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Deaths in Custody; Is Ireland's Investigative Process Compliant with Article 2 of the European Convention on Human Rights?

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Executive Summary

Deaths in Custody

The right to life is an affirmative right protected under Article 2 of the European Convention on Human Rights (ECHR). The protection of this right involves both the protection of the right to life prior to death and the investigative process after a death in custody has occurred. The former relates to what measures or standards of care are necessary to ensure prisoners' rights are being respected, essentially to avoid deaths in custody occurring. The latter is relevant after a death has occurred; the investigative process must meet the highest standards.

In this report we outline how prison authorities must ensure they are meeting their obligations under this ECHR provision. Measures such as the process of contacting next-of-kin and the information they are given regarding a death in custody need to be standardised across the prison system. One recommendation we make is that prison officers receive specialised training in the care and management of prisoners. They need greater expertise in assessing prisoner mental health in particular. This is especially important given the large number of 'dual prognosis' prisoners, prisoners with both addiction and mental health problems in Irish prisons.

In Ireland, the investigative system has improved greatly with appointment of the Inspector of Prisons but lessons remain to be learned. We found that the Inspector of Prisons role is of limited use, if recommendations made in his reports are not translated into actions to be taken by prison authorities. We believe that the current investigative process incorporating the Gardaí, the Coroner and the Inspector are not

sufficient to meet the standards required by Article 2 of the ECHR because three separate investigations cannot address systemic issues in the prison system.

The UK and Canada are the two other jurisdictions explored in this report. Whilst there are flaws in their penal systems, the legislative frameworks used by both countries are models which Ireland should seek to emulate. Particularly noteworthy is the role of Prison Ombudsman. Whilst establishing a Prison Ombudsman in Ireland is a long term objective, it is the optimal solution to many of the issues facing the system. The role would provide cohesion and consistency to both standards of care in prisons and the investigative process for deaths in custody. In the interim, however, the enactment of the Coroners Bill 2007 would significantly improve the process of investigating deaths in custody.

Table of Cases

Irish Cases

Farrell v Attorney General [1998] 1 IR 203.

Eastern Health Board v Farrell [2001] 4 IR 627.

Magee v Farrell [2009] 4 IR 703.

Mulligan v Governor of Portlaoise Prison [2010] IEHC 269.

International Cases

Dougoz v. Greece 2001 App no 40907/98 (ECtHR 6 March 2001).

Kalashnikov v Russia App no 1413/07 (ECtHR 15 July 2002).

Edwards v. UK (2002) EHRR 19.

Jordan v United Kingdom App no 24746/94 (ECtHR, 4 May 2001).

R v Secretary of State for the Home Department, ex parte Amin (2003).

Finucane v. United Kingdom App No 29178/95 (ECtHR 2 July 2002).

Coselav v Turkey ECHR 1789 [2012]

McCann v United Kingdom App no 18984/91 (ECtHR, 27 September 1995).

Osman v United Kingdom App no 3452/94 (ECtHR) 28 October 1998).

Kats v Ukraine App no 29971/04 (ECtHR) 18 March 2009.

Keenan v United Kingdom App no 27229/95 (ECtHR) 3 April 2001

Regina v Secretary of State for the Home Department ex parte Amin [2003] UKHL 51.

Bailey v United Kingdom App no 39953/07 (ECtHR) 19 January 2010),

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Irish Statutes

Coroners Act 1962.

Coroners (Amendment) Act 2005.

Commission of Investigations Act 2004.

Criminal Justice Act 1984.

Freedom of Information Act 1997.

Freedom of Information Act 2014.

Garda Síochána Act 2005.

Mental Health Act 2001.

Prisons Act 1925.

Prisons Act 2007.

Police and Criminal Evidence Act 1984.

International Statutes

Corrections and Conditional Release (Canada) Act 1992.

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

Mental Health Act 1983.

Police (Northern Ireland) Act 1998.

Prison (Northern Ireland) Act 1953.

Police Reform Act 2002 (UK)

One - Introduction

1.1 Rationale for report

This research report on deaths in custody has been requested by the Irish Penal Reform Trust (IPRT) as there has been ‘a notable lack of robust empirical research in this context’.¹ The IPRT is a human rights based organisation, which advocates for prisoners’ rights and penal policy change. According to its chief executive, the role of the IPRT is to lobby on behalf of prisoners as a whole rather than on an individual basis’.² It seeks to ensure that basic human rights standards are being met in Irish prisons. Current issues which concern IPRT include the practice of ‘slopping out’ which constitutes degrading treatment under Article 2 of the European Convention of Human Rights, overcrowding and the length of time a prisoner is locked up per day. The IPRT is a non-governmental organisation (NGO), albeit one which does not receive government funding.

Upon imprisonment, a person’s constitutional right to liberty is restricted. In this situation, there is an obligation on those who have removed that liberty to ensure that standards of best practice are being met whilst a prisoner is being detained. The UK Joint Committee on Human

¹ Colette Barry, ‘Death in Irish Prisons: An Examination of the Causes of Death and the Compliance of Investigations with the European Convention on Human Rights, (Masters Dissertation, Dublin Institute of Technology, 2011) 1.

² Comment made by IPRT chief executive Deirdre Malone during a presentation in Dublin Institute of Technology, 6 October 2014.

Rights encapsulated this stating, ‘when the State takes away a person’s liberty, it assumes full responsibility for protecting their human rights’.³ In *Criminology*, Newburn captures the essence of prisons, describing them as ‘unusual places, where the basic conditions of existence require that some of the normal assumptions of everyday life are stripped away’. He draws an important distinction by stating that whilst the ‘removal of certain freedoms is the essence of imprisonment, that is not to say however, that prisoners have *no* rights’.⁴ In a similar vein, the seminal UK Woolf report asserted that offenders are sent to prison as punishment rather than *for* punishment.⁵ The Woolf report resulted in the establishment of an independent Prison Ombudsman in the UK in 1994.

This report will look at the process of how deaths in custody are investigated in Ireland, before looking at similar practices in the UK and Canada. In conclusion, the report will make some recommendations as to how the investigative process in Ireland can be improved.

1.2 The Irish Prison System

There are 14 prisons in Ireland. These include regional prisons such as Limerick Prison, male Prisons (Mountjoy Prison) and female prisons (the Dóchas Centre). There are prisons for specific types of crime, such as Arbour

³ UK Joint Committee on Human Rights Report, 5.
<<http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>> accessed 8 October 2015.

⁴ Tim Newburn, *Criminology* (2nd edn, Routledge, 2013), 732.

⁵ Woolf H and Tumim S, *Prison Disturbances, April 1990: Report of an Inquiry*, Cm 1456, London, HSMO, 1991 (Woolf Report).

Hill which houses sex offenders. Some Irish prisons are categorised in terms of security; Portlaoise Prison is maximum security, whereas Loughan House in Co. Cavan is a low security or 'open' prison. Practices and procedures vary across the prison system. Not all prisons meet standards of best practice in terms of human rights.⁶ The Dóchas women's prison in Dublin is consistently overcrowded and the outdated practice of 'slopping out' still occurs in Mountjoy Prison. Some prisons breach human rights standards by keeping prisoners locked up for more than 22 hours per day. The 2011 Committee for the Prevention of Torture (CPT) report stated that '23-hour lock-up should only be considered as a temporary respite. In the Irish prison system it has developed into a general measure'.⁷

Prisoners in Ireland: typical demographic profile

There are currently 4,267 people in prison in Ireland.⁸ The prison population has increased 400 per cent since 1970. In terms of education over fifty per cent of prisoners left school before the age of fifteen. Seventy per cent were unemployed upon committal. Perhaps the most staggering statistic on prison demographics is that a typical prisoner in Ireland is over twenty-five times more likely to have come from an area of socio-economic disadvantage than any other socio-economic background.⁹ The prison population in Ireland is a

⁶ 2011 CPT Report on visit to Ireland <<http://www.cpt.coe.int/documents/irl/2011-03-inf-eng.pdf>> accessed 12 January 2015

⁷ Ibid p.34.

⁸ Source Irish Prison Service <www.irishprisons.ie> accessed 7 January 2015.

⁹ Irish Penal Reform Trust, Prison Facts <<http://www.iprt.ie/prison-facts-2.>> accessed 02.12.14

relatively young one. According to the Irish Prison Service, in 2013 (the most recent year with statistics available) the majority of committals to Irish prisons (thirty nine per cent) were people aged between 21 and 30, whereas only 7.9 per cent of committals were people aged over 50.¹⁰

The Irish Prison Service

In their *Three Year Strategic Plan 2012-2015*,¹¹ the Irish Prison Service (IPS) make no reference whatsoever to deaths of prisoners in custody. This omission is startling given that in the decade prior to the publication of this plan, 95 people died in Irish prisons and twenty of these deaths were in the final two years.¹² The mission and values of the IPS include ‘safe and secure custody’ and its principles include accountability, yet there is no reference to deaths in custody in their strategic plan. This trend has continued as an average of almost 10 prisoners died each year from 2012-2014, the period covered in this report.

Deaths in Custody

Deaths which occur in prison custody differ in a number of respects from those occurring outside the penal system. Such deaths ‘are not open to any usual considerations, no doctor can talk to the family and no friends can reconstruct

¹⁰ Irish Prison Service, Census of Committals 2007-2013.

<http://www.irishprisons.ie/images/pdf/age_gender_2007_2013.pdf> accessed 08.10.14

¹¹ <<http://www.irishprisons.ie/images/pdf/strategicplanfinal.pdf>> accessed 8 October 2014.

