



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. R
Mountjoy Prison
26 October 2023
Aged 51

To the Minister: 31 July 2026

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GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
CCTV	Closed Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DFB	Dublin Fire Brigade
IPS	Irish Prison Service
NAS	National Ambulance Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
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 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 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 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. R's death in prison on 26 October 2023 and management of the events associated with his death.

4. Administration of Investigation

- 4.1 On 26 October 2023, the OIP was notified by email that Mr. R had passed away in Mountjoy Prison. The investigation team attended the prison on 26 October 2023 and met prison management who provided an overview of Mr. R's time in prison. The investigation team also met with persons who had contact with Mr. R during his time in prison.
- 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 contacted Mr. R's NoK (his sister) by letter on 7 November 2023 and met with her and Mr. R's son, daughter and sister on the 21 November 2023. The family asked a number of questions, which are contained **Section 12** of this report.
- 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. R's family in mind.
- 5.4 The OIP is grateful to Mr. R's family for their contribution to this investigation and we offer our sincere condolences on his loss.

INVESTIGATION

6. Mountjoy Prison

- 6.1 Mountjoy Prison is a closed, medium security prison for adult men. It is the main committal prison for Dublin city and county. At the time of Mr. R's passing, it had an operational capacity of 755 with 755 people in custody. As such, it was at 100% capacity.
- 6.2 At the time of his death, Mr. R's was the fifth death of a prisoner from Mountjoy Prison in 2023; and the eighteenth death in IPS custody that year.

7. Family Concerns

- 7.1 The NoK stated that they believed Mr. R's mental health deteriorated after his transfer from Midlands Prison to Mountjoy Prison. The family further stated that the lack of routine and meaningful work in Mountjoy Prison had a negative impact on Mr. R, noting that he had regular work while he was in the Midlands Prison.
- 7.2 The family informed the investigation team that Mr. R had been transferred from the Midlands Prison to the Progression Unit, in Mountjoy Prison, to complete an educational course in order to meet his Parole Board recommendations. According to the family, the course was not available to Mr. R when he transferred to the Progression Unit. Mountjoy Prison informed the investigation team that there was no record of Mr. R either applying for or declining any educational course.
- 7.3 The family informed the investigation team that they visited Mr. R every two weeks while he was in Midlands Prison. However, following his transfer to Mountjoy Prison, the regularity of their visits diminished as they found it difficult due to the increased travel distance and associated obstacles.

8. Background

- 8.1 Mr. R was 51 years old when he passed away in Mountjoy Prison on 26 October 2023.
- 8.2 Mr. R was remanded to Limerick Prison on the 23 March 2003. On 20 December 2003, he was sentenced to life imprisonment and transferred to Mountjoy Prison. Mr. R was moved between multiple prisons during his time in custody. Mr. R was last transferred into the Midlands Prison on 29 December 2022 and then to Mountjoy Prison on 21 January 2023. Mr. R was transferred to the Progression Unit, in Mountjoy Prison, on 3 April 2023.
- 8.3 At that time, the Progression Unit had a less restricted regime than that of the main prison. Those accommodated in the Progression Unit gave a commitment to remain drug free and abstain from illicit substance use, non-prescribed medication, alcohol and other intoxicating substances. A breach of that commitment could have resulted in a prisoner being transferred back to the main prison.

- 8.4 Mr. R was the subject of a P19¹ disciplinary report on 16 October 2023. The report summarised his misconduct as “*misuse of drugs and controlled substance*”. This P19 report resulted in Mr. R’s transfer out of the Progression Unit to the C wing of Mountjoy’s main prison on 18 October 2023; and then to the D3 landing on 19 October 2023.
- 8.5 At the time of his death, Mr. R was accommodated in cell 25, a single occupancy cell, on the D3 landing of Mountjoy Prison.
- 8.6 Mr. R maintained regular phone contact and received some visits from his family. His most recent recorded visit was on 17 October 2023, following earlier visits on 12 October and 5 October 2023. A visit with his daughter had been scheduled for 26 October 2023.

