Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. B

In the Mater Misericordiae University Hospital while in the custody of Mountjoy Prison

5 January 2022

[Submitted to Minister on 30 July 2024]

CONTENTS

GLOSSARY

A&E	Accident and Emergency
BPM	Beats Per Minute
CCTV	Closed Circuit Television
DiC	Death in Custody
ICU	Intensive Care Unit
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
PO	Prison Officer

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 Irish Prison Service;
- 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 has an opportunity to raise any concerns they may have, and take these into account in the investigation;
- Assist the Coroner's investigation and help to fulfil the obligations of the State 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. B during his time in prison.

4. Administration of Investigation

4.1 On 5 January 2022, the OIP was notified that Mr. B had passed away in the Mater Misericordiae University Hospital. Mr. B had been transferred to hospital from Mountjoy Prison on 4 January 2022.

4.2 Mountjoy Prison Senior Management provided the OIP with all relevant information in accordance with the standardised checklist of 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 Inspectorate of Prisons role when investigating a death in custody.

5.2 The recorded NoK was Mr. B's estranged wife, who had predeceased him. The IPS provided the OIP with contact details for Mr. B's two sisters, one of whom, NoK A, engaged with the OIP. However, Inspectors became aware through documentation provided by the IPS that Mr. B had children and that his son NoK B had attended the Mater Hospital on 5 January 2022 at the time of his father's passing. The records showed that, on 7 January 2022, Mr. B's son met with both Assistant Governor A and Prison Doctor A in relation to his father's death. On 11 May 2022, the OIP received contact details for NoK B from the IPS.

5.3 An Inspector spoke with NoK B over the telephone on 19 May 2022 and Inspectors met NoK B in-person on 10 June 2022. During this meeting he raised a number of concerns regarding the care provided to his father during his time in custody. These questions and concerns are addressed in **section 7**.

INVESTIGATION

6. Mountjoy Prison

6.1 Mountjoy Prison is a closed, medium security prison for adult males. It is the main committal prison for Dublin city and county. It has an operational capacity of 755 beds.

6.2 Mr. B was the second death of a prisoner from Mountjoy Prison in 2022 and, at the time of his death, the second death in IPS custody that year.

7. Family Concerns

7.1 Mr. B's son stated that, during his meeting with Doctor A on 7 January 2022, the doctor was visibly upset and that she had apologised for the treatment afforded to his father while in prison. Doctor A has since left the employment of the IPS and the OIP was not able to meet with her. Mr. B's son asked the following questions and raised some concerns.

A. My father made a number of phone calls to family members complaining that he had a swollen/infected leg that required medical treatment, did he receive any treatment?
The healthcare provided to Mr. B is outlined in section 9 of this report.

B. Why did Mr. B not receive medical treatment at an earlier stage?

Details of the healthcare provided to Mr. B are outlined in section 9 of this report.

C. Why was my father transferred to hospital?

The referral and removal to hospital of Mr. B on 4 January 2022 is set out in section 11 of this report.

D. Was my father transferred to hospital in a prison van?

On 18 December 2021, Mr. B was transferred to hospital in an IPS van. On 4 January 2022, Mr. B was transferred via ambulance.

E. What treatment did my father receive on 18 December 2021?
Details of Mr. B's examination by the prison doctor and referral to hospital is outlined in section 9.3. Mr. B was returned to the prison before he was seen by the hospital medical team – details are provided in section 9.4.

8. Background

8.1 Mr. B was a 47 year old man from the Leinster region who was serving a life sentence imposed on him on 7 May 2021, which was backdated to 20 July 2019, when he first entered custody. Mr. B passed away in the Mater Misericordiae University Hospital on 5 January 2022.

8.2 Mr. B was accommodated in a single occupancy cell, cell 8 on the A2 landing. Mr. B was on the enhanced level of the Incentivised Regime[1] while in Mountjoy Prison.

8.3 Mr. B was a protection prisoner under Rule 63[2] of the Irish Prison Rules. Records examined showed that Mr. B was on protection at his own request, citing an ongoing feud with other persons in the custody of Mountjoy Prison.

8.4 Due to COVID-19 restrictions in place at the time, Mr. B had no in-person family visits during the time leading up to his passing. However, he had daily phone contact with his family.

9. Healthcare Provision

9.1 Mr. B was on a methadone treatment plan throughout this time in custody. On 6 December 2021, Mr. B was placed on a waiting list for an Addiction Counsellor by Nurse Officer A.