¹² Colette Barry, ‘Death in Irish Prisons: An Examination of the Causes of Death and the Compliance of Investigations with the European Convention on Human Rights, (Masters Dissertation, Dublin Institute of Technology, 2011) 1.

the incident'.¹³ The exceptional nature of a death in custody warrants a prompt, transparent and robust investigation as will be outlined in this report.

Number of deaths

There were 34 deaths in custody from 2012-2014. The Inspector of Prisons has published reports on 32 of these deaths. These reports established that 9 of these deaths occurred in prisons, 16 occurred whilst a prisoner was on temporary release and seven occurred in a hospital near the prison.¹⁴

The gender dimension

Virtually all deaths have been of male prisoners. A death by suicide in the Dóchas women's prison in 2010 has been the only death of a female prisoner in Ireland. Whilst the numbers of women imprisoned in Ireland is much smaller, this still doesn't account for the difference. In her research into deaths in Irish prisons, Barry points out that the Dóchas women's prison and Arbour Hill male prison are of a relatively similar size yet there is a marked discrepancy in the number of deaths.¹⁵

¹³ Clare Beckett, 'Deaths in Custody and the Inquest System' (1999) *Critical Social Policy* (19) 271.

¹⁴ Inspector of Prisons, *Deaths in Custody reports 2012-2014*.
<<http://www.inspectorofprisons.gov.ie/>> accessed 2 December 2014.

¹⁵ Colette Barry, 'Death in Irish Prisons: An Examination of the Causes of Death and the Compliance of Investigations with the European Convention on Human Rights', (Masters Dissertation, Dublin Institute of Technology, 2011) 28.

What are the main causes of prison deaths in Ireland?

It must be noted that a significant number of deaths are due to natural causes such as illness or age. Some natural deaths may have occurred due to the very fact of being imprisoned, where a prisoner's health may have deteriorated due to lack of exercise or complications from previous drug addiction and so forth. The main reasons for non-natural deaths include suicide, drug overdose and violence. These causes of death have a strong correlation with issues of mental health care, drug addiction and prison overcrowding respectively.

Suicide & Mental Health Care

Many of those who enter the prison system are already vulnerable adults and often incarceration further exacerbates this vulnerability. Being locked up for a large part of the day whilst also being separated from family and friends serves to diminish one's mental health. Prisoners with acute mental illness are usually accommodated in the National Forensic Mental Health Service (formerly known as the Central Mental Hospital, Dundrum). It is crucial that prisoners receive adequate psychological support if required and that prison staff make adequate and appropriate risk assessments on prisoners to anticipate any potential problems. The Committee for the Prevention of Torture (CPT) were critical of the over reliance on prescription medication in Irish prisons rather than talk-based therapeutic methods such as counselling to alleviate mental

health issues.¹⁶ Inadequate aftercare upon release from prison may also increase the likelihood of mental health difficulties occurring.

Drug Abuse

Drug overdose in Irish prisons is a significant cause of death in custody and correlates with the high level of drug use in prisons. Deaths resulting from drug use may be by accidental or intentional overdose. Merchants Quay Ireland is a non-governmental organisation (NGO) which provides addiction counselling services in Irish Prisons. In 2011, they had 2,792 referrals to their service and 2,241 prisoners received methadone treatment.¹⁷ There was an average prison population of 4,390 in 2011 meaning that 51% of prisoners were attempting to detoxify from drug addiction.¹⁸

Violence

There are a large number of prisoners in Ireland 'on protection' on any given day and concerns have been raised about this by both the CPT and the Inspector of Prisons. Around 50 prisoners per day in Ireland spend 22-23 hours alone in their cells.¹⁹ Some prisoners may be serving sentences for violent crime but for others, the very fact of being imprisoned may result in an increased likelihood of them encountering some form of violence. Conditions

¹⁶ Ibid p.35.

¹⁷ Irish Prison Service Annual Report 2011, 37

<<http://www.irishprisons.ie/images/pdf/annualreport11.pdf>> accessed 4 February 2015.

¹⁸ Ibid, 20. Accessed 18 March 2015

¹⁹ Ibid p.3.

in prison may give rise to violence. Overcrowding is an issue in Irish prisons, which may lead to an increased likelihood of violence occurring. Overcrowding in prisons has gained significance as a human rights issue. Article 3 of the ECHR prohibits torture and inhuman or degrading treatment or punishment. Van Zyl Smit & Snacken believe the European Court of Human Rights (ECtHR) has undergone an important evolution in its attitude to prison overcrowding. Chronic forms of overcrowding had previously been described as ‘undesirable’ but had not been considered to constitute inhuman or degrading treatment until *Dougoz v Greece* (2001) and *Kalashnikov v Russia* (2002) where the Court stated explicitly that the absence on the part of State authorities of an intention to humiliate did not exclude a breach of Article 3.²⁰

*Statistics on overcrowding in Irish Prisons (January 2014)*²¹

Single cell occupancy	2 person cell occupancy	3 person cell occupancy	Cells with 4 or more occupants
47% of prison population	1600 prisoners	300 prisoners	36 cells

²⁰Dirk van Zyl Smit and Sonja Snacken, *Principles of European Prison Law and Policy* (Oxford University Press, 2009) 88.

²¹ Mary Rogan, *Prison Law* (Bloomsbury, 2014) 2.

1.3 The Investigative Process

All deaths of prisoners in custody must be investigated to determine the cause of death. The ECtHR first applied the 'Jordan principles' in the case of *Edwards v. UK*²². These principles determined that the investigative process must be robust, transparent and capable of determining responsibility. The investigation needs to be prompt and the next-of-kin ought to be involved. The purpose of an investigation is to ensure that those responsible are held accountable. This ensures that both families of the deceased and the wider public have confidence in the justice system, a fundamental necessity in a democracy.

The European Convention on Human Rights (ECHR)

The ECHR is the overarching legal framework which covers the issue of deaths in custody. Article 2, the right to life, is a fundamental article of the Convention. Article 2 read in conjunction with Article 1, means there is an onus on States who have ratified the Convention to investigate any deaths which have occurred in custody, irrespective of whether they were caused by the State or not. Such investigations need to be prompt, independent and involve the next-of-kin. The investigations must also be capable of assigning responsibility for the death.

²² *Edwards v. UK* (2002) EHRR 19 para 73.

1.4 What legislation covers prison deaths?

The Prisons Act 2007

The Prisons Act 2007 is the legislation which outlines the various roles, functions and responsibilities of all of those working or imprisoned in the penal system.

The Coroners Act 1962

The Coroners Act 1962 is the primary legislation which covers the remit of the Coroner. The Coroners Bill 2007 sought to update the Coroners Act 1962 and amend the laws relating to Coroners' Inquests. This research group contacted the Minister for Justice and Equality via email to ascertain why the Bill was never enacted. Despite making numerous requests, we received no reply from her office. The Coroners Bill is currently categorised as 'lapsed legislation'. This means the Bill is no longer valid and would need to be reintroduced to the Oireachtas and pass through the various stages of the legislative process.

1.5 Who is responsible for investigating deaths in custody in Ireland?

The three main investigations carried out when a death in custody occurs in Ireland are investigations by the Inspector of Prisons, An Garda Síochána (the police force) and the Coroner. In the event of a death, the Irish Prison Service gathers relevant information, although the procedures for how this is done varies across the prison system. Prison staff complete 'half sheets' as a

reporting mechanism and the Inspector of Prisons has been critical of the minimal information these provide.²³

Inspector of Prisons

The Inspector of Prison Office was established in 2002, but was not put on a statutory footing until 2007²⁴. The Inspector himself devised procedures for investigating deaths in custody, though significantly, these have not yet been placed on a statutory footing. In 2012, the remit of the Inspector of Prisons was broadened to include investigating deaths of those on temporary release. Statistics from his website indeed demonstrate that this was a necessary expansion as deaths of prisoners on temporary release constituted just over 50% of all deaths in the 2012-2014 period.

The Coroner

The Coroner's remit is narrow. Under the Coroner's Act 1962, his/her function is to ascertain the medical cause of death. The Coroner is precluded from returning a narrative verdict and, therefore, from addressing wider, systemic issues relating to the death and the circumstances in which it occurred.²⁵ Beckett believes there is a 'mismatch in public perception' about the role of the Coroner, with the public tending to overestimate the scope of their remit. Often

²³ Comments made during presentation by PhD Student Colette Barry, DIT Aungier St, 17 November 2014.

²⁴ Prisons Act 2007

²⁵ Agnieszka Martynowicz, 'Oversight of Prison Conditions and Investigations of Deaths in Custody: International Human Rights Standards and the Practice in Ireland' (2011) *The Prison Journal* 94.

there is a discrepancy between the cause of death and the coroner's verdict, as will be outlined later in this report.

Commission of Investigation

A Commission of Investigation may be held if deemed necessary by the Minister for Justice. This commission is established if there is public concern about a particular death. In this respect, the media have an important role as a conduit to express public sentiment. They can act as a catalyst to a commission being established.

1.6 Is Ireland compliant with the ECHR?

At a conference entitled *Human Rights at the Heart of Penal Policy* held in DIT Grangegorman on November 28th 2014, the Inspector of Prisons Judge Michael Reilly stated that he believed Ireland was fulfilling its obligations under the ECHR due to the combination of investigations carried out. This stance is consistently echoed in his annual reports, where he describes the combination of investigations as a 'three pronged process'.²⁶

But is Ireland really compliant with the ECHR? Martynowicz believes the shortcomings in the Irish penal system to be 'most acute in the cases of deaths in custody where the currently available mechanisms rarely give an opportunity for the investigation of systemic issues that may have contributed to the death,

²⁶ Inspector of Prisons Omnibus Report 2012-2014, 5.
<<http://www.inspectorofprisons.gov.ie/en/IOP/Omnibus%20report%20of%20investigations%20into%20the%20deaths%20of%20prisoners.pdf/Files/Omnibus%20report%20of%20investigations%20into%20the%20deaths%20of%20prisoners.pdf>> accessed 13.01.15.

such as overcrowding, lack of risk assessment and mismanagement of safety procedures'.²⁷

1.7 What are the shortcomings in Ireland's compliance?

A piecemeal approach

Investigations into deaths in custody in Ireland have been characterised by a piecemeal approach; where quantity appears to take precedence over quality and a thorough investigation with an attributable cause is therefore difficult. One could argue that there are too many reports yet too little responsibility. Whilst each institution has its own internal accountability, overall accountability of the penal system is virtually absent. Various bodies investigate a particular angle but no one takes an overview. Hence, we believe Ireland does not satisfy its obligations under the ECHR. The approach taken ensures systemic analysis of prison deaths is absent as will be explored in this report, where we will offer recommendations to improve Ireland's penal system.

