



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. F

Midlands Prison

14 March 2023

Aged 78

To the Minister: 31 July 2026

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GLOSSARY

AGS	An Garda Síochána
ADLs	Activities of Daily Living
CNO	Chief Nurse Officer
CNS	Clinical Nurse Specialist
CT scan	Computer Tomography scan
DNR	Do Not Resuscitate
HCA	Health Care Assistant
HSE	Health Service Executive
IPS	Irish Prison Service
LTOT	Long-term Oxygen Therapy
MRHP	Midlands Regional Hospital, Portlaoise
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PCO	Prison Clerical Officer
PIMS	Prisoner Information Management System
PHMS	Prison 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 includes 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. F's death in prison, on 14 March 2023, and the management of the events associated with his death.

4. Administration of Investigation

- 4.1 On 14 March 2023, the OIP was notified that Mr. F had passed away in the Midlands Prison. The investigation team attended the prison on 16 March 2023 and met with prison management who provided an overview of Mr. F's 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 Mr. F's NoK, his niece, by letter on 11 July 2023 and during a follow-up telephone conversation on 25 August 2023. Mr. F's NoK did not wish to meet with the OIP, explaining that she had limited contact with her uncle and he was estranged from his family. Mr. F's niece provided her consent to allow access to Mr. F's medical records and the OIP is grateful for her assistance in this respect.
- 5.3 Although this report is for the Minister for Justice, Home Affairs and Migration, it may also inform several interested parties.

INVESTIGATION

6. Midlands Prison

- 6.1 Midlands Prison is a closed, medium security prison for adults. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Laois, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. It has an operational capacity of 875 beds. On 14 March 2023, the date when Mr. F passed away, the Midlands Prison was operating at a capacity of 102%, with 890 prisoners in custody.
- 6.2 At the time of his death, Mr. F's was the second death of a prisoner from the Midlands Prison in 2023; and the sixth death in IPS custody that year.

7. Family Concerns

- 7.1 Mr. F's next of kin (NoK) did not share any concerns regarding the circumstances of Mr. F's passing nor his time in custody. She praised the Midlands Prison's chaplaincy service communication with her.

8. Background

- 8.1 On 20 December 2022, Mr. F was sentenced to four years imprisonment at Waterford Circuit Court, after having been convicted on 16 June 2022. Mr. F's remission date was 18 December 2025.
- 8.2 Immediately following his sentence, Mr. F was transported to Cork Prison. On that same evening, at approximately 21:15, Mr. F was transferred to the Midlands Prison. Mr. F was accommodated in a single occupancy cell, cell 2, on the G1 landing.
- 8.3 Mr. F was registered as homeless on the IPS's Prisoner Information Management System (PIMS). Prior to receiving his sentence, Mr. F had been residing at a nursing home for a period of two years. Mr. F lived in the nursing home during the intermittent period between his conviction and sentencing dates.
- 8.4 Mr. F had a number of pre-existing health conditions and related needs that the IPS was not aware of prior to his committal into its custody.

9. Committal to the Midlands Prison

- 9.1 At 20:54, on 20 December 2022, Mr. F arrived at Cork Prison and was reviewed by Nurse A. His temperature was taken and he was screened for COVID-19. The Prison Healthcare Management System (PHMS) recorded that at approximately 23:22, on that same day, Mr. F was seen by Nurse B in the Midlands Prison following his immediate transfer from Cork Prison. Nurse B recorded that Mr. F reported that he felt well and was provided with his medication for the night. A health care assistant (HCA) helped Mr. F to settle into his single cell.
- 9.2 An entry on PHMS, at 05:38 on the morning of 21 December 2022, by Nurse B recorded that she had been called by HCA A to attend to Mr. F as he had fallen from his bed. Nurse B documented that the healthcare staff were unaware that Mr. F was at a particular risk of falling. Upon arriving at his cell, Nurse B discovered Mr. F lying on the floor with a small laceration to his left eyebrow. With the assistance of an officer, Nurse B moved Mr. F to a mattress on the floor, using a pillow and duvet to make him comfortable, and advised HCA A to monitor him closely. Nurse B placed Mr. F on the doctor's list for an urgent review.
- 9.3 Later that morning, on 21 December 2022, Doctor A met with Mr. F for his committal interview and review. Doctor A noted that Mr. F had a laceration and bruising/swelling above his left eye and presented as mildly confused. As a result of his assessment, Doctor A referred Mr. F for a CT scan¹ of his brain. He noted that Mr. F required regular assistance from carers and that confirmation of his medication was required. He also questioned if there was any medical handover from Mr. F's former nursing home and if his last diabetic bloods were available. Mr. F is recorded as telling the doctor, *"I'm fed up, can you put me to sleep"*.
- 9.4 On the afternoon of 21 December 2022, as a result Doctor A's assessment and referral, Mr. F was brought to the Accident and Emergency department at the Midlands Regional Hospital, Portlaoise (MRHP), and was admitted.
- 9.5 On 22 December 2022, the prison's Chief Nurse Officer (CNO) A contacted Mr. F's former nursing home. Governor A informed the investigation team that they were only aware of the nursing home as it was named on the medication pack Mr. F had with him on committal. As a result of the contact, CNO A learned about Mr. F's medical history, which included an atrial flutter², a cerebrovascular accident (CVA)³, ischaemic heart disease (IHD)⁴, gastritis⁵, hypertension⁶ and that he was diabetic. In addition, Mr. F used a mobility aid and required assessment regarding his activities of daily living (ADLs). Mr. F was also known to have had *"some cognitive impairment and intermittent confusion"* and had a *"high risk of falls"* due to fifteen slips/trips recorded during his time in care.