9.2 On 8 December 2021, Nurse Officer B recorded on the Prisoner Healthcare Management System (PHMS) that Mr. B reported that the pain in his left knee had increased. Mr. B informed the nurse that he was unable to manage stairs to retrieve his meals without the assistance of other prisoners and officers. On 9 December 2021, Mr. B was referred to an orthopedic consultant.

9.3 On the morning of 18 December 2021, Doctor B reviewed Mr. B in his cell and recorded that Mr. B had a swollen left leg. The doctor noted that the skin was dark in colour, painful and causing discomfort. Doctor B referred Mr. B to the Emergency Department at the Mater Misericordiae University Hospital for deep vein thrombosis investigation. Mr. B departed Mountjoy Prison in an IPS van under prison officer escort to the hospital shortly afterwards.

9.4 At 03:30 on 19 December 2021 it was recorded on PHMS that Mr. B returned from hospital without receiving treatment. A treatment refusal form had been signed by Mr. B. In a phone call with his sister later on 19 December 2021 Mr. B stated that he asked to return to the prison as he had waited for 14 hours in A&E and had not been treated. Mr. B's attendance at the hospital Emergency Department is referenced in section 10.3.

9.5 On 20 December 2021, Mr. B was identified as a COVID-19 close contact. Mr. B was placed in quarantine under Rule 103 of the Prison Rules which was in accordance with the IPS algorithm in place at the time. The IPS algorithm "*IPS Risk Assessment for People Presenting to and in Prisons - Clinical Criteria for Prisoner(s) to be Tested*" outlined the criteria to be followed. Where a prisoner was identified as a close contact of a confirmed Covid case they were immediately

[1] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.
[2] A prisoner may, either at his own request or when the Governor considers it necessary be kept separate from other prisoners who are reasonably likely to cause significant harm to him.

placed in isolation and testing was arranged by the healthcare team. If a prisoner received a negative result from the swab test, isolation was stopped once a prisoner had been asymptomatic for a specific period of time. While in quarantine Mr. B was reviewed daily by the nurses. On the morning of 22 December 2021, Mr. B's test results were negative for COVID-19, he was asymptomatic and was removed from quarantine.

9.6 At approximately 08:30 on 1 January 2022, an Officer reported to Pharmacist A that while unlocking cells on the A wing he heard Mr. B vomiting in his cell. At the critical incident meeting following the passing of Mr. B, Chief Officer A reported that an Officer viewed vomit on Mr. B's cell floor. It was recorded on the PHMS that Pharmacist A emailed healthcare staff and requested that a doctor review Mr. B. Pharmacist A reported that at approximately 10:30 he checked on Mr. B in his cell. Mr. B reported feeling better and the pharmacist recorded that Mr. B was lucid and coherent. Pharmacist A dispensed Mr. B his full dose of methadone. At 11:14 Nurse Officer C recorded on the PHMS that Mr. B had a 40.1ºC temperature, 97 BPM heart rate and blood pressure of 133/62mmHg. Mr. B was then PCR[3] tested for COVID-19. Mr. B was again placed in quarantine awaiting the PCR result.

9.7 At 11:45 on 1 January 2022, Nurse Officer C reviewed Mr. B in his cell. Mr. B's temperature was recorded as 37.2 ºC. Mr. B was antigen tested which returned a negative result for COVID-19.

9.8 In the afternoon of 1 January 2022, Nurse Officer C recorded on PHMS that Mr. B was again reviewed in his cell. Mr. B informed Nurse Officer C that he was feeling better. His temperature was recorded as 36.4ºC.

9.9 On 2 January 2022, during medication rounds, Pharmacist B noted that Mr. B was still awaiting PCR results. It was also noted that his temperature had been taken by Nurse Officer C and it was recorded as normal and that Mr. B informed the nurses that he was feeling better.

9.10 On 3 January 2022, following a negative PCR test result, Mr. B was removed from quarantine and collected his daily methadone from the dispensing hatch on the A1 landing. Pharmacist B described Mr. B as being in a "*jovial mood*".

10. Prisoner Phone calls

10.1 The OIP reviewed 14 of Mr. B's phone calls dating from 11 December 2021 to 31 December 2021. Mr. B's phone calls were mainly to his two sisters with one call to his mother. He regularly enquired about the health of his mother and his children. He also spoke about his own poor health.

10.2 On 18 December 2021, Mr. B called his sister NoK A. During this conversation he stated "*my two legs are swollen to fuck*" and that he was in pain. He also told his sister that the IPS wouldn't bring him to hospital. Mr. B stated that he was waiting on an appointment at St James's Hospital. He explained that he could not take painkillers due to a long standing liver condition.