Next-of-Kin

Families of prisoners who have died in Ireland often face uncertainty and confusion after a death has occurred. It may take months or even years for questions they may have about how or why the death occurred to be answered. Procedures for informing families about the death or the inquest should be standardised across the system. Families are not always entitled to

²⁷ Ibid p.98.

legal aid for representation at an inquest. It is important families are involved in the investigative process for their own grieving and to ensure they feel justice has been done. The role the next-of-kin play in the investigative process will be explored in greater detail in this report.

Transparency

Having an open and transparent investigation helps reassure families that justice has been done. It also serves to allay any public concerns about possible injustice. Public perception of injustice can undermine the agents of the state. The importance of clarity was asserted in *Edwards v. UK* where the court held that a 'sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory'²⁸ is necessary.

Delays

The Inspector of Prisons has envisaged that an investigation of a death in custody be concluded with six months²⁹. These reports must then await Ministerial approval before publication, so a significant time lag may occur. This report focuses on 2012-2014. Currently 32 out of 34 deaths in custody reports have been published.

²⁸ *Edwards v. UK* (2002) ECHR 19 para 73.

²⁹ Mary Rogan, *Prison Law* (Bloomsbury, 2014) 6.43.

1.8 What are the key issues arising from this research?

Role of Minister for Justice and Equality

One of the most striking features of the investigative process of deaths in Irish custody is the powerful role of Minister for Justice and Equality. The Minister is responsible for visiting committee personnel appointments. A robust and empowered prison visiting committee may offset problems at an early stage. The Inspector of Prisons must submit their reports to the Minister for Justice and Equality, who decides when and whether to publish the reports. In terms of possible Commission of Investigations, the Minister decides whether to establish one, what the terms of reference will be. After the Commission has submitted its report to that same Minister, they may exercise the power to redact some of the report. This sequence alone points to a very centrally controlled system, which lacks both independence and transparency.

Lack of available data

The dearth of research on the issue of deaths in custody has been somewhat compounded by the lack of available data. Whilst accessing inquest files in the Coroners' Court, Barry discovered 'there is seldom an indication in the ledger that the death has occurred in a prison'³⁰. Not having available data means there is less potential for research and analysis of deaths in custody. A

³⁰ Colette Barry, 'Death in Irish Prisons: An Examination of the Causes of Death and the Compliance of Investigations with the European Convention on Human Rights, (Masters Dissertation, Dublin Institute of Technology, 2011) 23.

consequence of this is an inability to either identify or address any systemic issues.

1.8 The Optional Protocol to the Convention Against Torture

Ireland has signed but not yet ratified the Optional Protocol to the Convention Against Torture (OPCAT). Speaking at the Human Rights at the Heart of Penal Policy Conference in DIT Grangegorman in November 2014, Elina Steinerte from the University of Bristol outlined the importance of the OPCAT as the ‘first human rights treaty dedicated to prevention’.³¹ Under the OPCAT, Ireland would establish National Preventative Mechanisms to ensure breaches don’t occur by ensuring regular unannounced inspections of prisons. Speaking at the same conference, Deirdre Malone, the chief executive of the IPRT reinforced the importance of this stating how such ‘accountability mechanisms are the mechanisms necessary to vindicate human rights’.

1.9 European Convention on Human Rights

A death in custody is a death of a person in the custody of the police, prison service or other state authorities. Some apparently ‘natural’ deaths in custody can constitute a violation of the right to life, particularly where such deaths result from torture, ill-treatment (including medical neglect), poor prison conditions, excessive use of force, overcrowding or lack of appropriate diet. Conditions of detention may also constitute cruel, inhuman, or degrading

³¹ Comments made at ‘Human Rights at the Heart of Penal Policy’ conference DIT, Grangegorman, 28 November 2014.

treatment, and under these circumstances, custodial deaths will constitute a human rights violation.

The most important international monitoring institutions in Europe for prisoners' rights are the European Court of Human Rights³² (ECtHR) and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).³³ These two bodies are institutions of the Council of Europe.³⁴ Both institutions are independent of each other but they do co-operate. The ECtHR uses the work of the CPT by relying on its visit reports in cases of alleged human rights violations. The CPT has visited Ireland for inspection purposes on a number of occasions. Following its 2010 visit to Ireland, the CPT recommended that prison authorities ensure that all prisoners 'are kept in decent conditions of detention'.³⁵ Further, they recommended that authorities deliver at regular intervals the message that ill-treatment of prisoners will not be tolerated and will have severe sanctions attached.³⁶

³² An international court based in Strasbourg, France. It consists of a number of judges equal to the number of states of Council of Europe that have ratified the Convention for the protection of Human Rights and Fundamental Freedoms.

³³ A monitoring institution, preventing ill-treatment of persons deprived of their liberty in Europe.

³⁴ An international organisation promoting human rights and democracy in Europe.

³⁵ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from the 25 January to 5 February 2010 (CPT 2011) Appendix 1. Available at: www.cpt.coe.int/documents/irl/2011-03-inf-eng.htm.

³⁶ Ibid.

The committee recommended a number of measures to address these issues; single cell occupancy, the eradication of ‘slopping out’, a sentence plan for each prisoner with due attention to purposeful activities and the health care needs of prisoners, and ongoing training of staff in the management of inter-prisoner violence.³⁷ The situation in some Irish prisons as described by the committee could amount to inhuman or degrading treatment in accordance with the ECtHR decision in *Peers v Greece*³⁸ in which the court held that mistreatment did not have to be intentional for it to be regarded as a violation of Article 3 of the European Convention on Human Rights (ECHR).

There are two main human rights issues that arise from death in custody. The first is whether the positive obligation on the state authority to take reasonable steps to prevent the death was fulfilled, and secondly, whether a subsequent investigation was compatible with the prison rules, constitutional principles and the provisions of the ECHR. When a death occurs, an investigation is necessary to identify whether the prisoner’s right to life had been adequately vindicated and protected. The right to life is protected by the Irish Constitution (Article 40.3) and Article 2 ECHR.

Article 2 of the ECHR provides substantive protection of the right to life. The right to life is a fundamental human right and according to the ECHR, contracting states have a duty to respect and ensure the right to life of

³⁷ Ibid.

³⁸ Appl. No. 28524/95 (ECHR, 19 April 2001)

persons within their jurisdiction, including when such persons are held in custody, whether in public or in private settings. The duty to respect and ensure the right to life requires that no one may be arbitrarily deprived of his or her life. No exceptional circumstance may be invoked to justify derogation from the duty to respect the right to life. The duty applies to all branches and organs of the State, including law enforcement agencies and security forces.

Article 2 ECHR

Article 2.1 states that:

Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Prisoners have a right to life and prison authorities have a duty not to take life intentionally or by disproportionate use of force. Under Article 2, the obligations on a State consist of three principal aspects:³⁹

1. The duty to refrain from unlawful deprivation of life;
2. The duty to investigate suspicious deaths and in certain circumstances;
3. A positive obligation to take steps to prevent avoidable losses of life.

Deprivation of Life

Article 2. of the ECHR states that:

³⁹ Appl. No 18984/91 (Grand Chamber, 27/09/1995).

Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) In defence of any person from unlawful violence

(b) In order to effect a lawful arrest or to prevent escape of a person lawfully detained

(c) In action lawfully taken for the purpose of quelling a riot or insurrection.

The first substantive right proclaimed by the ECHR is the right to life. The right to life is listed first because it is the most basic human right of all: if a person's right to life could be arbitrarily deprived, all other rights would become illusory. The fundamental nature of the right to life is also clear from the fact that it cannot be derogated from. In *McCann & Others v UK*⁴⁰, a case involving three persons shot in Gibraltar by members of the Special Air Service, the Court concluded that there had been a violation of Article 2 because the operation could have been executed without the need to kill persons suspected of planting a bomb in Gibraltar. In its Grand Chamber judgment, the Court commented that Article 2 ranks as one of the most fundamental provisions in the ECHR.

The protection of the life of citizens, including those in custody, must meet ECHR standards. To protect human rights, mechanisms must be put in

⁴⁰ Ibid.

place to safeguard people against arbitrariness and abuse of force, some of which have resulted in custodial deaths. In *Jordan v UK*⁴¹, the applicant alleged that his son, Pearse Jordan, had been unjustifiably shot and killed by an unnamed officer of the RUC⁴². The ECtHR held that the circumstances surrounding Jordan's death amounted to a violation of Article 2 of the ECHR. The obligation under Article 2 is for the state to refrain from causing deprivation of life through its agents. The use of lethal force by agents of the state must be regulated, and force must not be used in a disproportionate way in their duty to maintain law and order.