¹ A CT (computer tomography) scan is a medical imaging test that provides detailed internal images of the body to allow medical assessment.

² An Atrial flutter refers to an abnormal heart rhythm that is too fast.

³ A Cerebrovascular Accident (CVA) is another name for a stroke. A stroke occurs when there is a loss of blood flow to a brain.

⁴ Ischaemic Heart Disease (IHD) refers to damage to the heart caused by it not receiving enough oxygen or blood.

⁵ Gastritis is the inflammation of a person's stomach lining.

⁶ Hypertension is also known as high blood pressure.

- 9.6 On 23 December 2022, CNO A emailed senior management within the IPS to raise her concerns regarding Mr. F's transfer of care. The email advised that there were "*numerous handover letters*" from Mr. F's former nursing home that had not reached the prison. CNO A highlighted the absence of any planning in the community in relation to Mr. F, noting that he was "*on remand in his nursing home so there was an awareness that he has some nursing needs*". In conclusion, CNO A requested the matter be escalated so that a system could be implemented to make the IPS aware, in advance, of a prisoner with extensive healthcare needs.
- 9.7 On that same day, 23 December 2022, Governor A sent his own email to senior management in the IPS to reiterate the concerns raised by CNO A. He noted that Mr. F was placed in custody without any notice provided by An Garda Síochána (AGS), the Courts Service or the Health Service Executive (HSE) and described it as "*potentially a very dangerous transfer*" that "*probably led to this man's hospitalisation*". Governor A requested that the matter be escalated to the Department of Justice and the Department of Health.

10. Medical Care in Custody

- 10.1 On 25 December 2022, Mr. F was discharged from MRHP back to the prison and was seen, on 26 December 2022, by Nurse C. During the remaining days of December 2022, nursing staff and HCA's attended to Mr. F's personal care and monitored his health and well-being. Medical records refer to adjustments made, at that time, to meet Mr. F's needs, including the use of an electric bed, positioning the bed by the wall and the use of a bed rail.
- 10.2 On 30 December 2022, Nurse D recorded that Mr. F was unable to fully support his own weight and the assistance of a minimum of two staff was required to move him. On that same day, Nurse E reviewed Mr. F as he was experiencing shoulder pain. Nurse E provided him with pain relief and requested a doctor's assessment. Fifteen minutes later, Doctor B examined Mr. F in his cell. Doctor B recorded that Mr. F's eye was still blue from his fall but that his injuries had been assessed at the MRHP and there was no deformity evident. Mr. F informed Doctor B that his pain was an old injury to his shoulder and he was prescribed non-steroid anti-inflammatory drugs as treatment.
- 10.3 On 30 January 2023, Mr. F was transferred by ambulance to MRHP Accident and Emergency Department, accompanied by a referral letter from Doctor C, as there was an observed medical deterioration in his health, including ongoing confusion, chest pain, shortness of breath, cyanosis⁷, constipation and nausea (Hospital discharge summary). PHMS notes from 31 January 2023 document that a nurse at the hospital communicated that Mr. F was "*quite poorly*" and was receiving end of life care. The Governor of the Midlands Prison was provided with an update on Mr. F's condition by Doctor C evidencing compliance with Prison Rule 105⁸.
- 10.4 After consultation between the hospital and the prison healthcare team, Mr. F returned to the custody of the prison on 6 February 2023. His discharge summary identified that his diagnosis was "*exacerbation of heart failure*" and pneumonia and that he received treatment to clear his pulmonary congestion⁹. During Mr. F's time in hospital, it is recorded that he was seen by the

⁷ Cyanosis refers to the discoloration of body tissue due to a lack of oxygen in the blood.