10.3 On 19 December 2021, Mr. B informed his sister NoK C that he still had pain in his legs. Mr. B stated he was taken to A&E and waited for 14 hours without being seen and asked to return to prison.

[3] Polymerase chain reaction.

10.4 On 27 December 2021, Mr. B informed his sister, NoK C, that he still had pain in his legs. Mr. B described his legs as "*big*", "*getting huge*" and that both his "*knees are swollen*". He stated he was getting "*no help*" for his legs and discussed changing solicitor in order that contact be made with the prison regarding his medical treatment.

10.5 On 29 December 2021, Mr. B told his mother that it was his belief that COVID-19 was an excuse for the prison to restrict the regime and informed her that recently prisoners had "*rioted*" due to the restrictions in place. Mr. B informed his mother that he had been taken to hospital as he had fluid on his knee and had a very long wait without being seen. He described his legs as "*huge*" due to fluid retention.

10.6 Once a person in custody dials the number on their phone card the recording of the phone call commences. On 29 December 2021, before Mr. B's call connected he could be heard describing his leg to a person in his vicinity as "*like an elephant's trunk*".

10.7 On 31 December 2021 Mr. B made a call to his sister, NoK C, with whom he spoke for a short period of time. Mr. B made no further phone calls.

11. Events of 4 January 2022

11.1 PO A reported that, at approximately 03:30, he conducted a cell check and Mr. B asked to be unlocked to receive his methadone treatment. PO A informed Mr. B of the time and explained that his methadone would be dispensed at 09:00 as usual.

11:2 The CCTV footage viewed by the OIP showed a nurse accompanied by an officer dispensing medication on the landing. At 08:10:02 the officer unlocked the cell to facilitate the dispensing of medication to Mr. B by the nurse. The Medication Administration Chart recorded that Mr. B's prescribed medication was administered.

11.3 Pharmacist A reported that the Officer who unlocked Mr. B's cell at approximately 08:30 on 4 January 2022 reported that Mr. B appeared unwell and believed he was hallucinating. The pharmacist requested that Mr. B be left in his cell, advising the officer that he would review Mr. B once methadone was administered to the other prisoners on the A2 landing. At approximately 09:30, Mr. B was escorted to the landing gate to be assessed by the pharmacist.

11.4 Pharmacist A made the following note on PHMS; "*the time it took for him to leave his cell and come to the gate caused me concern and when he did reach the gate he was clearly disorientated and appeared particularly jaundiced*". Pharmacist A described his engagement with Mr. B as incoherent. The pharmacist also recorded that Mr. B had difficulty in understanding questions and recorded that he decided to withhold Mr. B's methadone treatment fearing that it may exacerbate his (Mr. B's) condition.

11.5 Following this interaction, Pharmacist A informed PO B and PO C that Mr. B required immediate medical assessment. Pharmacist A called the surgery and spoke to Doctor A and provided the doctor with details of Mr. B's recent high temperature and their concerns regarding his health. Pharmacist A recorded on PHMS that a short time later he witnessed Mr. B sitting upright in Doctor A's room receiving oxygen.

11.6 Doctor A recorded on PHMS that following referral by Pharmacist A she reviewed Mr. B in his cell and noted that he appeared jaundiced. His O2 oxygen level was recorded as 72%, which was below the normal range. His heartrate was recorded as approximately 138 BPM. Doctor A made a note of asking Mr. B "*where he was, what day it was, what month it was*". The doctor recorded that Mr. B "*was able to speak but not giving answers that made sense / repeating the questions*". PO B was present during this cell assessment and reported that "*Mr. B was not in an alert condition*".

11.7 Doctor A recorded that Mr. B "*needed urgent treatment*". Doctor A also recorded that members of the healthcare team spoke to the ambulance dispatch team a number of times requesting an urgent arrival. While he was awaiting transfer to hospital, the doctor treated Mr. B in the prison surgery, where he was placed on oxygen. Doctor A logged Mr. B's oxygen levels as *"about 90% dropping briefly at times when he was pulling the mask off*". The doctor recorded that Mr. B continued to appear confused and "*on auscultation[4] of his chest he had a coarse creps[5] audible on the left hand side*". Doctor A noted that they could hear breath sounds but not creps when auscultated right side. It was recorded that the pulse was regular. Doctor A recorded that "*throughout the time we were delivering care to Mr. B he maintained he was fine"*.

11.8 While awaiting the arrival of the ambulance an antigen COVID-19 test was conducted, the result was negative.

11.9 When the ambulance arrived, care was handed over to the ambulance personnel. Mr. B departed Mountjoy Prison at approximately 11:55. PO D and PO E escorted Mr. B to the hospital.

