Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. T
Midlands Prison
Reviewable Temporary Release
28 August 2024
Aged 33

To the Minister: 18 July 2025

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GLOSSARY

AGS	An Garda Síochána
CNM	Clinical Nurse Manager
CNO	Chief Nurse Officer
DiC	Death in Custody
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
RTR	Reviewable Temporary Release

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 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 to detail the events leading up to Mr. T's death while on Reviewable Temporary Release (RTR) on 28 August 2024 and the procedures followed leading up to his temporary release

4. Administration of Investigation

4.1 On 28 August 2024, the OIP was notified by email by Assistant Governor A that Mr. T had passed away in the Midlands Regional Hospital while on RTR from Midlands Prison. As this death occurred within one month of temporary release and before Mr. T's remission date of 5 October 2024, it was investigated by the OIP.

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. T's NoK, his father, on 12 November 2024 and a meeting took place with both of his parents on 20 December 2024. Mr. T's parents informed the investigating team that their son's life had been blighted by drug addiction.

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. T's NoK in mind.

5.4 The OIP is grateful to Mr. T's family for their contributions to this investigation and we offer our sincere condolences on their loss.

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. At the time of Mr. T's passing, it had an operational capacity of 875 beds, and, on 21 August 2024, the date of Mr. T's RTR, it was accommodating 966 prisoners, 110% of overall capacity.

6.2 At the time of his passing, Mr. T's was the seventh death of a prisoner from the Midlands Prison in 2024; and the twentieth death in IPS custody that year.

7. Family Concerns

7.1 Mr. T's, NoK asked the following two questions:

1. What medication was Mr. T on while he was in prison?

OIP Response: This is answered in section 10 of this report.

2. What treatment did Mr. T receive for his drug addiction while he was in prison?

OIP Response: This is addressed in section 10 of this report.

8. Background

8.1 Mr. T was committed to Cloverhill Prison on 3 October 2021 and transferred to the Midlands Prison on 3 November 2021.

8.2 Due to his engagement with services and good behaviour, Mr. T was transferred from the Midlands Prison to Shelton Abbey open prison on 23 April 2023. Prior to his transfer to the open prison Mr. T signed an agreement:

1. "*Not to take part in the illegal use of drugs, alcohol or any other mood altering substances.*
2. *To submit to urine testing.*
3. *That in the event of a positive test result; I will be advised of / reported for this failure. I am aware that such measures may include disciplinary procedures.*
4. *In the event I am found in possession of any illegal drugs, mood altering substances or paraphernalia used for taking such substances I will be placed on report.*
5. *When requested to provide a urine sample a refusal or failure to provide will be treated as failed test.*
6. *To encourage others to maintain a drug free environment.*
7. *To partake in whatever Industrial Training/ Education Programme that is assigned to me*".

8.3 Governor A of Shelton Abbey confirmed to the investigation team that, on 5 September 2023, Mr. T failed a routine drugs test, testing positive for cocaine and benzodiazepines. Mr. T refused to disclose where he had come into contact with these substances. Mr. T was offered drugs counselling, but declined the opportunity to engage with this service. As Mr. T failed to comply with the terms of the signed agreement and would not engage with the addiction counselling services, Governor A considered Mr. T unsuitable to remain at an open prison.

8.4 On 5 September 2023, Mr. T was transferred back to the Midlands Prison. On return to the Midlands Prison, Mr. T was placed on the standard level of the incentivised regime[1] and did not progress to the enhanced level, nor did he engage with the addiction support service prior to his release on RTR.

8.5 On 21 August 2024, Assistant Governor B recommended Mr. T for RTR. Official A, IPS Operations Directorate, replied on the same date (21 August 2024) approving the RTR recording "*RTR approved as he is coming to the end of his sentence*".

8.6 The Temporary Release Notice recorded the reason for RTR as "pre-release/resocialization". Mr. T signed the Temporary Release Notice agreeing to comply with the following TR conditions:

- *"Be of good behavior.*
- *Do not convey messages in/out of Prison.*
- *Keep the peace.*
- *Report to a [specified] Garda station within 24 hours of release and daily thereafter to get TR form stamped.*
- *Return to Midlands Prison on date and time listed above.*
- *Shall be of sober habits.*
- *Shall not enter a pub, club, or other licensed premises or off-licence premises.*
- *Shall reside at [specified address].*
- *Agree not to change address from [specified address] without new TR form".*

8.7 Mr. T's RTR was for review on 28 August 2024.

9. Events from 21 to 28 August 2024

9.1 Mr. T's NoK informed the investigation team that his son did not arrive home, as expected, following his release on 21 August 2024. Mr. T arrived at his parents' home address on 22 August 2024 and according to his father, he was "*out of it*". Mr. T left the house on the same date (22 August 2024) and did not return.

