An Roinn Dlí agus Cirt,
Gnóthaí Baile agus Imirce
Department of Justice,
Home Affairs and Migration

Death in Custody Report for Mr. J 2022 Statement on the Redaction of Paragraphs 13.2 and 13.3 of the Death in Custody Report

Section 13 of the Death in Custody report for Mr. J 2022 contains 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 from this Death in Custody report paragraphs 13.2 and 13.3 relating to the post mortem examination, on the basis that it would be contrary to the public interest to publish it in this report.

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Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. J
Midlands Prison
6 June 2022

Submitted to Minister: 25th October 2024

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CPR	Cardiopulmonary Resuscitation
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PEO	Prison Executive Officer
PHEO	Prison Higher Executive Officer
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 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 for 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 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 paying particular focus to the care that was afforded to Mr. J during his time in prison.

4. Administration of Investigation

4.1 On 6 June 2022, the OIP was notified that Mr. J had passed away in the Midlands Prison. The investigation team attended the prison on 7 June 2022 and met with prison management who provided an overview of Mr. J's time in prison. They also liaised with all relevant persons who had contact with Mr. J in order to understand the chain of events that preceded 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 The investigation team communicated with Mr. J's NoK, his wife, by telephone on 26 July 2022. Subsequently the investigation team also spoke with Mr. J's extended family. The family declined the opportunity to meet the investigation team in person as they felt phone contact was sufficient. The information provided to the investigation team by Mr. J's family is outlined in **section 7** of this report.

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

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

INVESTIGATION

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, Offaly and Westmeath. At the time of Mr. J's passing the prison had an operational capacity of 845.

6.2 Mr. J was the fourth death of a prisoner from the Midlands Prison in 2022 and the tenth death in IPS custody that year.

7. Family Concerns

7.1 Mr. J's family requested a timeline of the events and activities of Mr. J prior to him being found unresponsive.

7.2 Mr. J's family advised the investigation team that he had long-standing medical issues. The investigation team was provided with information in relation to his medical conditions, which included excess skin growths on the rear of his legs, back and arms. The family stated that these growths caused him considerable discomfort. The family also stated that Mr. J would regularly scratch the affected areas and they would bleed, sometimes heavily.

7.3 The NoK was complimentary regarding their engagement and communication with senior management at the Midlands Prison.

8. Background

8.1 Mr. J was a 73-year-old remand prisoner when committed to Cloverhill Prison on 10 May 2022. He was transferred to the Midlands Prison on 29 May 2022, where he was accommodated in a single occupancy cell, cell 31 on B2 landing.

8.2 Mr. J was due to appear in court on 24 June 2022.

8.3 In the early hours of 6 June 2022, an officer conducted checks and noticed a pool of blood on the cell floor under Mr. J's bed.

8.4 When the cell door was unlocked, a nurse formed the view that Mr. J had been deceased for some time.

9. Interaction with Healthcare

9.1 On 11 May 2022, Doctor A completed a medical committal interview with Mr. J in Cloverhill Prison, the details of which were recorded on the Prisoner Healthcare Management System (PHMS). Doctor A recorded that Mr. J had "*Psoriasis*"[1] and "*skin rashes*". It was also recorded by Doctor A that Mr. J had no history of mental illness.

9.2 The prison doctor prescribed medication for Mr. J including analgesia cream, painkillers, blood pressure medication and an inhaler. Contact was also made by healthcare personnel with the community pharmacy to confirm the correct hearing aid battery required for Mr. J.

9.3 On 12 May 2022, Nurse Officer A reviewed Mr. J in his cell following the activation of the in-cell call bell, which she recorded as having been activated by Mr. J's cellmate. Nurse Officer A notes stated a "*small superficial laceration observed on Mr. J's wrist"*. It is also recorded that Mr. J informed the nurse that "*my wrist was paining me, so I scratched it with a knife to elevate* [sic] *the pain*". Nurse Officer A informed Mr. J that healthcare support was available around the clock and if he required pain relief he should ask for same; Mr. J responded that he "*didn't want to disturb the staff*".

10. Family Visit

10.1 On 4 June 2022, Mr. J had an in-person visit with his wife. The COVID-19 protocol was in place which required prisoners and visitors to wear protective face masks and no physical contact was permitted. CCTV footage of this visit was reviewed by the investigation team. At the beginning of the visit Mr. J gestured in the direction of an officer indicating to his wife that they were unable to physically embrace. It was evident from the footage that both Mr. J and his wife were happy to see one another. At the end of the visit, Mr. J's wife was viewed offering to shake hands with Mr. J who again gestured that he was unable to shake hands or embrace. They both waved to one another as they exited through separate doors.

11. Phone call 5 June 2022

11.1 The investigation team reviewed Mr. J's recent phone calls. At 09:48 on 5 June 2022, Mr. J had a phone conversation with his wife. During this conversation, she mentioned that it was "*nice*" to have seen him the previous day and mentioned not being able to embrace. Mr. J asked his wife to contact the prison Chaplain to arrange a video call with his extended family. The conversation was calm and engaging and contained nothing out of the ordinary.

[1] Patches of skin that are dry, red and covered in silver scales. The HSE website, https://www2.hse.ie/conditions/psoriasis/ reports this as a symptom of psoriasis which causes itching or soreness.