Preventative Measures to Protect Life

Article 2 has been interpreted to include the positive requirement to ensure that preventative measures are taken to protect citizens when they are taken to custody. This was confirmed in the case of *Osman v UK*⁴³ in which the ECtHR overruled the UK court's decision in *Hill v West Yorkshire*⁴⁴ that public bodies could not be held liable in negligence. The Court declared that a detaining authority fails in its duty to protect life if the authority knows or ought to have known of a risk to a prisoner's life, but did not take reasonable steps to avert the risk.

⁴¹ [2001] ECHR 327

⁴² Royal Ulster Constabulary (The police force in Northern Ireland from 1922 to 2001).

⁴³ [1998] EHRR 101.

⁴⁴ [1998] 2 WLR 1049.

In another controversial case, *Alder v UK*⁴⁵, the ECtHR found the UK in breach of its obligation to preserve life and ensure that no one is subjected to inhuman or degrading treatment. The deceased in this case choked to death in handcuffs on the floor of a Hull police station in April, 1998. CCTV footage showed him gasping for air as officers chatted and joked around him. The film showed that he had received no assistance from the five officers, who thought he was play-acting. It was in this case that the UK admitted for the first time a violation of Articles 2 and 3 of the ECHR.

*Keenan v The United Kingdom*⁴⁶, a prisoner with a mental illness took his own life. He had been placed in segregation for seven days following an assault on two prison officers and his sentence was also extended by 28 days. In the case before the ECtHR, his mother argued that the UK government had failed to vindicate his right to life under Article 2 by failing to prevent his suicide. The Court acknowledged that prison authorities are obliged to safeguard prisoners' lives, but in this particular situation, no violation was found. The risk of suicide was known, but the authorities had taken reasonable steps having regard to the circumstance and his behaviour prior to his death. The test was whether the prisoner was at an immediate risk of suicide, and whether the authorities did all they could reasonably be expected to do.

⁴⁵ Appl. No 42078/02, (ECHR, 14 December 2010).

⁴⁶ [2001] 33 EHRR 38.

A failure to provide adequate health care service in prison led to the death of the prisoner in the case of *Tarariyeva v Russia*⁴⁷. The ECtHR found the state authority had failed in its duty to protect life. The failure of the authority to take preventive measures by providing the medical service needed at the particular time was said to have caused the death of the prisoner. This act, the court declared, amounted to a violation of the prisoner's right to life.

Obligation to Investigate Deaths in Custody

Article 2 ECHR places a positive obligation on contracting states to conduct an effective investigation following a death in state custody. The prohibition against the arbitrary deprivation of life, read in conjunction with the general obligation to respect and ensure human rights within the State's jurisdiction, has been interpreted as imposing by implication an obligation to investigate alleged violations of the right to life. This obligation is put into effect whenever a detainee, without injuries when taken into custody is injured or has died. The obligation to investigate deaths in custody has also been interpreted as deriving from a combination of the prohibition against the arbitrary deprivation of life and the obligation to provide an effective remedy.

Where an authority has failed in its duty to investigate the death of a person in its custody, such an authority will be held responsible. In *Salman v Turkey*⁴⁸, the ECtHR held that:

⁴⁷ Appl. No 4353/03 (ECHR, 14 December 2006).

⁴⁸ Appl. No 21986/93 (ECHR, 27/06/2000 (GC))

where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during such detention, indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation.

The Court further stated that:

People in custody are in a vulnerable position and the authorities are under a duty to protect them. The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent when that individual dies.

Similarly, in *Coselav v Turkey*⁴⁹, the Turkish authorities were found to have violated Article 2 due to delay and failure in their duty to investigate. The information about the death of the prisoner was conveyed to his parents thirteen days after it occurred. This prevented the parents or any other member of the family from participating in the investigation. Even after his death, no efforts were made by the authorities to establish why the prisoner committed suicide, or whether his death could have possibly involved another person or persons.

In the Irish case of *Magee v Ireland*⁵⁰, the ECtHR communicated to the Irish government complaints under Articles 2 and 13 ECHR with a view to

⁴⁹ [2012] ECHR 1789.

⁵⁰ Appl. No. 53743/09 (ECHR, 20 November 2012).

settlement. The deceased prisoner was handcuffed and placed in a police cell. While he was in custody, he showed signs of paranoid delusion. After a short time, he was found unconscious and taken to the hospital where he was pronounced dead.

In the Irish courts, the applicant (Mrs Magee, mother of the deceased prisoner) won her case in the High Court but the Supreme Court found that she was not entitled to legal aid to be represented at the Inquest and the Inquest jury returned a verdict of death by misadventure. The hearing of the Inquest proceeded eight years after the death of Mr Magee, a significant delay, while the applicant sought to secure through the Court, an entitlement to legal aid which had, at the time of the death, already been established and expanded upon by the Court. The applicant complained to the ECtHR about the investigation which took place following the death of her son and because the rights under the Convention do not operate in isolation, she invoked Articles 2⁵¹, 6⁵², 8⁵³ and 13⁵⁴ of the ECHR. She complained under Article 13 that civil proceedings did not constitute an effective remedy as regards the matters invoked under Article 2 of the Convention.

Article 13 provides for the right to an effective remedy before national authorities for violations of rights under the Convention. The inability to obtain

⁵¹ The right to life.

⁵² The right to a fair trial.

⁵³ The right to respect for private and family life.

⁵⁴ The right to effective remedy.

a remedy before a national court for an infringement of a Convention right is thus a free-standing and separately actionable infringement of the Convention.

The ECtHR decided to communicate to the Irish Government complaints under Article 2 about investigative obligations and under Article 13 about effective remedies. As a result, the Government indicated its intention to pursue a settlement of the case and to enact into law the Coroner's Bill 2007⁵⁵ and in particular section 86 of the Bill providing for legal aid. Unfortunately, the Bill was not pursued and it has now lapsed.

The government agreed to pay Mrs Magee in respect of non-pecuniary loss, for costs and expenses incurred in filling the application with the court and also agreed to pay the costs of the domestic proceedings. The ECtHR was satisfied that the settlement was based on respect for human rights as defined in the Convention and, found no reasons to continue the examination of the application. As a result the case was struck out of the court's list.

The purpose of investigation therefore, is to protect the interests of all parties involved: the deceased, the next of kin, the detaining authorities, and society as a whole. The investigation's immediate purpose is to clarify the circumstances of the death. It should establish the facts surrounding the death.

⁵⁵The Bill would amend, consolidate and extend the law relating to coroners, coroners' investigations and coroner' Inquests.

The investigation may also contribute to realising other objectives, such as reducing trauma and providing an effective remedy for the next of kin. Having a clearer understanding of the circumstances surrounding a death may help the next of kin to cope with their suffering. If the state's culpability for the death is established, the next of kin are entitled to suitable reparation, such as monetary compensation or a public apology.

Two - Ireland

2.1 Introduction

This chapter explores deaths in custody in Ireland and specifically deaths in Irish prisons. The primary focus is on the nature of investigations that take place when a death occurs in prison custody. The compatibility of such investigations with Ireland's obligations under the European Convention of Human Rights (ECHR) is examined. Themes in the findings of reports by the Inspector of Prisons into deaths in custody are outlined.⁵⁶ Within the latter context, the nature and extent of the role of next-of-kin are explored.

An account is also given of the nature of investigations following a death in two other custodial settings; in the custody of An Garda Síochána and in secure psychiatric hospitals. The findings provide some comparative information for investigations into deaths in prisons.

There is an obligation on the state to protect a prisoner's right to life and to protect him/her from inhuman or degrading treatment.⁵⁷ The right to life enshrined in Article 2 ECHR is the most fundamental of human rights and freedoms.

⁵⁶ Reports of the Inspector of Prisons are available at: www.inspectorofprisons.gov.ie/en/IOP/qsearch.

⁵⁷ Bunreacht na hÉireann 1937, Article 40.3.1, Article 40.3.2.

2.2 Article 2 of the European Convention on Human Rights (ECHR)

Judge Michael Reilly, the current Inspector of Prisons, cites three elements of Article 2 ECHR that are of particular relevance to investigations of deaths in custody in Ireland:⁵⁸

The state must protect those within its jurisdiction from killing inflicted by a state agent and from any unintentional killing by a state agent arising from more than the minimum amount of force necessary in the circumstances as specified in Article 2.⁵⁹

A positive obligation is imposed on the state to protect those known to be at risk or those whom the state ought to have known were at risk.⁶⁰ A person in custody is in a vulnerable position by virtue of the deprivation of his/her liberty. Authorities have a particularly high duty of care to protect the right to life of such persons.⁶¹ The state must take reasonable measures to protect a person in custody from potential harm from himself/herself. The state must also protect a person in prison custody from a known threat of harm from a third party for example from a prison cellmate who may have a serious psychiatric disorder or violent tendencies.⁶²

⁵⁸ Michael Reilly, Inspector of Prisons, *Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody* (Inspector of Prisons 2010), 9.

⁵⁹ *McCann v United Kingdom* App no 18984/91 (ECtHR, 27 September 1995).

⁶⁰ *Osman v United Kingdom* App no 23452/94 (ECtHR, 28 October 1998).

⁶¹ *Kats v Ukraine* App no 29971/04 (ECtHR, 18 March 2009). The deceased prisoner had health conditions and was HIV positive but was not given adequate medical care which contributed to her death.

⁶² *Edwards v United Kingdom* App no 13071/87 (ECtHR, 16 December 1992).

A second positive obligation is placed on the state to investigate all deaths in custody and to undertake such investigations in an effective manner.⁶³ The criteria whereby an investigation into a death in custody is deemed effective were laid out in *Jordan v United Kingdom* and have become known as the *Jordan* principles.⁶⁴

2.3 The Jordan Principles

The six *Jordan* principles are as follows:

- The state must initiate a formal investigation when a death occurs in custody. It cannot be left to the next-of-kin to seek such an investigation;
- The investigation must be conducted in an independent manner and those conducting the investigation must be both institutionally and practically independent;
- The investigation must be sufficiently thorough to lead firstly to a determination, where relevant, whether or not the force used was justified in the circumstances, and secondly, to the identification and punishment of those responsible for the death;⁶⁵
- The investigation must be initiated in a prompt manner following the death;

⁶³ *Ibid.*

⁶⁴ *Jordan v United Kingdom* App no 24746/94 (ECtHR, 4 May 2001).