⁸ Prison Rules 2007: Rule 105 refers to information provided to the Governor, from a prison doctor, on the state of health of a prisoner.

⁹ Pulmonary congestion, also known as Pulmonary Edema, refers to the abnormal accumulation of fluid in the lungs.

Speech and Language Therapy team and by the Palliative Clinical Nurse Specialist (CNS). On Mr. F's return to the prison, Doctor D reviewed him as did Nurse F. The latter recorded that Mr. F was physically frail, required full care and remained in bed.

- 10.5 On 7 February 2023, Doctor C reviewed Mr. F in his cell. She described him as alert and orientated, noting he believed that his date of birth was in April 2013; his cognitive impairment was recorded as dementia on PHMS. The notes document that Mr. F was not under the palliative care team at this point.
- 10.6 On 13 February 2023, Doctor C recorded that Mr. F required hospitalisation and had a urinary tract infection and a respiratory tract infection. However, the notes stated that Mr. F refused to go to hospital and this was witnessed by two HCAs. Doctor C prescribed antibiotics and nutritional supplements for Mr. F, requested ongoing monitoring, and placed him on the list for a doctor's review the following day.
- 10.7 Later in the afternoon, on 13 February 2023, Nurse G documented that Mr. F was refusing to eat and drink. Nurse G recorded that Mr. F refused to go to hospital, he verbalised he did not wish to be resuscitated in the event of cardiac or respiratory arrest, and he expressed that he was ready to die.
- 10.8 On 14 February 2023, Mr. F was referred and transported to the MRHP's Accident and Emergency Department after Doctor C observed a further medical deterioration in his health including "*intermittent confusion*". Nurse F recorded that Mr. F was discharged back to the prison the following day, 15 February 2023. Doctor C reviewed Mr. F on his return and noted that he had been discharged from the hospital without communication with the prison.
- 10.9 Doctor C assessed that Mr. F required re-admission to hospital as he remained dehydrated and was not clinically stable. Within her referral letter to the hospital, Doctor C stated that Mr. F expressed his wish to be treated at the hospital and that he wanted "*to be resuscitated should cardio-respiratory arrest occur*". Mr. F was re-admitted to MRHP late that afternoon.
- 10.10 Nurse H recorded that Mr. F was discharged back to the prison, by ambulance, on 16 February 2023 at 04:00 and was attended to by a HCA. There was evidence that Nurse H monitored Mr. F during the remainder of the morning. Doctor C reviewed Mr. F at 10:00 that same morning, 16 February 2023, and documented that he was coherent, was not in pain or discomfort and was "*orientated only concerning his own person, but not to time*". Doctor C's care plan, at that time, included referring Mr. F to the palliative care team, which she did by email on that same day, 16 February 2023.
- 10.11 On 17 February 2023, Doctor C reviewed Mr. F in the presence of Nurse G and HCA B. Doctor C documented that she spoke with Mr. F regarding advanced care planning and sought his views regarding resuscitation where she recorded that she ensured he understood the meaning of resuscitation. Doctor C asserted in her notes that Mr. F stated he did not wish to be resuscitated and Nurse G confirmed that he had witnessed this interaction. Doctor C recorded that the MRGH had a '*do not resuscitate status*' for Mr. F. On the same date, 17 February 2023, Nurse G documented that he had contacted Mr. F's NoK and discussed his care plan, most notably the involvement of palliative care.
- 10.12 Doctor C recorded that she had consulted with Community Palliative Care Nurse A by telephone, on 17 February 2023, who advised on the appropriate pain management medication for Mr. F.

In addition, Doctor E, a consultant in Palliative medicine, responded to Doctor C's referral and engaged in an email exchange with her regarding Mr. F's medical profile. Doctor C informed Doctor E about Mr. F's expressed wish to not be resuscitated whilst advising that he did not have "*compos mentis*"¹⁰ due to dementia, noting how his cognition and his decision-making capacity fluctuated. Doctor E confirmed that he had updated the palliative on call nurse regarding Mr. F and provided assistance regarding medication options.