12. Events of 6 June 2022

12.1 Officer A was the night guard in charge of the B1 and B2 landings on the night of 5 June and into the morning of 6 June 2022. He reported that at approximately 06:00 while completing cell checks he noticed a pool of blood on the cell floor occupied by Mr. J. Officer A requested medical assistance via his Tetra radio. He then alerted ACO A who immediately contacted the nurse on duty, Nurse Officer B. The CCTV reviewed showed an officer arrived at Mr. J's cell at 05:57 and checked through the cell door viewing panel for about 20 seconds.

12.2 ACO A unlocked Mr. J's cell at 06:07. This is corroborated by CCTV footage. ACO A reported finding Mr. J unresponsive.

12.3 Nurse Officer B arrived at Mr. J's cell at approximately 06:10 where she met ACO A, ACO B and Officer A. ACO A called the National Ambulance Service at approximately 06:10. ACO B went to the main gate to facilitate immediate access for the ambulance on arrival.

12.4 Upon entering the cell Nurse Officer B discovered Mr. J unresponsive in his bed with a large amount of congealed blood visible on the lower part of Mr. J's bed. Nurse Officer B clinically assessed Mr. J for signs of life and reported there were none. Nurse Officer B reported checking for the source of blood and was assisted by ACO A in moving Mr. J onto a front lying position. She observed blood pooling which indicated Mr. J had been deceased for a period of time[2]. Nurse Officer B and ACO A placed Mr. J onto his back before exiting the cell.

12.5 Nurse Officer B recorded on PHMS that CPR was not commenced as Mr. J's clinical signs indicated he was deceased and that rigor mortis appeared to have set in. It was also recorded that Mr. J had two small lacerations approximately 1cm in length on his lower legs. The CCTV footage showed that the nurse spent 10 minutes in the cell. Doctor B was contacted and requested to attend the prison.

12.6 At approximately 06:40, members of the Ambulance Service arrived at Mr. J's cell and departed at 06:47.

12.7 At 07:30 Chaplain A was informed of the passing of Mr. J. Chaplain A made contact with and informed Mr. J's wife and NoK.

12.8 Doctor B arrived at the cell and pronounced death at 08:32.

12.9 Doctor B recorded on PHMS that "*bloodstains were visible on legs and to a lesser extent on [*Mr. J's*] arms. Large quantity of congealed blood evident on bedclothes between legs, large towel visible between legs*". Doctor B also recorded that there was no obvious instrument evident that may have inflicted a wound. At 10:05, Garda Sergeant A, Garda A and Scenes of Crime Garda B arrived on B2 landing. At 10:20, Garda B entered Mr. J's cell to commence the scene investigation which included the taking of photographs.

[2] Blood pooling typically occurs 20 to 30 minutes after death.

12.10 At 10:45, Doctor B entered Mr. J's cell accompanied by the Scenes of Crime Garda B. Doctor B recorded on PHMS that upon a second review of Mr. J he noted that superficial incisions were evident on both legs including a perforated varicose vein on Mr. J's leg above the medial popliteal fossa[3]. Doctor B recorded observing "*blood sodden tissue and paper evident on bedclothes along with a blood soaked towel".*

12.11 At 12:27, funeral directors removed Mr. J's remains from his cell and exited the Midlands Prison at 12:40.

12.12 At 14:25, Garda Sergeant B and Garda C conducted a further search of Mr. J's cell before departing at 14:40.

13 Post Mortem Findings

13.1 In cases where a Post Mortem is performed, the OIP usually receives a copy of the Final Post Mortem Examination Report. The Assistant State Pathologist carried out a Post Mortem Examination of Mr J's body on 6 June 2022. This section of the OIP's investigation report briefly summarises the Assistant State Pathologist's key Post Mortem Findings. Mr J's family may request a copy of the full Post Mortem Report from the Coroner for County Laois.

13.2 [redacted]

13.3 [redacted]

[3] This is a diamond-shaped space found behind the knee joint.

14 Critical Incident Review Meeting

14.1 At 10:00 on 7 June 2022, a Critical Incident Review Meeting[4] was held by Governor A. In attendance were Chief Officer A, Doctor B, Chief Nurse Officer A, Chaplain B and prison administrative staff members PHEO and PEO who took a note of the meeting. A detailed timeline of events including the prison personnel response to the incident was recorded as part of this meeting. However, no reference was made to a blood stained razor blade having been found in a rubbish bag in Mr. J's cell. No recommendations were made.

15. Recommendations

15.1 The Office of the Inspector of Prisons makes two recommendations:

1. In order to facilitate the effective investigation of deaths in prison custody and to ensure that all necessary lessons are learned, it is essential that a complete and accurate record be kept by the Irish Prison Service (IPS) of all items found in/removed from a prisoner's cell following a death in custody. This applies irrespective of whether the items are found/removed by IPS staff or by members of An Garda Síochána (AGS). In the event that items are found/removed by members of An Garda Síochána, the prison's Governor should be provided with a complete list of the items concerned. Implementation of this recommendation may require the development of a protocol between the IPS and AGS;

2. The IPS Directorate of Care and Rehabilitation is invited to develop a new plain English information resource for prisoners, clearly highlighting the potentially fatal consequences of self-inflicted injuries.

16. Support Organisations

16.1 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.

[4] This meeting is between prison management and all prison staff who were involved in the incident or 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.