11.10 Nurse Officer D recorded on the PHMS at 16:46 that the General Practice Liaison Nurse at the Mater Misericordiae Hospital was contacted for an update on Mr. B's condition. Nurse Officer D was informed that Mr. B had been admitted to the Intensive Care Unit (ICU) under intubation and assisted ventilation.

11.11 Nurse Officer C recorded on the PHMS at 13:41 on 5 January 2022 that Mr. B had severe sepsis and was on "*maximum treatment*".

11.12 Doctor A made an entry on PHMS that the Mater Misericordiae Hospital contacted the Mountjoy Prison (Chief Officers Office) to report the passing of Mr. B at 17:25.

11.13 There was no evidence in the documentation examined by the OIP that Mr. B was reviewed or treated by a prison doctor from the time he returned untreated from the hospital on 19 December 2021 to the time of his referral back to hospital on 4 January 2022.

[4] The medical definition of auscultation is listening to the sounds of your heart, lungs, arteries and abdomen.
[5] Coarse crackles indicate excessive fluid on the lungs.

12. CCTV

12.1 The OIP reviewed CCTV footage of Mr. B's cell from 08:00 on 4 January 2022 to the time he left the landing, the following was noted:

Time Displayed (From media clock)	Narrative
08:06:50	Officers began to lay out breakfast packs outside cells on the A landing.
08:10:02	An Officer opened Mr. B's cell and a nurse administered medication to Mr. B. The Officer then handed in a breakfast pack to Mr. B's cell.
08:31:02	Mr. B's cell door was unlocked by an Officer who then continued to unlock other cells on the A2 landing.
08:32:57	Mr. B appeared at his cell doorway. Mr. B's movements were slow and he appeared to stagger to his cell doorway. Mr. B took two right footed steps forward, he appeared to drag his left leg and then leaned on the door frame with his right arm. Mr. B remained in the doorway and looked up and down the landing.
08:34:15	Mr. B remained in the doorway and spoke to an Officer. They were in conversation for approx. 15 seconds. The Officer departed and Mr. B remained in doorway. Mr. B appeared unsteady on his feet, he again leaned on the doorframe and looked as if he was supporting his weight.
08:35:06	The Officer returned to the cell and spoke to Mr. B in the cell doorway. Mr. B stood upright speaking to the Officer. He took steps where he dragged his left leg.
08:35:30	Mr. B turned to enter the cell, his movement was laboured and it appeared as if he had an issue with his leg/mobility. The Officer closed the cell door and departed.
08:42:00	A prisoner communicated with Mr. B from the doorway.
08:43:20	An Officer arrived at Mr. B's cell door. The Officer and the prisoner walked away from Mr. B's cell.
09:44:39	A prisoner communicated with Mr. B through his cell door.
09:45:45	An Officer unlocked Mr. B's cell and stood in the doorway, he appeared to be talking to Mr. B but he (Mr. B) couldn't be seen.
09:46:45	The Officer walked from the doorway and continued to the end of the A2 landing towards other Officers.
09:48:45	A prisoner entered Mr. B's cell.
09:49:19	A second prisoner entered Mr. B's cell

09:49:37	Two prisoners exited Mr. B's cell.
09:50:02	One of these prisoner entered the Class Office.
09:50:53	Two more prisoners entered Mr. B's cell and spent approximately 30 seconds in his cell before exiting.
09:51:59	Four prisoners repeatedly entered and exited Mr. B's cell for the next five minutes.
10:03:03	Mr. B exited his cell and could be seen sweeping out his cell with a brush. He appeared unsteady on his feet. Mr. B then re-entered his cell.
10:06:43	An Officer stood in the cell doorway and appeared to be speaking to Mr. B.
10:07:48	Mr. B exited his cell accompanied by an Officer. Mr. B walked slowly to the end of the landing and walked towards the medication dispensing hatch.
10:09:26	Mr. B returned to the landing. Mr. B walked slowly and he leaned on a hand rail with his left hand as he walked past his cell and out of frame.
10:12:01	Mr. B returned to the frame walking slowly and leaning on rail with his right hand. Two prisoners followed behind Mr. B as he slowly made his way to his cell. Two prisoners observed from the doorway as Mr. B entered the cell.
10:13:03	Two Officers stopped outside Mr. B's cell. One prisoner was inside Mr. B's cell. The Prisoner exited the cell as one Officer entered briefly before exiting and closing over the door but did not appear to lock the cell door.
10:14:52	A Prisoner returned to Mr. B's cell door, lifted the flap over the viewing hatch on the cell door and appeared to communicate through door.
10:15:48	A second prisoner arrived and communicated through the door. Prisoners repeatedly returned to Mr B's cell up to 10:30:00.
10:31:05	Two Officers and a Doctor arrived at Mr. B's cell.
10:31:26	The Doctor entered the cell as an officer stood in the doorway.
10:36:03	Mr. B exited his cell accompanied by Doctor. Mr. B again leaned on the handrail with his right hand, his movement appeared laboured. It took Mr. B approximately 17 seconds to walk past five cell doors to the end of the landing before he exited the landing.