- 10.13 On 20 February 2023, Doctor C and Palliative Clinical Nurse Specialist (CNS) A reviewed Mr. F after Nurse I recorded that there was observed deterioration in his health including his experience of pain upon movement. Nurse I updated Mr. F's care plan based on the Palliative CNS A's assessment and recommendations regarding his medication.
- 10.14 On 22 February 2023, Nurse G observed that Mr. F appeared much brighter than in previous days and Nurse J's observations concurred, where she noted that Mr. F was "*bright and alert*" with no complaints regarding pain or distress. Doctor C again spoke with Mr. F regarding his views on resuscitation and he re-confirmed his wish for a Do Not Resuscitate (DNR) order to apply and that he did not wish to be transferred to hospital should his condition deteriorate.
- 10.15 There are daily medical notes throughout the remaining days of February 2023 and early March 2023 evidencing nurse and doctor reviews taking place, including Mr. F's care plan being updated based on his presentation, as well as consultation with the palliative care team. During this period, Mr. F was receiving significant care including the administration of medication; maintenance of his catheter; assistance with eating, drinking, movement and hygiene; pain management; as well as the monitoring of his vital signs, fluid intake, bodily functions and overall well-being. Mr. F was also prescribed antibiotics, during this time, to treat a urinary tract infection.

11. Events of 14 March 2023

- 11.1 HCA C, who was assigned to the G1 landing on 14 March 2023, described Mr. F as lethargic and "*sleeping a lot*" throughout the morning where she also noted that he refused breakfast and fluids. HCA B shared HCA C's observations and added that Mr. F was assisted with his personal hygiene. HCA C recalled that Mr. F's mouth appeared unclean and she had concerns regarding his breathing, so she reported it to the nursing staff on duty.
- 11.2 At approximately 11:31, Nurse K recorded that she had reviewed Mr. F in his cell and found him to sound "*chesty*". Nurse K further noted that he was repositioned in his bed, his vital signs were reviewed, and he was provided with mouth care.
- 11.3 At 11:47, Nurse K recorded that she reviewed Mr. F again. On this occasion she noted that he appeared comfortable and did not sound as chesty as he had previously, but he was not fully expectorating so he was to be reviewed by a doctor. She documented that he had received his medication¹¹ earlier in the day and was not complaining of any pain.
- 11.4 At approximately 12:20, HCA B and HCA C checked on Mr. F. HCA B stated that he observed Mr. F's breathing to be "*very laboured*". Nurse K reviewed Mr. F and agreed that Mr. F's

¹⁰ Compos Mentis is a Latin phrase which means to be of sound mind and mentally competent and capable.

¹¹ At this stage Mr. F was prescribed Oramorph, a liquid form of morphine, as per his end of life pain management care.

breathing was laboured, and he sounded chesty again. She placed him on oxygen, via a mask, after measuring his oxygen saturation levels.

- 11.5 Doctor C attended to Mr. F at approximately 12.20 and recorded that Mr. F's breathing was "very laboured" and "he appeared to be loaded with secretions in his lungs". Doctor C recorded that when she asked him whether he wished to go to the hospital, he indicated with his head that it was not what he wanted.
- 11.6 Based on her clinical assessment, Doctor C recorded that Mr. F was, in her professional opinion, presenting with "aspiration pneumonia", "respiratory failure" and was "actively dying". Her care plan was to send Mr. F to the hospital to relieve his respiratory distress. She wrote a referral letter to MRHP however, she recorded that she wanted to speak with the Palliative CNS prior to sending him. Doctor C instructed the nursing staff to give Mr. F medication, namely Buscopan¹². PHMS records that a LTOT¹³ machine was used to provide Mr. F with supplementary oxygen at this time.
- 11.7 At 13:19, Nurse G recorded that he left a message with Palliative CNS A regarding the deterioration in Mr. F's health. Doctor C added that she received a call from Palliative CNS A and requested that she attend the prison to help put Mr. F on a syringe driver¹⁴. Palliative CNS A and Doctor C discussed the appropriate medication required, all of which needed to be ordered from the pharmacy with an arrival time of 19:00 that same day. Palliative CNS A informed Doctor C that she would attend the prison and bring medication with her. Doctor C recorded that she was advised by Palliative CNS A to give Mr. F a further dose of Buscopan, prior to her arrival, which Nurse G confirmed he administered at 15:00.
- 11.8 Chaplain A recalled contacting Mr. F's NoK, upon hearing the news, to facilitate a visit, but could not reach her by telephone. Chaplain A stated that he then went to visit Mr. F and said prayers over him and anointed him. Chaplain A recalled that following his visit to Mr. F, he again attempted to call Mr. F's NoK but with no success.
- 11.9 Nurse G recorded on PHMS that it was at approximately 15:30 when Mr. F's condition deteriorated further and he notified Doctor C. HCA C stated that she was with Mr. F at this time and remained with him. Nurse G recorded that it was at approximately 15:40 when Mr. F's breathing ceased and he had no palpable pulse. Doctor C's entry on PHMS confirmed that she was advised, by the nursing staff, that Mr. F's breathing had ceased at 15:40 and she attended his cell at 15:46.
- 11.10 Following an examination of Mr. F, Doctor C confirmed the absence of breathing, the absence of a pulse, and the absence of heartbeats. She noted that rigor mortis¹⁵ was not present but there was evidence of the inception of livor mortis¹⁶ to Mr. F's right elbow. Doctor C pronounced the time of death at 15:48.