⁶⁵ *Coselav v Turkey* App no 1413/07 (ECtHR 9 October 2012).

- There must be an element of public scrutiny of both the investigation and the outcome mindful of case-by-case sensitivities;
- Next-of-kin must be involved in order to protect their legitimate interests.⁶⁶ This may require the provision of free legal aid to next-of-kin.

The *Jordan* principles provide a set of benchmarks against which an investigative process into a death in custody in Ireland can be measured in terms of its levels of robustness, fairness, transparency and overall effectiveness as an investigation. An important point to note is that all six *Jordan* principles need not be fulfilled in a single investigation. The procedural requirements of Article 2 ECHR are met if the state can show that the principles are evident across a combination of investigations into a death in custody.⁶⁷

Each investigation must however, retain its own integrity and cannot rely on 'collective' robustness across investigations as an excuse for shortcomings in its own particular investigation. A number of flaws in the various individual investigations were cited in the House of Lords case of *R (Amin) v Secretary of State for the Home Department*,⁶⁸ The case dealt with the death of a young offender (Zahid Mubarek) at the hands of a cellmate who suffered from a severe psychiatric illness and had known racist tendencies. There was no inquest. The police investigations were conducted in private. There was no

⁶⁶ *Kats v Ukraine* App no 29971/04 (ECtHR, 18 March 2009).

⁶⁷ *Jordan v United Kingdom* (2001) App 24746/96 (ECtHR, 4 May 2001) para 143.

⁶⁸ *R(Amin) v Sectary of State for the Home Department* (2003) UKHL 51.

next-of-kin involvement in the criminal investigation and little exploration of wider issues concerning the death which would be standard practice in criminal trials.⁶⁹ An internal prison inquiry was conducted in private by a serving member of the Prison Service compromising greatly the *Jordan* independence principle. No report was published. There was limited opportunity for next-of-kin to be involved in any meaningful way in the internal prison inquiry.⁷⁰ The various investigations were seriously flawed and a violation of Article 2 ECHR was held. Investigations however, are not expected to cast their inquiry net so broad as to make the investigation unmanageable.⁷¹

The Jordan Principles in Case Law

The *Jordan* principles were applied in the inter-prisoner violence case of *Edwards v United Kingdom*.⁷² The deceased (prisoner) had been placed in the same cell as a prisoner who was suffering from a psychiatric illness and violent tendencies when the prison authorities should have taken all reasonable steps to prevent the threat of harm to another prisoner. The investigation conducted was a non-statutory, private investigation with no powers in respect of compellability of witnesses. The next-of-kin initiated the formal investigation.⁷³

⁶⁹ See findings in *Kats v Ukraine* referring the need in an investigation into a death in prison custody to establish all material facts, causes and circumstances of death, exposing shortcomings in systems and bringing to justice those responsible for the death.

⁷⁰ *Regina v Secretary of State for the Home Department ex parte Amin* [2003] UKHL 51.

⁷¹ See for example *Bailey v United Kingdom* App no 39953/07 (ECtHR, 19 January 2010).

⁷² *Edwards v United Kingdom* App no 13071/87 (ECtHR, 16 December 1992).

⁷³ *Edwards v United Kingdom* App no 13071/87 (ECtHR, 16 December 1992).

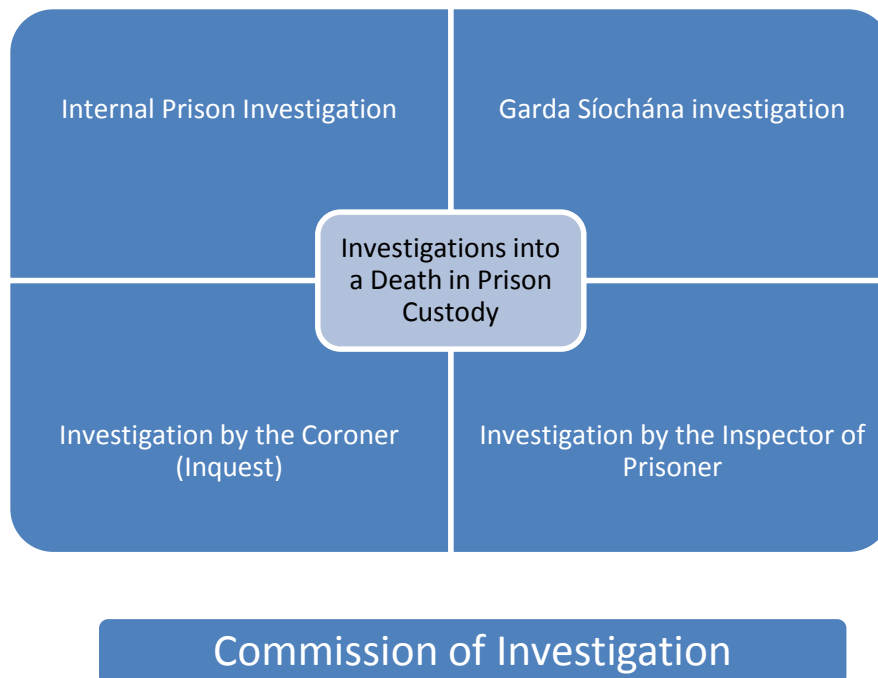
The European Court of Human Rights (ECtHR) held that there had been a violation of the procedural aspects of Article 2 ECHR.

2.4 Investigations into Deaths in Prison Custody in Ireland

A death in prison custody refers not only to a death within prison walls but also to a death of a prisoner who may be on temporary release. When a person dies in prison custody, four investigations take place:

- (1) an internal prison investigation;
- (2) an investigation by the Garda Síochána;
- (3) an investigation by the Coroner;
- (4) an investigation by the Inspector of Prisons.

Figure X: Types of Investigations into a Death in Prison Custody



2.5 Commission of Investigation

A Commission of Investigation may be set up pursuant to section 3 of the Commission of Investigations Act 2004. It is an independent inquiry convened by the Government 'to investigate into and report on matters to be of significant public concern.'⁷⁴ A Commission of Investigation works largely in private.⁷⁵ To date, it has been used only once in a death in custody context in the investigation into the death of a young prisoner, Gary Douch.⁷⁶

Case Study – Gary Douch

The death of 21 year old prisoner Gary Douch while in custody in Mountjoy Prison is one of the most high profile deaths in an Irish prison in recent years. The circumstances of which have been compared by commentators to that of Edwards in the UK.⁷⁷ On the night of 31st July 2006 Mr. Douch was being detained in a holding cell with six others in the 'B Base' of Mountjoy Prison, an area which is used to house prisoners in need of protection from other prisoners. During the night Mr. Douch was the victim of an assault by Stephen Egan, a fellow prisoner in the holding cell. His unconscious body was found by prison officers the following morning.⁷⁸

⁷⁴ Commissions of Investigation Act 2004.

⁷⁵ Commissions of Investigation Act 2004 s11.

⁷⁶ SI 371/2007 Commission of Investigation (Death of Gary Douch in Mountjoy Prison) Order 2007.

⁷⁷ M Rogan, 'Visiting Committees and Accountability in the Irish Prison System: Some Proposals for Reform. 2009' 31 Dublin University Law Journal .

⁷⁸ Report of the Commission of Investigation into the Death of Gary Douch. 2014 pg 2.

Mr. Egan had a history of violent assaults and mental health problems which were known to prison authorities. He previously assaulted a prison officer on 27th November 2005 during a transfer from Cork to Cloverhill Prison. On 17th December 2005 he set fire to his cell reporting visual and auditory hallucinations. On 5th July 2006 when admitted to the Central Mental Hospital his treating psychiatrist described him as 'acutely psychotic'. Mr. Egan was transferred from Cloverhill Prison to Mountjoy Prison on 29th July 2006. He was not seen by a prison doctor during the three days prior to the assault, nor were the prison doctors aware of his presence in the prison. Mr. Egan did not receive his anti-psychotic medication during this period. On arrival Mr. Egan could not be placed in a cell on any of the main wings of Mountjoy Prions due to threats made to him from other prisoners. He was placed as the seventh prisoner in the holding cell with Mr. Douch on 31st July 2006.⁷⁹

Following the incident, Stephen Egan was arrested and charged with the murder of Gary Douch. He was convicted of manslaughter by reason of diminished responsibility and received a sentence of life imprisonment on 29th June 2009. An appeal was rejected by the Court of Criminal Appeal on 29th November 2010.⁸⁰

⁷⁹ Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014), 21.

⁸⁰ Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014), 2.

The inquiry into the death of Gary Douch was set up under the Commissions of Investigations Act 2004 in August 2006. Grainne McMorrow SC was appointed as the sole member and the commission became fully operational in mid-August 2007. The McMorrow Report was presented to the Minister for Justice and Equality in January 2014. The report was not published until May 2014 and contained four volumes.⁸¹

The McMorrow Report was very critical of the fact that seven prisoners, each with different vulnerabilities, were held in a small holding cell. The report criticised the supervision regime in place for vulnerable prisoners such as Gary Douch who had sought special protection and ended up in a small holding cell with six other prisoners. Shortcomings in risk-assessment strategies and in the management of violent prisoners were cited. The report noted lacunae in inter-prison communications with mental health services and the limited provision for the psychiatric care needs of prisoners who had spent time in the Central Mental Hospital. An important recommendation stated that alternatives to prison custody should be explored.⁸² A key recommendation related to the setting up of a protocol system for contacting next-of-kin of the death of a family member in custody. This recommendation was made to avoid the situation

⁸¹ Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014).