12. 2 Prisoner 1 was captured on CCTV assisting Mr. B. Prisoner 1 was released from prison in February 2022. The OIP contacted him by phone and while he declined to meet in person he informed the OIP that it was clear to him that Mr. B was in poor health as his left leg was badly swollen for a number of weeks. Prisoner 1 stated that Mr. B could barely walk.

13 Critical Incident Meeting

13.1 A critical incident meeting[6] was held on 5 January 2022. Assistant Governor A chaired the meeting. In attendance were Chief Nurse Officer A, Chief Officer B, Assistant Governor B, Pharmacist A, Prison Higher Executive Officer A, Integrated Sentence Management Officer A, Chief Officer A, Doctor A , Doctor C and Prison Clerical Officer A.

13.2 Chief Officer A provided a brief outline on the timeline of events. This included information that Mr. B's NoK were present at the time of his death. The timeline is detailed as follows:

13.2.1 Mr. B was unlocked on 1 January 2022 to retrieve his methadone treatment and was observed by the officer vomiting in his cell.

13.2.2 Following review by the nurse Mr. B presented as symptomatic for COVID-19. A negative antigen test result was returned and he was placed in precautionary isolation.

13.2.3 Mr. B returned a negative PCR test on 2 January 2022.

13.2.4 On 4 January 2022, an officer observed that Mr. B appeared unwell in his cell. He was reviewed by nursing staff and presented as disorientated and jaundiced in colour. Doctor A was asked to review Mr. B as a priority. Doctor A, having examined Mr. B, provided oxygen to him before requesting that a nurse call an ambulance. Mr. B was transferred to hospital where he was admitted to ICU.

13.2.5 The hospital contacted the Chief's Office on 5 January 2022 at 17:25 to report Mr. B's passing. As per the Death in Custody protocol, Chief Officer A informed the OIP, the Governor of Mountjoy Prison, An Garda Síochána and IPS Operations Directorate.

13.3 It was reported that Mr. B had engaged well with the Integrated Sentence Management team and had been reviewed in December 2021 in relation to the Lifers program[7] and action plan. Mr. B had been referred to psychology, but he had not been seen by psychology prior to his passing.

13.4 Assistant Governor A commended all those involved for their professionalism and response. It was noted that from a prison point of view all protocols and procedures were followed.

13.5 The purpose of the Critical Incident Review Meeting (CIRM) is to establish the facts, to provide an opportunity to share views on how the situation was managed and identify any additional supports or learning.

13.6 The IPS SOP entitled *'Critical Incident Reporting and Debriefing Procedures'*, which came into effect on 1 July 2020, provides for the holding of both a hot and cold debrief following a critical incident such as a death in custody and *'should include, to the greatest possible extent, all the staff involved in the incident.'* There is no evidence that a cold debrief was held and very few staff members involved in the incident attended the hot debrief.

13.7 In response to a recommendation made by the OIP in the report into the circumstances surrounding the death of Mr. C 2022, published on 30 May 2023, the IPS committed to reissue the Circular relating to the '*Critical Incident Reporting and Debriefing Procedures'* to all prison

[6] Staff meeting held following the death of a prisoner.
[7] Rehabilitation program for life sentenced prisoners.

staff to remind staff of their obligations. The commitment by the IPS to reissue the Circular is welcomed by the OIP.

14. Recommendations

The Office of the Inspector of Prisons has made two recommendations:

1. It is recommended that any prisoner who has been referred to an Emergency Department, or any hospital appointment, and who returns to prison without treatment be seen by the prison doctor as soon as possible following their return to the prison.

2. The IPS Director of Care and Rehabilitation should conduct a detailed review of the quality of the medical care provided to Mr B while in the custody of the Prison Service, with a view to establishing whether or not an earlier medical intervention in the prison and/or hospitalisation at an earlier stage might have saved his life.

   The Inspectorate would like to be informed of the outcome of that review, including any lessons learned.

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.