Oifig An Chigire Príosún
Office of the Inspector of Prisons

# Death in Custody Investigation Report

Mr. H
Mater Misericordiae Hospital
While in the Custody of
Mountjoy Prison
3 May 2022

Submitted to Minister: 23 October 2024

# CONTENTS

# GLOSSARY

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|---|---|
| ACO | Assistant Chief Officer |
| CCTV | Closed Circuit Television |
| CPR | Cardio Pulmonary Resuscitation |
| IPS | Irish Prison Service |
| ISM | Integrated Service Management |
| NO | Nurse Officer |
| NoK | Next of Kin |
| OIP | Office of the Inspector of Prisons |
| PIMS | Prisoner Information Management System |
| PIP | Personal Integration Plan |

# 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 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 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. H during his time in prison.

## 4. Administration of Investigation

4.1 On 3 May 2022, the OIP was notified that Mr. H had passed away in the Mater Misericordiae University Hospital, Dublin. The investigation team attended Mountjoy Prison and met prison management who provided an overview of Mr. H's time in prison.

4.2 Mountjoy Prison Management provided the investigation team 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 Inspector of Prisons' role when investigating a death in custody.

5.2 The investigation team communicated with Mr. H's NoK, his daughter, by telephone on 20 May 2022 and subsequently an in-person meeting took place on 2 June 2022. The NoK asked about Mr. H's passing and raised one concern. This is addressed in **section 7**.

## 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. In May 2022, it had an operational capacity of 755.

6.2 Mr. H was the third death of a prisoner from Mountjoy Prison in 2022 and the eighth death in IPS custody that year.

## 7. Family Concerns

7.1 Mr. H's NoK requested information on the events that occurred prior to Mr. H's transfer to hospital.

7.2 Mr. H's daughter stated that she was informed of her father's passing by telephone while driving. The investigation team established that following Mr. H's passing, Chaplain A made an in-person visit to the last recorded address on the Prisoner Information Management System (PIMS) for Mr. H. Upon arrival it was clear to Chaplain A that no person was resident at this address. In order to make contact with the NoK a phone call was made.

7.3 The NoK reported that Mr. H was diagnosed with an irregular heartbeat approximately three years before he entered prison. It was also reported that Mr. H had long term mental health problems that they believed had gone untreated for over a decade before he entered prison. The investigation team reviewed Mr. H's medication chart which covered 3 April 2022 to 3 May 2022. Mr. H received Olanzapine[1], Lansoprazole[2] and Methadone on a daily basis. Mr. H was not prescribed heart medication at the time of his passing.

## 8. Background

8.1 Mr. H was 48 years old when he passed away in the Mater Misericordiae University Hospital. Mr. H was a father of three who came from the Leinster Region.

8.2 Mr. H was committed to Mountjoy Prison on 17 December 2021 to serve a life sentence. Mr. H was accommodated in Cell 9 on the A1 landing. Prior to sentencing, Mr. H was on remand at Cloverhill Prison from 1 April 2019.

[1] Antipsychotic medication.
[2] Medication which reduces stomach acid.

## 9. Events Related to 3 May 2022

9.1 On 3 May 2022, whilst in the communal shower area on the A1 landing, Mr. H reported to Prisoner 1 that he felt unwell and requested that Prisoner 1 call for medical assistance.

9.2 Prisoner 1 provided a statement to the investigation team on 4 May 2022. Prisoner 1 stated, *"I got down to the shower and [Mr. H] was sitting on a chair at the first shower and he was struggling to breathe, he was grey in the face and not the right colour to me. He asked me to call the officers and that he needed a medic as he couldn't breathe. I went straight down and told Class Officer [A]. He went from halfway down the landing, he went very quickly and obviously seen [Mr. H] and went for the medic. I went back to my cell. I was outside my cell and I saw medics arrive in quick time."*

9.3 Class Officer A reported that at approximately 14:39 Prisoner 1 approached him and stated that Mr. H was unwell in the shower area. Class Officer A and Officer B immediately made their way to the shower area and upon seeing Mr. H called for medical assistance over the Tetra radio system. Class Officer A reported that medical staff arrived on the scene at 14:41 and took charge of the situation.

9.4 ACO A was in charge of A Division. He reported responding to the call for assistance at 14:40. On arrival at the shower area, he spoke to Mr. H who, he stated, was having difficulty breathing. The ACO reported that Mr. H had an inhaler in his hand. The ACO reported witnessing Mr. H slump from his chair onto the floor and also stated that the healthcare staff arrived promptly.