⁸² Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014), Volume One, Executive Summary and Recommendations, 47.

whereby the family would hear of the death from the media as happened in the case of Gary Douch.

It took almost seven years for the McMorrow report to be published. The decision to publish Commission of Investigation reports rests with the Minister for Justice and Equality. Based on ECtHR judgments, the extent of delay in publishing the Commission of Investigation into the death of Gary Douch is unlikely to satisfy the reasonable promptness *Jordan* principle. It is therefore unlikely to satisfy the procedural requirements of Article 2 ECHR. The *Finucane v United Kingdom* case demonstrates that inordinate delays (in the latter case, some 10 years after the event) prevent an effective investigation taking place amounting to a violation of Article 2 ECHR.⁸³ The delay in the publication of the McMorrow Report is in part understandable. The Commission's Report could not have been published until all criminal proceedings and appeals relating to the case were completed. Concern in relation to the level of Ministerial control over Commission of Investigation processes has been aired by both Rogan⁸⁴ and Martynowicz.⁸⁵

The setting up of an Office of the Ombudsman for Prisoners with a statutory authority to investigate prisoner complaints was recommended by the

⁸³ *Finucane v United Kingdom* App no 29178/95 (ECtHR, 1 July 2003) para 80.

⁸⁴ Mary Rogan, *Prison Law* (Bloomsbury Professional 2014).

⁸⁵ Agnieszka Martynowicz (2011) 'Oversight of Prison Conditions and Investigations of Deaths in Custody: International Human Rights Standards and the Practice in Ireland' *Prison Journal* 91(1), 81-102.

Commission of Investigation into the death of Gary Douch.⁸⁶ There is no Ombudsman for Prisoners in Ireland. If one were established, the position holder could have responsibility for the investigation of all deaths and complaints in prisons. He/she could also be required to report publicly on the findings.

2.6 Other Research Findings

Barry's research identifies a range of factors contributing to prison deaths such as, prisoner mental health problems, substance abuse problems, and adverse prison conditions. Her research also unearths systemic deficiencies in prison systems for example poor medical care and inadequate monitoring of at-risk prisoners.⁸⁷ The Bradley report in the United Kingdom referred to the prevalence of 'dual prognosis' prisoners. Such prisoners suffer a combination of both substance abuse and mental health problems. The Bradley report recommended that mental health services and substance abuse services need to work hand-in-hand in order to meet the needs of dual prognosis prisoners.⁸⁸ The Report of the National Steering Group on Deaths in Prisons recommended that a special unit be established in prisons for prisoners with serious

⁸⁶ Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014), Volume 2, Final Report, Gráinne McMorrow SC, 467.

⁸⁷ Colette Barry, 'Death in Irish Prisons: An Examination of the Causes of Deaths and the Compliance of Investigations with the European Convention on Human Rights' 2011, Unpublished MA thesis, Dublin Institute of Technology.

⁸⁸ Lord Bradley, *The Bradley Report* (2009). Available at: http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf.

behavioural and/or psychiatric difficulties.⁸⁹ It also recommended up-to-date training for prison staff in the area of suicide prevention.⁹⁰

2.7 Internal Prison Investigation

When a prisoner dies in a prison, under Rule 47 (7) of the Prison Rules, there is a statutory obligation on the prison Governor to notify 'as soon as may be' the death to the Minister for Justice and Equality. Under Rule 47 (8), the Governor must submit a report to the Minister. The circumstances of the death and all matters pertaining to the death must be outlined in the report. The Inspector of Prisons receives a copy of the report. The Governor's report includes statements from prison officers, the assistant chief officer and chief officer on duty at the time of the death. All others who had contact with the deceased in the days prior to the death are also interviewed. The report comments on the existence and operational status of security systems in place at the time, for example CCTV, and other relevant information available in standard operational records. However, the most recent omnibus report from the Inspector of Prisons into deaths in prisons was strongly critical of prison written records:

Part of the documentation provided to me comprises operational statements of prison officers. In a number of my investigations I have found such statements to be minimal in content, misleading and in certain cases inaccurate.⁹¹

⁸⁹ Department of Justice, Report of the National Steering Committee on Deaths in Prisons (2000) 35.

⁹⁰ *ibid.*

⁹¹ Michael Reilly, *Report, into the deaths of prisoners in custody or on temporary release for the period 1st January 2012 - 11th June 2014* (Inspector of Prisons 2014), 10.

The Governor's report to the Minister documents the chronology of the prisoner's prison history, whether or not a criminal investigation has taken place and the results if available. Any medical evidence and the results of the post-mortem and toxicology reports where relevant are included. The Governor's report is not finalised until after the Coroner's inquest. Inquests can be adjourned indefinitely if criminal proceedings are in train. The role of next-of-kin is mentioned in the Governor's report but no substantive role for next-of-kin is evident. In the case of a death of a prisoner on temporary release, the Governor's report includes details of assessment reports and medical reports prior to release.

2.8 Level of Satisfaction of the Inspector of Prisons with Investigations

In 2010, the Inspector of Prisons had the following to say about internal prison investigations: 'The internal investigation is neither robust, independent nor transparent.'⁹² In his 2014 report, the Inspector of Prisons is highly critical of record-keeping in prisons and stated that in some cases internal prison records contained inaccuracies: 'Prison records are official records and it is a very

⁹² Michael Reilly, *Inspector of Prisons, Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody* (2010), 19. Available at: www.inspectorofprisons.gov.ie.

serious matter to falsify official records'. He goes further in stating that his Office was 'entitled to rely on the veracity of official records'.⁹³

Without access to internal prison reports, it is difficult to ascertain whether all prisons follow a common reporting template in reporting prison deaths. A uniform approach may help to develop consistency in reporting approaches at penal system level and increase accountability in reporting on death in custody cases. The current system whereby the investigation is the sole responsibility of the prison Governor leaves the investigation open to criticism that it is not independent (either hierarchically or at a practical level) of the circumstances of the death. The fact that the Prison Governor's report is not open to general public scrutiny leaves the investigation open to the charge of not being transparent.

An important *Jordan* principle in conducting an effective investigation relates to the need for the investigation to bring to justice those responsible for the custodial death. The Irish Prison Service has its own internal disciplinary procedures.⁹⁴ The report of the Commission of Investigation into the death of Gary Douch was exceptionally direct in calling to account those it believed should bear significant responsibility for the death of the prisoner: 'In the discharge of their functions, Governor Lonergan of Mountjoy Prison and Governor Somers of Cloverhill Prison must bear considerable responsibility for

⁹³ Office of the Inspector of Prisons Annual Report 2013-2014. Inspector of Prisons, 2014, 15. Available at:

http://www.justice.ie/en/JELR/IOP_Annual_Report_.pdf/Files/IOP_Annual_Report_.pdf

⁹⁴ Prison (Disciplinary Code for Officers) Rules 1996, SI 289/1996.

what tragically transpired'.⁹⁵ The Inspector of Prisons in his 2014 annual report is equally clear in emphasising consequential accountability when prison officers do not do their job: 'There must be consequences when this does not happen and the consequences should not depend on rank'.⁹⁶

2.9 Garda Investigation into a death in prison custody

The Governor of the prison in which a prisoner dies is required under Rule 47(7) of the Prison Rules 2007 to contact the Garda Síochána. Standard operational procedures are followed in the Garda investigation. These include examination of the death scene and details recorded for example whether or not the death scene was preserved and/or the nature of any scene-contamination. Details in relation to the identity, place, and time of death are recorded and other relevant information including statements from prison officers. Confirmation is sought that the next-of-kin, the prison doctor and the Coroner have all been contacted. Where foul play is suspected the pathologist may also need to be called. The primary purpose of a Garda investigation into a death in prison custody is to establish whether or not there is a criminal aspect to the death that warrants criminal investigation. The Garda investigation takes its own course if criminality is suspected and may or may not result in prosecution.

⁹⁵ Department of Justice, *Report of Commission of Investigation into the Death of Gary Douch, Volume 2, Final Report* (2014) 431.

⁹⁶ Office of the Inspector of Prisons Annual Report 2013-2014. Inspector of Prisons, 2014, 15. Available at: http://www.justice.ie/en/JELR/IOP_Annual_Report_.pdf/Files/IOP_Annual_Report_.pdf

The role of the next-of-kin in a Garda investigation is limited. If a defendant pleads not guilty there is no public disclosure of the circumstances surrounding the prison death. This means that the broader context of a death in custody is not open to public scrutiny. The Garda investigation therefore is susceptible to the charge of non-compliance with the public scrutiny element of the procedural requirements of Article 2 ECHR. However, the ECtHR has clarified that fulfilment of procedural requirements of Article 2 ECHR may be distributed across a range of investigations. A violation of Article 2 will not be arise if a state can attest to the collective contribution of a range of investigations in fulfilment of its international human rights obligations.⁹⁷

If foul play is not suspected in a prison death, a full Garda investigation will not take place. Garda investigation records of prison deaths are available to the Coroner for the purposes of an inquest. They are also available to the Courts if criminal proceedings are involved.

2.10 Investigation by the Coroner into a death in prison custody

The Coroner in the relevant district in which the prison death occurs conducts an independent investigation (known as an inquest).⁹⁸ Power to do so is conferred under Part III of the Coroners Act 1962, as amended.⁹⁹ An inquest

⁹⁷ *Jordan v United Kingdom* (2001) App 24746/96 (ECtHR, 4 May 2001) para 143, 'If the aims of fact finding, criminal investigation and prosecution are carried out or shared between several authorities, as in Northern Ireland, the Court considers that the requirements of Article 2 may nonetheless be satisfied'.

