Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. C
In the Mater Misericordiae Hospital while in the Custody of
Arbour Hill Prison on
25 January 2025
Aged 76

To the Minister: 5 October 2026

CONTENTS

GLOSSARY **3**

INTRODUCTION **4**

1. Preface 4
2. Objectives 4
3. Methodology 4
4. Administration of Investigation 5
5. Family Liaison 5

INVESTIGATION **6**

6. Arbour Hill Prison 6
7. Family Concerns 6
8. Background 6
9. Events of 24 to 25 January 2025 6
10. CCTV 7
11. Medical Care 8
12. Critical Incident Review Meeting 8
13. Recommendations 9
14. Support Organisations 9

GLOSSARY

ACO	Assistant Chief Officer
AGS	An Garda Síochána
CNO	Chief Nurse Officer
COPD	Chronic Obstructive Pulmonary Disease
DFB	Dublin Fire Brigade
DiC	Death in Custody
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
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 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. C's death in hospital on 25 January 2025 and management of the events associated with his death.

4. Administration of Investigation

4.1 On 25 January 2025, the OIP was notified that Mr. C had passed away in the Mater Hospital, Dublin while in the custody of Arbour Hill Prison. The investigation team attended the prison on 26 January 2025 and met prison management who provided an overview of Mr. C's time in prison. Inspectors also met with persons who had contact with Mr. C 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 communicated with Mr. C's, NoK, (his sister) by letter on 4 July 2025. The NoK responded in writing on 7 July stating that they had no concerns or questions about Mr. C's time in Arbour Hill Prison. They also informed the OIP that they did not wish to have a meeting with the investigation team and added that Mr. C *"was content and happy to serve his time in Arbour Hill prison."* Mr. C's sister went on to inform the OIP that her brother was *"treated with great care and kindness, which meant a lot to me."* The NoK concluded the correspondence by adding, *"[Mr. C] had great praise for everyone, all the probation workers, and the chaplains who dealt with him over the years and in the latter particularly Fr. A and Sister B and many more…."*

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. C's NoK in mind.

5.4 The OIP is grateful to Mr. C's sister for her contribution to this investigation and we offer our sincere condolences on the loss of her brother.

INVESTIGATION

6. Arbour Hill Prison

6.1 Arbour Hill Prison is a closed, medium security prison for adult men. The prisoner profile is largely made up of long-term sentenced prisoners. In January 2025 it had an operational capacity of 137 beds. At the time of Mr. C's passing there were 135 occupied beds, representing 99% of capacity.

6.2 Mr. C was the first death of a prisoner from Arbour Hill Prison in 2025 and the third death in IPS custody that year.

7. Family Concerns

7.1 As already mentioned, the family of Mr. C had no concerns or questions regarding Mr. C's time in the custody of Arbour Hill Prison.

8. Background

8.1 Mr. C was a 76 year old man from the Leinster area. He was serving a life sentence having been committed to prison on 31 October 2002.

8.2 Chief A provided additional background information on Mr. C to the investigation team. Chief A confirmed that he had known Mr. C for nine years in the prison and in that time had witnessed Mr. C's health declining gradually. He reported that Mr. C had been a "great worker" but due to his ill-health had retired approximately three years ago.

8.3 Mr. C was accommodated in cell 1 on E1 landing in an adapted single cell with an in-cell shower. E1 is also a smoke free landing and was therefore safer for Mr. C given that he had Chronic Obstructive Pulmonary Disease (COPD) and needed oxygen tanks and an oxygen concentrator. Mr. C was estranged from most of his family and had no recent visits. A number of years ago one of his daughters had visited him regularly over a short period but these visits were discontinued. He had daily phone calls with his sister and a friend.

9. Events of 24 to 25 January 2025

9.1 At approximately 03:00 on 24 January 2025, Mr. C was found to be unwell and in respiratory distress in his cell. Although Mr. C had been provided with a personal call bell, staff were alerted to his deteriorating medical condition as a result of routine checks (the frequency of which were reported to be more regular than is standard in other prisons). Nurse A responded quickly and remained with Mr. C as they tried to stabilise him. Despite their efforts from 03:00 onwards, the nurse was unable to stabilise Mr. C sufficiently, and at 05:00 Nurse A realised that Mr. C was *"experiencing end of life symptoms."* At 06:15, Nurse B approached Chief A (who had reported for duty at 05:49) to notify him of the situation and to request an emergency discharge of Mr. C to Accident & Emergency[1]. Chief A agreed with the proposed

course of action and at 06:18 he called for an ambulance to attend the prison.

9.2 A Dublin Fire Brigade (DFB) ambulance was called at 06:18 and attended the prison at 06:40. The ambulance brought Mr. C to the nearby Mater Hospital, leaving the prison at 07:00. His sister was informed shortly afterwards that Mr. C was in hospital. The hospital provided regular updates to Arbour Hill Prison and reported that his condition was deteriorating.

9.3 On 25 January 2025, Chief A attended the Mater Hospital to check on officers there and to get an update on the current medical condition of Mr. C. Chief A briefly spoke with Mr. C's family before departing. Mr. C's sister attended along with one of his children and remained by his side until he died at approximately 14:00 on Saturday, 25 January.

9.4 Although the IPS and Mr. C were aware that his life expectancy was short, the investigation team was informed that no application had been made for Compassionate Temporary Release (CTR) for Mr. C.