¹² Buscopan is the brand name for Hyoscine Butylbromide which can be used to treat patients with lung secretions

¹³ LTOT stands for Long-term oxygen therapy that is provided by a machine which filters oxygen from the air through a small tube fitted to a patient's nose.

¹⁴ A syringe driver is used to allow the flow of medications to be delivered to a patient through a tube or needle just under their skin.

¹⁵ Rigor Mortis refers to the stiffening of limbs, which occurs following death.

¹⁶ Livor Mortis occurs following death and is a discoloration of the skin.

- 11.11 At approximately 15.55, Chaplain A stated that he was informed by a member of the medical team that Mr. F had passed away. He then telephoned Mr. F's NoK and informed her that her uncle had passed away.
- 11.12 Mr. F's cell was master locked and the IPS initiated their Death in Custody protocols including notifying AGS that Mr. F had passed away. AGS are recorded as having attended the prison at 16:24.

12. Critical Incident Review Meeting

- 12.1 On 15 March 2023, a Critical Incident Review Meeting¹⁷ was held with the following prison staff in attendance: Governor B, Governor C, Governor D and Governor E, Chief A and Prison Clerical Officer (PCO) A.
- 12.2 By way of an introduction, the meeting heard a brief overview of Mr. F's personal circumstances; including his sentence, and that he had been receiving palliative care in the prison. Details regarding staff activity at the time Mr. F passed away were noted as was the protocol that was followed.
- 12.3 There were no recommendations recorded at the conclusion of the meeting.

13. Internal Review Report

- 13.1 The investigation team were informed of the internal IPS review findings report compiled by Governor F, dated 16 March 2023. The report outlines the circumstances surrounding Mr. F's death and describes the care that Mr. F received at the Midlands Prison as "*exemplary*".
- 13.2 The main concern identified by Governor F was at the point of Mr. F's committal. Governor F described the lack of clinical handover as "*fragmented*" and confirmed the matter had been escalated to prevent reoccurrence.
- 13.3 The only recommendation made by Governor F was to seek to expedite the planned development of the 'end-of-life' suite at the Midlands Prison.
- 13.4 In conclusion, Governor F offered condolences, on behalf of the prison, to Mr. F's family and friends.

14. Recommendations

- 14.1 The investigation established that Mr. F received excellent care from the prison healthcare team during his time at the Midlands Prison and this is commended.

¹⁷ 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.

- 14.2 Nonetheless, it is highly questionable why a man in Mr F's condition should have to reach the end of his life in prison, rather than in a palliative care setting in a hospital or hospice. The OIP's concerns about cases such as this have led it to embark on an announced thematic inspection of the treatment of older persons in the custody of the IPS. At the time of writing, that inspection remains suspended due to cooperation shortcomings experienced in the Midlands Prison and one other establishment. Due to the evident gravity of the interests at stake, the Chief Inspector of Prisons trusts that the necessary steps will be taken by the IPS to enable that inspection to resume and to reach systemic conclusions.
- 14.3 In cases involving persons entering prison with serious health needs, particularly those nearing the end of life, there must be much better coordination between AGS, the Courts Services and HSE to ensure appropriate care. Mr. F's case is an instance of an elderly and ill man being transferred from a nursing home to prison without advance warning. This highlights a critical gap in planning. The IPS only became aware that Mr. F was in a nursing home immediately prior to his incarceration due to labelling on his prescription medication.
- 14.4 The OIP acknowledges the efforts of both Governor A and the CNO A in highlighting learning from the circumstances of Mr. F's committal and escalating this to senior management in the IPS to prevent future harm from occurring.
- 14.5 **The OIP makes the following recommendation:**
1. The IPS should engage with AGS, the Courts Services and HSE, with a view to implementing a mandatory advance notification system to inform prisons where they are likely to receive individuals with serious medical needs, ensuring proper care arrangements are in place before arrival.

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.