⁹⁸ Brian Farrell, *Coroners: Practice and Procedure* (Roundhall Dublin 2000).

⁹⁹ Coroners (Amendment) Act 2005.

is held in public. The purpose of an inquest is to establish the identity of the deceased person, how, when, and where the death occurred, and to place these facts on public record.¹⁰⁰ An inquest is inquisitorial by nature. Accordingly, no civil or criminal liability can be established or investigated at an inquest. Any censure or exoneration of a person is prohibited.¹⁰¹

An inquest is not permitted to probe the wider circumstances surrounding the death as held in *Farrell v Attorney General*.¹⁰² This is problematic from the perspective of the deceased's next-of-kin for whom the inquest is the primary source of information in helping them understand how and why their family member died in prison. As Beckett notes: '[w]hen the deceased person is not long out of childhood, or is still seen as being 'cared for', then questions of responsibility are fundamental to the process of How? and Why?'¹⁰³ However, in practice, coroners may forward any coronial concerns about systemic failures in prison polices and/or standard operational procedures directly to the Irish Prison Service and to the Inspector of Prisons. Concerns forwarded do not apportion blame to anyone. So, in a roundabout way, concerns in relation to the circumstances of a prison death can be brought by the Coroner into a 'public' arena of sorts. The rather outdated law on inquests in Ireland has thus been overtaken by actual coronial practices.¹⁰⁴

¹⁰⁰ Coroners Act 1962 s30.

¹⁰¹ Coroners Act 1962 s31.

¹⁰² *Farrell v Attorney General* [1998] 1 IR 203.

¹⁰³ Clare Beckett, 'Deaths in Custody and the Inquest System' (1999) *Critical Social Policy* 19, 272.

¹⁰⁴ Mary Rogan, *Prison Law* (Bloomsbury Professional 2014) 240.

This is of particular importance given that there is only a 'general duty to hold to hold an inquest'.¹⁰⁵ No automatic 'trigger' exists to hold an inquest following a death.¹⁰⁶ The Coroners Bill 2007 (if enacted) requires that an inquest takes place following a prison death.

2.11 Coronial Reports and Inquests

Unlike the Inspector of Prisons, the Coroner has power to compel witnesses.¹⁰⁷ The family of the deceased prisoner or their legal representatives are entitled to question witnesses at an inquest. They may also raise legitimate questions of concern but not to attribute blame. The family are also entitled to receive advance disclosure of relevant materials insofar as the failure to disclose would prevent the family's full participation in the inquest.¹⁰⁸

An inquest may be adjourned for lengthy periods until criminal proceedings and appeals are completed.¹⁰⁹ No requirement exists for an inquest to resume following completion of criminal prosecutions. Delays could give rise to a breach of the reasonable promptness *Jordan* principle. As an investigation commenced by the state as opposed to an individual, it complies with the procedural requirements outlined in the *Jordan* principles.

¹⁰⁵ Coroners Act 1962 s17.

¹⁰⁶ Colette Barry, 'Death in Irish Prisons: An Examination of the Causes of Deaths and the Compliance of Investigations with the European Convention on Human Rights' (MA thesis, Dublin Institute of Technology 2011).

¹⁰⁷ Coroners Act 1962 s26, s38.

¹⁰⁸ *Jordan v United Kingdom* (2001) App 24746/96 (ECtHR, 4 May 2001); *Lawlor v Geraghty* [2011] 4 IR 486.

¹⁰⁹ Coroners Act 1962 s25.

2.12 Investigations by the Inspector of Prisons into a death in prison custody

Since April 2012, the Inspector of Prisons has statutory powers to investigate all deaths in prison custody. These include deaths whilst a prisoner is on temporary release or whilst in hospital. The standards for investigations into prison deaths are outlined in the publication: Standards for the Inspection of Prisons in Ireland.¹¹⁰ The Inspector of Prisons views his role as part of a three-pronged investigative approach into deaths in custody; the Garda investigation, the Coroner's investigation/inquest, and the Inspector of Prisons investigations. The combination of all three investigative processes means that Ireland is:

In compliance with its national and international obligations and meets the strict criteria laid down by the European Court of Human Rights when interpreting the procedural requirements of Article 2 of the European Convention on Human Rights.¹¹¹

The Inspector of Prisons has sought additional powers that would enable him to compel witnesses to cooperate with his requests for information and disclosure. He has also called for the required legislation to confer such powers.¹¹² In the context of next-of-kin involvement, the Inspector consults 'as

¹¹⁰ Inspector of Prisons, Standards for the Inspection of Prisons in Ireland, (Inspector of Prisons) 2009. Available at: www.inspectorofprisons.gov.ie.

¹¹¹ Omnibus report by Judge Michael Reilly Inspector of Prisons of his investigations into the deaths of prisoners in custody or on temporary release for the period 1st January 2012 – 11th June 2014. 5-6.

¹¹² Michael Reilly, *An Assessment of the Irish Prison System* (Inspector of Prisons 2013), 40

appropriate, with members of the family of the deceased'.¹¹³ The Inspector of Prisons does not have the power to investigate deaths in secure mental hospitals or deaths in Garda custody. However, in his 2010 Report, the Inspector of Prisons recommended the establishment of a system similar to the Garda Ombudsman Commission.¹¹⁴ Its role would be to undertake independent investigation of all deaths in Garda custody.¹¹⁵ The recommendation was endorsed by the McMorrow Report.¹¹⁶

2.13 Investigation of a death in Garda Custody

A person held in Garda custody must be treated in line with statutory provisions.¹¹⁷ An investigation into the death of a person whilst in the custody of An Garda Síochána is covered by the Garda Síochána Act 2005. This legislation was enacted following the various Morris Tribunal findings.¹¹⁸ The Garda Commissioner is required to refer to the Garda Síochána Ombudsman Commission (GSOC) any matter that appears to indicate that the conduct of a member of An Garda Síochána may have resulted in the death of, or serious harm to, a person.¹¹⁹ GSOC has a 24 hour 'on call' facility in its Investigations

¹¹³ Michael Reilly, *An Assessment of the Irish Prison System* (Inspector of Prisons 2013), 39.

¹¹⁴ Michael Reilly, *Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody* (Inspector of Prisons 2010), 20..

¹¹⁵ Michael Reilly, *Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody* (Inspector of Prisons 2010), 20..

¹¹⁶ Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch*, Volume 1, Executive Summary and Recommendations (2014) 77..

¹¹⁷ The Criminal Justice Act, 1984 (Treatment of Persons in Custody in Garda Síochána Stations) Regulations, 1987 and 2006

¹¹⁸ The Morris Tribunal Reports are available at: <http://www.morristribunal.ie/index.htm>.

¹¹⁹ Garda Síochána Act 2005, s102(1).

Unit. This enables GSOC to respond and to investigate promptly any referrals by the Garda Commissioner under Section 102 (1) of the Garda Síochána Act 2005. Section 91 of the Act deals specifically with investigations of complaints concerning the death of, or serious harm to, a person. The procedure is clear:¹²⁰

2.14 Referrals Under Section 102 (1)

GSOC's procedure for investigations of referrals includes a specialised role for liaising with next-of-kin of the deceased. Referrals may be made by officers of the rank of Garda Superintendent upwards with the delegated authority of the Garda Commissioner. In 2013, the Garda Commissioner referred 41 incidents to GSOC under section 102(1) of the Garda Síochána Act 2005. This compared with 72 in 2012, 90 in 2011 and 103 in 2010.¹²¹ GSOC has no immediate explanation for this trend. GSOC's investigation team comprises a senior investigating officer (SIO), two investigating officers and an assistant investigating officer. An outline of the investigative procedures is presented in GSOC's 2011 Annual Report.¹²²

A summary of the procedures is as follows:

- The referral is examined by the SIO under Section 91 (Garda Síochána Act 2005);

¹²⁰ Garda Síochána Act 2005, s91.

¹²¹ Garda Ombudsman Commission Annual Report 2013. Available at: https://www.gardaombudsman.ie/docs/publications/GSOC_Annual_Report_2013_FINAL.pdf

¹²² Available at: http://www.gardaombudsman.ie/docs/publications/GSOC_Annual_Report_2011.pdf,31-32.

- A decision is made to hold a criminal or disciplinary inquiry;
- The Director or Deputy Director of Investigations provides direction if required;
- A specialist investigator takes on the role of Family Liaison Officer (FLO) to liaise with the family of the deceased and to assist the family throughout the investigation. A key task of the FLO is to ensure that the family is informed of the progress of the investigation. The FLO and the SIO deliver the investigation results to the family.

GSOC's investigation into a death in Garda custody can involve several processes. These can include a criminal inquiry into the circumstances that resulted in the loss of life. A disciplinary inquiry may be held should any misconduct issues arise during the investigation. GSOC's investigators may assist the Coroner in the coronial process. The Irish Council for Civil Liberties (ICCL) argue that GSOC should investigate the broadest possible range of complaints and not simply those under Section 91 (1) of the Garda Síochána Act 2005.¹²³ The ICCL further recommends that in the event of any investigations referred back to the Garda Commissioner, that GSOC should closely monitor these investigations.¹²⁴ GSOC's 2013 Annual Report stated 'that members of the Garda Síochána should make proper notebook entries

¹²³ Irish Council for Civil Liberties, *Implementing Morris - An Agenda for Change; Placing Human Rights at the Core of Policing in Ireland*, 13.

¹²⁴ *Ibid.*

regarding the events in which they are involved'.¹²⁵ This was based on recommendations of a jury.