10. CCTV

10.1 As part of the investigation, CCTV footage from various locations around Arbour Hill Prison was reviewed by the OIP investigation team. The times recorded are taken from the CCTV displayed clock. The relevant timeframe spans the period 02:57:25 on 24 January 2025 when officers first attended Mr. C's cell until 07:00:00 that morning when the Dublin Fire Brigade ambulance left the Prison via the main gate. The CCTV footage viewed by the investigation team corroborates the timeline and accounts provided by the IPS.

10.2 At 02:57:25, an officer arrives at Mr. C's cell, proceeds to check all the cells and presses a button on the wall beside each cell as she checks each cell. A few seconds later, at 03:02:20, two officers, one believed to be a nurse, attend Mr. C's cell and one enters the cell while her colleague stands outside. At 03:08:05, one officer emerges from the cell and confers with her colleague before walking out of sight of the camera leaving the landing. The second officer remains opposite outside the cell.

10.3 At 05:16:55, nursing staff attend the cell with a red medical bag and a nurse enters the cell. A Dublin Fire Brigade (DFB) ambulance arrives at the front gate of the prison at 06:36:00 and drives inside. At 06:39:00 DFB paramedics attend Mr. C's cell. Mr. C can be seen being brought out of his cell at 06:53:00 by paramedics, placed in a wheelchair and wheeled off. Mr. C then comes into view of the Circle[2] camera - he is wearing an oxygen mask and seems alert and conscious. One minute later at 06:54:00 Mr. C is moved out of the prison building in a wheelchair and placed (still in the wheelchair) into the rear of an ambulance. The DFB ambulance reverses out at the Front Gate and leaves the prison at 07:00.

[1] It was noted in the CIRM minutes that the staff had to coax Mr. C into agreeing to go to hospital, thus accounting for the delay between 05:00 and the nurse requesting the emergency discharge at 06:15.
[2] The "Circle" is a central hub from which wings of prison cells radiate, allowing a single prison officer to monitor multiple areas.

11. Medical Care

11.1 A report (undated) was submitted after Mr. C's death by Chief Nurse Officer (CNO) A. The report was included as part of the IPS Death in Custody documentation and set out Mr. C's relevant medical history in summary form. The CNO noted that Mr. C was 76 years old at the time of his death and had been in prison since 2002. It was further stated in the report that Mr. C suffered from *"stage 4 chronic obstructive pulmonary disease, urology and heart complications [….] [Mr. C] was oxygen dependent with increasing care needs in the latter 6 months of his life."* While in Arbour Hill Prison, Mr. C was under the care of a number of consultants in the Mater Hospital, and his medical condition resulted in two or more admissions to hospital each year due to *"acute exacerbations of disease."* As recently as 13 January 2025, Mr. C had been an in-patient at the Mater Hospital for four days requiring *"investigations and stabilisation."*

11.2 The extensive clinical records examined by the investigation team indicate that Mr. C was relatively stable up until the final few months of his life. He was receiving oxygen therapy and various medications for his clinical conditions but was noted by healthcare staff to be in good form overall.

11.3 According to the clinical notes supplied to the investigation team the last time Mr. C was seen by a prison doctor (Doctor A) was on 22 January 2025. On that occasion Doctor A noted nothing of major concern or urgency, recording that, although Mr. C had the symptoms of cold or flu, his vital signs were within the normal level. The outcome of the medical assessment was for Mr. C to be monitored and reviewed and medication to be taken as needed.

11.4 In the early hours of 24 January 2025 Mr. C's health took a serious turn for the worse and he began to experience respiratory distress to the point that an ambulance was called at 06:18 and Mr. C was brought to the Mater Hospital where, as detailed above, he subsequently died on 25 January 2025.

11.5 It is clear from the OIP's investigation that in the period leading up to his death Mr. C was extremely ill with a number of chronic, life-debilitating medical conditions. The records show that Mr. C received a level of healthcare within the prison (and as an outpatient) that was appropriate given his various illnesses and he was treated compassionately by the staff (healthcare and operational) of Arbour Hill Prison. The kitchen staff assisted the healthcare team by preparing specific nutritional items of food for Mr. C as and when requested. From 23 September 2024 onwards Mr. C was prescribed Augmentin antibiotic for a urinary tract infection in addition to his existing daily paracetamol pain relief medication.

12. Critical Incident Review Meeting

12.1 On 30 January 2025 a critical incident review meeting[3] was held by Governor A and Assistant Governor A. In attendance were Chief A, Chief B, CNO A, Assistant Chief Officer (ACO) A, ACO B, Nurse A, Senior Probation Officer A, Chaplain A and Prison Clerical Officer A.

[3] 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.

12.2 Governor A offered condolences on the passing of Mr. C and commended the relevant staff for their hard work, diligence and compassion during the time leading up to, and after, the death of Mr. C in the Mater Hospital.

12.3 Assistant Governor A reiterated the Governor's praise of the staff and suggested that consideration be given to holding a small religious service in the prison in memory of Mr. C. This would be beneficial to Mr. C's friends in Arbour Hill. Supports for Mr. C's fellow prisoners were also discussed at the meeting, including the Listener service and the involvement of the Red Cross.

12.4 ACO B reminded the meeting that supports were also available to the staff who might have been affected by death of Mr. C.

12.5 The following recommendations or actions were recorded at the conclusion of the critical incident review meeting:

- "Possibility of issuing life alert devices to frail/limited mobility prisoners."
- "Possibility of SOPs [Standard Operating Procedures] being attached to hospital log books."
- "Procedures re: phone numbers available to officers on hospital duty to be discussed by Chiefs and ACOs."

13. Recommendations

13.1 The Inspectorate of Prisons makes no recommendations.

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.