8 The ACO noted he then went to the G Division and met with Officer B and established she did not have the key and she did not know who had the key. He stated he then contacted the E

Division to see if the key was there, but the Officer there did not have the key. He then asked ACO C to check the internal Keys Office and if the key was not there, to check with ACO B who he believed was in the gym. ACO C informed the investigation team that he checked the internal Keys Office and the key was not there. He believed ACO C then checked with ACO B who told him that Officer C had the key.

11.9 ACO A stated he did not know where Officer C was and went in search of him. ACO A said he climbed the internal staircase towards the G3 circle area, where the staff tearoom is located, met Officer C and established that he had the key ACO A took the key and ran back down the stairs with Officer B. ACO A stated he went to the key room, retrieved the master key and gave it to Officer B who then ran to cell 25 on G1 and opened the cell and allowed the nursing staff to enter. ACO A said he too went to cell 25 and assisted the nurses with CPR.

11.10 The investigation team were provided with the recommendation of Chief A submitted following his review of CCTV footage. It was established that the delay of 14 minutes in locating the keys to the E and G key room could not be ignored. He attributed it to poor communications between all parties. He noted that Officer C, while working with the best of intentions, did not inform any of the dinner guards or the ACO in charge of the E and G divisions for the Dinner Guard, that he was in the possession of the keys to the E and G key room should they be required. Chief A recommended that the dinner guard post in the E and G key room be reinstated and also that a Standard Operating Procedure (SOP) should be drawn up to ensure that the keys to the E and G key room are available at all times should they be needed in an emergency and the ACO in charge of this area, during meal breaks, is in possession of these keys. The latter recommendation was actioned and the investigation team has received a copy of the SOP which is operational.

11.11 It is noted that throughout the night of 1 August 2021 into 2 August 2021, there were 130 prisoners on E Division and 167 prisoners on G Division. On 2 August 2021, there were 297 prisoners who could not be accessed, in an emergency, as the keys had been taken from the landing.

11.12

12. Critical Incident Review Meeting

12.1 On 3 August 2021, a Critical Incident Review Meeting[7] took place. Attendees included Governor A, Assistant Governor A, Chief Nurse Officer (CNO) A, Chaplain A, Chief A, Chief B, Nurse C, ACO A, Officer A, Officer B and a note taker. Officer C was not present at this meeting.

12.2 Governor A invited all involved to give an account of what happened. Officer B, ACO A, Nurse C, Chief C and Chaplain A then relayed their role in relation to the incident.

12.3 CNO A advised that generally Mr. D was unwell with a cardiac condition. She said he had been on antibiotics from the 25 July 2021, that one of these was penicillin-based, and he had been on these antibiotics before.

12.4 Officer B and ACO A outlined their role as is noted above. ACO A noted that he was looking for keys to unlock the cell but initially he could not locate them. He said the reason for the delay in retrieving the keys was due to a crossover of staff at dinner break.

12.5 Nurse C outlined her role and noted that while waiting for the cell to be opened she was telling Mr D to try to relax and consoled him. She said she could see Mr D was struggling and kicking, after a while he lay on the bed and turned on his side, he was visibly not breathing.

12.6 Chief C noted that he became aware of an issue on G1 at 12:30 (approximately) and met Governor B at G1 at 12:39. He said that he and Governor B adopted the death in custody protocols.

12.7 Officer A noted his interaction with Mr D on the morning of 2 August 2021 as is outlined in **Section 10** of this report.

12.8 It was noted that the issues over the key access where the incident occurred, needed to be examined and relevant SOPs reviewed.

[7] 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. Recommendations

13.1 This is a particularly tragic case, in which a prison nurse was obliged to watch helplessly through a cell door while a person lost consciousness and died, as prison officers scrambled and failed to locate the missing key to his cell in sufficient time.

In the report on its 2024 visit to Ireland, the Council of Europe's European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) emphasised that "the duty of care that is owed by the prison authorities to prisoners in their charge [,,,] includes the responsibility not only to keep them safe, but also to proactively protect their lives, as required under the positive obligation enshrined in Article 2 of the ECHR. Seriously ill prisoners who die while being held in prison custody and who may have otherwise been saved also fall into this safety category."[8]

That Mr. D should lose his life in these circumstances is unconscionable.

The Office of the Inspector of Prisons makes the following four recommendations:

1. The Irish Prison Service must ensure that it is never the case that cells cannot be rapidly unlocked in the case of a medical emergency. The OIP would like to be informed of the system-wide measures that the IPS intends to take to ensure that the circumstances in which Mr. D lost his life can never be repeated. It would also like to be informed of whether, in the aftermath of the death of Mr. D, any disciplinary action was taken by the IPS against Officer C and/or those responsible for Officer C's supervision at the time of Mr. D's death.

2. The Irish Prison Service should conduct a clinical review of the circumstances in which Mr. D came to be prescribed antibiotics by a locum doctor, who failed to record the reason for this prescription (or any patient allergy information) in the PHMS. The review should also examine why the locum doctor's referral to a prison doctor was not acted upon. More generally, the IPS should review the adequacy of its arrangements to ensure continuity of care for patients when locum doctors are employed.

3. The Director General of the Irish Prison Service should issue instructions to all prisons, making clear that the weight and height of all prisoners must be accurately recorded by prison staff on committal, regardless of whether or not the person concerned has previously been imprisoned.

4. The IPS Director of Care and Rehabilitation should issue a reminder to all nurses and doctors working in the prison system that the weight, height, systolic and diastolic blood pressure of all prisoners should be accurately recorded on committal.

[8] See paragraph 76 of the Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 21 to 31 May 2024 (CPT/Inf (2025) 22) available at this link: https://rm.coe.int/1680b6c60a

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