9. Medical Care

- 9.1 On 24 January 2023, Nurse A recorded in the Prison Healthcare Management System (PHMS) that Mr. R attended a medical/nurse’s committal interview. Nurse A noted that Mr. R denied any past medical, surgical, psychiatric, or self-harm related concerns. Nurse A recorded that Mr. R was “*allergic to penicillin*” and that he was to be reviewed by the doctor the following morning.
- 9.2 On 25 January 2023, Doctor A recorded a review of Mr. R and noted that there were “*no new medical problems, reminded of all services*”. That same day, Psychiatric Nurse A recorded in the PHMS that Mr. R was referred to the mental health prison in reach team “*through a system generated referral*”. Psychiatric Nurse A noted that there was “*no clear indication for mental health assessment at this time*” but that a further referral could be generated if required in the future.
- 9.3 On 3 April 2023, Nurse B recorded that Mr. R had been administered paracetamol for a headache. The following day, 4 April 2023, Nurse B made another entry noting that Mr. R had again requested paracetamol and was attending every medication round requesting the same. She recorded that Mr. R continued to complain of headaches and that she advised him of the risks associated with excessive paracetamol use. Nurse B noted that Mr. R “*will need to be reviewed by the GP*” and that he was unhappy when informed of this. The investigation reviewed Mr. R’s PHMS records and found no documentation indicating that the GP reviewed his paracetamol use.
- 9.4 On 25 May 2023, Nurse B noted that Mr. R was administered Brufen² for dental pain. On 29 May 2023, Nurse A recorded that Mr. R was administered paracetamol for reported headaches.
- 9.5 On 12 August 2023, Nurse B documented that Mr. R requested and was given paracetamol for a headache. On 22 August 2023, Nurse B recorded that Mr. R requested paracetamol for dental pain, but it was not noted whether the medication was administered.
- 9.6 On 14 September 2023, Nurse B recorded that Mr. R again requested paracetamol for a headache. PHMS notes do not confirm if this was administered.

¹ The P19 system refers to the disciplinary system in place under the Prison Act 2007. A breach of prison discipline generates a P19 report, which allows Governors to impose sanctions, such as a loss of privileges, e.g. loss of phone calls.

² Medication to relieve the symptoms of pain and inflammation.

10. Events of 25 and 26 October 2023

- 10.1 On 25 October 2023 at 19:00, Officer A was detailed as a night guard³ with responsibility for the C3 and D3 landings. At 19:00, he was redeployed on escort duty and handed over responsibility for the D3 landing to Officer B. The investigation team reviewed CCTV as part of their investigation and observed that four cell checks were conducted between the locking of the cell at 19:04:42 and 23:47:36. These checks were at 19:15:14, 19:39:14, 21:26:35, and 23:47:36.
- 10.2 Officer A returned to the prison at 23:20 and took back charge of the C3 and D3 landings from Officer B. Officer A reported that he conducted a full cell check of D3 at 23:40 and he was observed, on CCTV, checking cell 25 at 23:47:36.
- 10.3 While conducting this cell check (cell 25), Officer A observed that Mr. R was not in his bed. Officer A recorded that, *"My vision of him wasn't clear. I wasn't satisfied with my view of him and wanted to further check on him"*. The investigation team reviewed CCTV and observed Officer A lifting the panel over the viewing hatch and kicking the cell door during this cell check.
- 10.4 Officer A reported that he contacted Assistant Chief Officer A (ACO) by radio and requested to meet with him to secure access to a master key. Only an ACO has access to the master key of the cells during a night shift.
- 10.5 Officer A stated he asked Officer C to request medical assistance to attend the cell while he went to meet with ACO A, who issued him with a master key to unlock the cell. The investigation team reviewed CCTV and observed that cell entry was made at 23:54:36. This was seven minutes after Officer A was observed kicking the cell door.
- 10.6 When the cell door was opened, Mr. R was observed lying on his back close to the door. ACO A further recorded that upon entry it was Nurse B who commenced CPR⁴.
- 10.7 On 26 October 2023, Nurse B recorded in the PHMS that on entering the cell she noted that Mr. R was unresponsive, that he was not breathing, with no pulse present; his pupils were fixed and non-responsive. However, he was warm to touch with no evidence of pooling⁵. Nurse B immediately commenced CPR and emergency services were called. Nurse B noted that the AED⁶ was attached, which provided a *"no shock advised"*⁷ message for the entire time that Nurse B continued to deliver CPR.
- 10.8 On 26 October 2023 at 00:06, Dublin Fire Brigade (DFB) paramedics arrived on the scene and assumed control of the medical emergency, including the application of CPR. At 00:13, National Ambulance Service (NAS) personnel arrived and a Lucas Automated Chest Compressor⁸ was passed into the cell. During this time, NAS and DFB personnel remained in the cell with Mr. R.

³ A prison officer on night duty.

⁴ An emergency procedure consisting of chest compressions.

⁵ Pooling or Livor mortis (also called hypostasis) is the pooling of the blood in the body due to gravity and the lack of blood circulation as a result of the cessation of cardiac activity. These factors cause the blood to pool in the lowest points of the body, giving the skin a purplish-red discoloration.

⁶ Automated External Defibrillator

⁷ A no shock message from the AED can mean that the person has a pulse, regained a pulse, or the victim is pulseless but is not in a shockable rhythm.

⁸ Mechanical chest compression device.

- 10.9 On 26 October 2023 at 00:40:38, NAS and DFB personnel were observed on CCTV leaving Mr. R's cell. Records examined by the investigation team note that Mr. R was pronounced dead at 00:30 by Advanced Paramedic A.
- 10.10 On 26 October 2023 at 00:48:27, cell 25 was master locked and Officer D was posted at the cell door entrance to monitor and record the details of any official person who arrived to view the cell.