9.2 In accordance with a condition of Mr. T's RTR, he attended the specified Garda Station at 08:37 on 22 August 2024 where his TR form was stamped.

9.3 On 23 August 2024, the NoK was contacted by An Garda Síochána (AGS) in the early hours of the morning, and informed that his son had been found unconscious in the street and was in the

[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.

Midlands Regional Hospital, Portlaoise. The investigation team was informed by the NoK that Mr. T had checked himself out of hospital at approximately 13:00, against medical advice.

9.4 At 19:13 on 23 August 2024, AGS attended a property in Portlaoise where Mr. T was discovered in an unresponsive state. Mr. T was transferred by ambulance to the Midlands Regional Hospital, Portlaoise and placed on life support. The NoK informed the investigation team that they were advised by doctors that Mr. T had no brain function and that his condition was irreversible. The NoK informed the investigation team that they consented to the withdrawal of life support on 28 August 2024.

9.5 On 28 August 2024, Chief Nurse Officer (CNO) A received two telephone calls from Clinical Nurse Manager A, Critical Care Unit, Midlands General Hospital. The first call was notifying the healthcare team in the prison that Mr. T's was a patient at the hospital and was critically ill. Clinical Nurse Manager A informed CNO A that Mr. T had been admitted with a suspected drug overdose on 23 August 2024. He had departed A&E against medical advice, suffered a cardiac arrest shortly afterwards and was readmitted to hospital. Later in the day, Clinical Nurse Manager A rang CNO A to report the passing of Mr. T.

10. Engagement with Healthcare

10.1 The prison's prescriptions chart recorded that Mr. T was prescribed 'Lustral 50mg Tabs' from 4 October 2021 until 30 November 2023, to be taken once per day. Lustral is commonly used to treat depression and to prevent the recurrence of depression. Doctor A made an entry on the PHMS on 13 September 2023, "*Lustral stopped, not taking same*".

10.2 The PHMS record also recorded that Mr. T was prescribed 'Quetiapine 25mg Tabs' from 4 October 21 until his release on 21 August 2024, to be taken daily. Quetiapine is commonly used to treat schizophrenia, bipolar disorder and depression.

10.3 On 23 April 2023, Nurse A in Shelton Abbey recorded "*New committal transfer from Midlands. Denies any medical issues. Has a diagnosis of depression and is on Antidepressants. Stable for years. Strong Hx of polysubstance abuse and admitted to still dabbling with heroin occasionally*. *Advised strongly to link in with Addiction counsellor*".

10.4 On 24 April 2023, Addiction Counsellor A met with Mr. T and recorded discussing "*expected goals of counselling and the parameters of same. Addiction present. Wants to address this.1 Day in Shelton, did not expect to be here."* Mr. T was taken onto the addiction counsellor's caseload.

10.5 On 2 May 2023, Addiction Counsellor A noted on the PHMS that "[Mr. T] *attended today. Stated he is feeling ok. A bit anxious about counselling. Explored feelings and discussed what to expect".*

10.6 Addiction Counsellor A made a note in the PHMS on 29 May 2023 that Mr T "*Did not attend"* his appointment.

10.7 Nurse B made an entry in the PHMS on 5 September 2023 that Mr. T was "*for transfer to Midlands this morning, positive for cocaine and benzodiazepines on recent urine test*".

10.8 Doctor B met with Mr. T on 6 September 2023 on his return to the Midlands Prison and recorded on PHMS that he (Mr. T) "*Came back from Shelton Abbey. Failed in drug test. No requests or medical complaints. Medications re-prescribed*".

10.9 On foot of a committal initiated referral to the Psychiatrics in-reach team, on 14 September 2023 Psychiatric Nurse A recorded that Mr. T's clinical records had been reviewed and *"following discussion of this man's case at the psychiatry team meeting"* Psychiatric Nurse A noted that a decision had been made that *"there appears to be no indication for a psychiatry assessment at this time"* but he could be referred at a later date if the situation changed.

10.10 On 15 September 2023, it was recorded on PHMS by Nurse C that Mr. T was due "*for addiction assessment, declined to attend, does not wish to engage with services*".

11. Recommendations

11.1 The OIP has no recommendations.

12. Support Organisations

12.1 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.