9.5 Nurse A and Nurse B both reported responding to Class Officer A's call for medical assistance. On arrival at the shower area they found [Mr. H] suffering from shortness of breath. Nurse A stated *"[Mr. H] was coherent in conversation but visibly having difficulties breathing. [Mr. H] stated he had used his Ventolin[3] inhaler but to no effect".* Nurse B reported that Mr. H's medical observations were recorded and that oxygen was administered to Mr. H. Nurse A requested that Doctor A attend the scene.

9.6 Doctor A responded and was shown to the shower area by Nurse C. Doctor A recorded that Mr. H was *"visibly pale and distressed with low blood oxygen levels"*. Despite the efforts of medical staff Mr. H's oxygen levels did not improve. Doctor A requested that emergency services be called. Doctor A reported that Mr. H's condition was considered stable for approximately two minutes before he collapsed. Nursing staff immediately commenced CPR[4].

9.7 At 15:20, two Dublin Fire Brigade paramedics and two National Ambulance Service paramedics arrived on the scene and immediately took charge of the resuscitation attempts on Mr. H.

9.8 At approximately 16:09, Mr. H was removed to the Mater Misericordiae University Hospital Dublin. At approximately 17:30 on 3 May 2022, prison management was informed that Mr. H had passed away in hospital.

[3] Inhaler used to relieve asthma symptoms.
[4] Cardiopulmonary Resuscitation – life saving technique administered to those suffering from cardiac arrest.

## 10. Critical Incident Review Meeting

10.1 Assistant Governor A chaired the Critical Incident Review Meeting on 3 May 2022. It was attended by officers and nurse officers who were present at the time of the incident. A timeline of events was read at the meeting.

10.2 It was noted that Mr. H had recently engaged with Integrated Service Management (ISM)[5] and developed his Personal Integration Plan (PIP)[6].

10.3 It was also reported that Mr. H was assessed and engaged with the Psychology Service within the prison and it was reported that he appeared very settled within the prison.

10.4 The meeting note recorded that all protocols and procedures were followed.

## 11. CCTV Footage

As part of the investigation, the investigation team reviewed CCTV footage of the A1 landing from 14:25 on 3 May 2022. The footage displayed the following:

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| 14:27:39 | Mr. H exited Cell 9 holding a chair and towel, he made his way towards the shower area. |
| 14:28:10 | Mr. H entered the shower area. |
| 14:38:33 | Prisoner 1 collected a mop from the store room adjacent to the shower area. He can be seen to become alerted to the shower area and appeared to hold a brief communication at the shower door entrance. |
| 14:38:35 | Prisoner 1 departed the shower area and quickly walked up the landing towards Officer A. They briefly communicated. |
| 14:39:05 | Prisoner 1 and Officer A arrived at the shower area. |
| 14:39:10 | Officer A is seen communicating via Tetra radio. |
| 14:39:22 | Officer A walked away from the shower area and can be seen speaking to Officer B. |
| 14:39:38 | Officer B arrived at the shower area. Officers directed other prisoners away from the shower area and provided a level of privacy for Mr. H. Prisoners were locked back in their cells. |
| 14:41:09 | Nurse A and Nurse B arrived on the A landing. |
| 14:41:30 | Nurse A and Nurse B entered the shower area. |
| 14:52:10 | Doctor A entered the shower area. |
| 15:20:24 | Two Dublin Fire Brigade paramedics arrived at the shower area. |

[5] The Integrated Sentence Management (ISM) system was developed to ensure co-ordination of interactions with prisoners based on agreed sentence plans.
[6] This is a plan of actions for the prisoner to complete during his/her time in prison.

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|---|---|
| 15:24:39 | Two National Ambulance Service paramedics arrived with a wheeled ambulance trolley. Both entered the shower area. |
| 16:02:15 | Paramedics moved the ambulance trolley into the shower area. |
| 16:03:54 | Mr. H is seen exiting the shower area secured to the ambulance trolley. An automatic compression device was operational on Mr. H's chest. Mr. H was then removed from the A landing and departed to hospital. |

## 12. Recommendations

12.1 The OIP has made two recommendations.

1. It is recommended that on committal or as soon as possible thereafter that contact be made with the nominated next-of-kin to obtain their consent to be recorded as NoK and ensure that the details provided are valid.

2. It is recommended that the IPS put in place streamlined procedures to enable the nominated NoK of prisoners to easily update their contact details, for example, through the use of a dedicated email address for the IPS section with responsibility for updating PIMS prisoner details.

## 13. Support Organisations

13.1 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.