11. Critical Incident Review Meeting

- 11.1 On 31 October 2023, a Critical Incident Review Meeting⁹ (CIRM) was chaired by Governor A. Also in attendance were Assistant Governor A, Chief A, ACO A, ACO B, Chief Nurse Officer (CNO) A, Nurse B, Chaplain A, Acting Senior Psychologist A, Clerical Officer A and Executive Officer A.
- 11.2 Governor A extended his condolences to the family of Mr. R and provided a summary of the events surrounding his death. The summary recorded that Assistant Governor B attended the prison on 26 October 2023 at 01:30 and contacted Chaplain A. He also contacted Garda A of An Garda Síochána Limerick, requesting they notify the NoK.
- 11.3 Chaplain A stated that she attended the prison and contacted Mr. R's NoK, who reported they were already aware of Mr. R's passing.
- 11.4 ACO A outlined the events of the night in question and stated that he conducted a full search of Mr. R's cell, to identify if there was any contraband present which might have assisted with the delivery of medical assistance. ACO A noted that there were no obvious signs of contraband present.
- 11.5 Nurse B described how extremely difficult it was for one staff member to deliver CPR over a prolonged period and noted that an extra nurse on nights would be helpful in dealing with such emergencies. CNO A agreed with Nurse B's assessment and supported the request for another nurse for night duty.
- 11.6 Acting Senior Psychologist A stated that the Psychology Service would offer support to all affected by this incident. Chief A was appointed to liaise with the OIP and to submit the required documentation.
- 11.7 Governor A noted that he contacted the Samaritans and the Visiting Committee¹⁰ and arranged for the prison listener¹¹ volunteers to provide support to the prison community.
- 11.8 Two recommendations were recorded at the conclusion of the CIRM:
1. A rota for chaplains to be identified.
 2. Extra nursing staff at night.
- 11.9 The investigation team enquired about the status of these recommendations. Chief A provided this update:
1. There has been a rota put in place for the chaplains and the governor and chiefs are informed on a weekly basis.

⁹ 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.

¹⁰ A committee whose function is to visit a specific prison at frequent intervals.

¹¹ Prisoners who are trained to provide emotional support to their peers.

2. There has been no change in this regard as it is a national workforce planning issue needing a complete nursing task review.

12. Family Questions

12.1 The NoK asked the investigation team the following two questions:

1. Why was Mr. R moved to a holding cell after he was told he was being moved back to Midlands Prison?

OIP Response: On 18 October 2023, Mr. R was moved from the C1 West landing in the Progression Unit to a committal cell on the C landing. The Investigation team was informed that this move was due to Mr. R breaching a prison rule and he was subject to a disciplinary process. This is a normal procedure for a breach of prison rules. As Mr. R was a new committal to Mountjoy Prison, he was met by a Governor B on 19 October 2023 and transferred to the D3 landing on the same date. Mr. R had requested a transfer to the Midlands Prison and at his meeting with Governor A, he was assured that his breach of the prison rules would not interfere with his request to transfer back to the Midlands Prison. His application to do this was submitted on 18 October 2023 to Chief B and this was approved on the same date. The delay in moving Mr. R to the Midlands Prison was due to staffing the transfer and a place becoming available in the Midlands Prison.

2. How did Mr. R die and were cell checks completed?

OIP Response: The cause of death is a matter for the Coroner. The investigation team reviewed the CCTV footage and between 19:04:42 (time of lockdown) and 23:47:36 on 25 October 2023, four cell checks were carried out on Mr. R's cell. This is in accordance with the policy in force at the time.

13. Recommendations

13.1 The Office of the Inspector of Prisons makes the following three recommendations:

1. On 4 April 2023, Nurse B submitted an entry into the PHMS, recording that Mr. R had again requested paracetamol and noted her concern that Mr. R attended every drug round, requesting paracetamol. Nurse B entered that Mr. R "will need to reviewed by the GP" because of this. The OIP recommends that where a member of nursing staff highlights concern over the repeated requests and potential over-use of prescription medication, a clinical review of that prisoner is conducted by a doctor before any such medication is further provided.
2. The OIP can only agree with the views expressed by Nurse B and CNO A at the CIRM, regarding the difficulty of one nurse providing CPR (chest compressions) for a prolonged period.
3. On the night Mr. R died, there were 755 prisoners in custody. Given that the IPS continues to refuse to provide CPR training to all prisoner officers (as repeatedly recommended by the Inspectorate), it was unacceptable that only one nurse was on duty to provide a medical emergency response for 755 prisoners.

In the period since Mr R's death, the population of Mountjoy Prison has mushroomed to well over 1,000 people. However, during the Inspectorate's 2025 follow-up inspection of Mountjoy Prison, there was *still* only one nurse on duty at night. The OIP reiterates the recommendation [MJ22-12] in the report on its follow-up inspection that a second nurse be made available in Mountjoy Prison at night.

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.