GSOC's 2013 Annual report cited the following in relation to custody records:¹²⁶

- Specific guidance is needed in relation to when a custody record should be opened.
- A digital clock is needed in the custody area.
- The digital clock in the custody area needs to be synchronised with CCTV.
- Regular monitoring of synchronisation needs to be undertaken by relevant officers.

Whilst GSOC's annual reports provide recommendations around deaths in custody, there is no timeline for recommendations to be implemented at garda level. Neither is there any mention of steps that GSOC might take if recommendations are not implemented by Gardaí.

2.15 Deaths in a Secure Psychiatric Hospital

A death of a person in the custody of the mental health services must be reported to the Mental Health Commission.¹²⁷ All death notifications are forwarded to the Inspector of Mental Health Services. Where death by violent means or by suicide is suspected, the Inspector requests that a review is carried out by the service in question. A report on the investigation is

¹²⁵ Garda Síochána Ombudsman Commission Annual Report 2013, available at: https://www.gardaombudsman.ie/docs/publications/GSOC_Annual_Report_2013_FINAL.pdf.

¹²⁶ Garda Síochána Ombudsman Commission, Annual Report 2013, 23.

¹²⁷ Mental Health Act 2001 (Approved Centres) Regulations 2006, Article 14 (4); Code of Practice for Mental Health Services on Notification of Deaths and Incident Report, s2 (2).

forwarded to the Inspector. The Mental Health Commission Annual Report 2012 cites a high level of compliance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Report; 74% compliance in 2012 slightly up on 70% compliance in 2011.¹²⁸ Efforts to establish how a death in a secure psychiatric hospital is investigated proved to be unsuccessful.

2.16 Next-of-Kin

Informing the deceased's next-of-kin under the Prison Rules

Rule 47(7) of the Prison Rules 2007 outlines the range of persons to be contacted as soon as may be in the event of a prisoner's death. The Governor must contact the following: the next-of-kin; the Coroner (in whose jurisdiction the death has occurred); An Garda Síochána; the Minister for Justice and Equality; the Director General (of the Irish Prison Service); the prison doctor; the prison chaplain; the Inspector of Prisons, and the Chair of the Visiting Committee (of the relevant prison).¹²⁹

The next-of-kin must be contacted in the first instance, but the clause 'as soon as may be' in Rule 47 of the Prison Rules 2007 does not convey a sense of urgency. The fact that the family of the deceased prisoner in *Coselav*

¹²⁸ Mental Health Commission Annual Report 2012 including Report of the Inspector of Mental Health Services, available at: <http://www.mhcirl.ie/File/MHC-2012-Annual-Report.pdf>, 27.

¹²⁹ Each prison in Ireland has a Visiting Committee appointed under the Prisons (Visiting Committees) Act 1925 and the Prisons (Visiting Committees) Order 1925. Appointments to Visiting Committees are ministerial appointments. All matters relating to publication of reports of Visiting Committees rest with the Minister.

v Turkey were not told of the prison death (by suicide) of their son until almost two weeks after his death led to a finding of a violation of Article 2 ECHR.¹³⁰ The tardiness in contacting the next-of-kin in the Gary Douch case was severely criticised in the Commission of Investigation's report into his death.¹³¹

Among the recommendations in the Report of the Commission of Investigation into the death of Gary Douch is a protocol for the next-of-kin of the deceased in the event of a sudden and unexpected death. A minimum of two prisoner officers (or delegated persons such as Gardaí or a Prison Chaplain, if there is a perceived risk to prison officers) one of whom one should be at senior management level, should travel to the home of the next-of-kin to inform them immediately of the death. They should accompany the next-of-kin to the hospital or prison if required by the circumstances of the case. The Protocol should require a qualified person such as a social worker to be appointed in a supportive role to advise and assist the family with the death and act as a liaison between the family and the authorities.¹³²

It could be argued that the proposed protocol is a direct response to the mishandling of the death by the authorities towards Mr. Douch's family. The Commission noted that the family first learnt of Gary Douch's death through the media rather from officials of the State. The Commission has taken the

¹³⁰ *Coselav v Turkey* App no 1413/07 (ECtHR 9 October 2012).

¹³¹ Government of Ireland, Reports of the Commission of Investigation into the death of Gary Douch (2014). Available at: <http://www.justice.ie/en/JELR/Pages/PB14000112>.

¹³² Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014)50

view that such an incident should not happen again and secondly the family of any prisoner who dies in prison is given the appropriate support and respect.¹³³

Recognising the failings by the Irish Prison Service, and the treatment of the family after the death, the Minister for Justice and Equality personally met Gary Douch's mother prior to publication of the Commission report. In a statement the Minister stated:

His death was avoidable and should not have happened. It is only right that I apologise on behalf of the State and Irish Prison Service to the family of Gary Douch. I hope this report helps to clarify for them what happened that night, what should have been avoided, and what can be learnt to ensure there is no possibility of this happening again.¹³⁴

2.17 Next-of-kin involvement in investigations into prison deaths

The Coroners Act 1962 requires an inquest to be held where the Coroner is of the opinion that the death may have occurred 'in a violent or unnatural manner, or suddenly and from unknown causes.'¹³⁵ Where an inquest is held following a death in prison the next-of-kin, or their legal representatives, are entitled to question witnesses at an inquest. The inquest therefore, is an important forum for next-of-kin involvement.

¹³³ Department of Justice, *Report of the Commission of Investigation into the Death of Gary Douch* (2014)35

¹³⁴ Statement by Minister Shatter and Minister Lynch on the publication of the Report of the Commission of Investigation into the death of Gary Douch and the Response by the Irish Prison Service 01.05.2014. www.justice.ie Accessed 20.02.2015.

¹³⁵ Coroners Act 1962, s 17.

However, the absence of legal aid for families may mean that some families may not be in a position to participate fully in an inquest.¹³⁶ Indirectly, the inquest therefore may not fulfil Article 2 ECHR requirements if next-of-kin do not have access to the Coroners Court. As Rogan notes, legal assistance is necessary for families to help them raise potential issues of concern.¹³⁷

The Coroners Bill 2007 provides for legal aid to family members of a person who died in custody, for the purposes of legal advice in relation to, or legal representation at, an inquest.¹³⁸ This assistance would also be provided to a long term friend if no family member was available. The assistance is limited in that it will only be provided if the Coroner is satisfied that there is a 'significant public interest' in the person receiving advice or representation having regard to all of the circumstances.¹³⁹ In any event, the family member or friend would have to qualify for legal aid under the Civil Legal Aid Act 1995. Although welcome, these provisions are limited, and offer no assistance with the cost of attending an inquest, which may be substantial, particularly where the inquest is held some distance from the family member's home. Martynowicz has called for this statutory provision to be extended to legal representation at Commissions of Investigation.¹⁴⁰

¹³⁶ *Magee v Farrell* [2009]4 IR 703.

¹³⁷ Mary Rogan, *Prison Law* (Bloomsbury Professional 2014) 246-247.

¹³⁸ Coroners Bill 2007, s 86.

¹³⁹ Coroners Bill 2007, s 86(3)(b).

¹⁴⁰ Agnieszka Martynowicz, 'Oversight of Prison Conditions and Investigations of Deaths in Custody: International Human Rights Standards and the Practice in Ireland' *Prison Journal* 91(1) 81-102.

Accessing Information under the Freedom of Information Act 2014

In relation to a death in prison, the Freedom of Information Act 2014 facilitates an application by the next-of-kin of the deceased for access to 'personal information' regarding the deceased held by the prison service. 'Personal information' is information that would, in the ordinary course of events, be known only to the individual, or members of the family, or friends, of the individual. It includes information relating to the educational, medical, psychiatric, or psychological history of the individual.¹⁴¹ An application for information under the 2014 Act relating to deceased individual can be made by a personal representative, spouse, civil partner, cohabitee or next-of-kin.¹⁴² The 2014 Act contains a number of exemptions. In particular, the Director of the Irish Prison Service can refuse to grant a freedom of information request where it might impair a criminal investigation or the security of the prison.¹⁴³ The 2014 Act, therefore, may be of assistance to next-of-kin where a death does not result from criminal activity, potentially giving them access to medical and other records held by the prison service.

¹⁴¹ Freedom of Information Act 2014, s2(1).

¹⁴² Freedom of Information Act, 1997 (Section 17(6)) Regulations 2009, Reg 4(1)(b).

¹⁴³ Freedom of Information Act 2014, Section 32(1).

Three - Inspector of Prisons Reports Analysis

The current Inspector of Prisons, Judge Michael Reilly, was commissioned by the then Minister of Justice, Alan Shatter, to investigate all deaths in custody, commencing his investigations with those that occurred on or after the 1st January 2012.¹⁴⁴ There have been 34 deaths investigated by the Inspector between 2012 and 2014.¹⁴⁵ 32 reports are available on the Inspector of Prisons website. Of those reports, only one concerned the death of a female prisoner, which occurred on temporary release.¹⁴⁶ There are two reports still unpublished as of yet. Of these one relates to a death in 2013 and the other to a death in 2014. These investigations have been conducted, but the reports are not published. Of the 32 reports, 14 cases were from the Dublin area, 9 from the Munster area, 5 from the Leinster area, 2 from the Connaught area, and 2 from outside Ireland. 12 of the prisoners concerned were aged between 20 and 29, twelve between 30 and 39, one between 40 and 50, six between 50-69, and one 70+.

As highlighted in Table Seven, there have been quite lengthy delays between the occurrence of deaths and the publication of reports. The reports

¹⁴⁴ *Inspector of Prisons Reports into Deaths in Custody and Temporary Release in 2012, Report* (Department of Justice, 16 December 2013)

¹⁴⁵ Judge Michael Reilly, *Report by Judge Michael Reilly Inspector of Prisons of his investigations into the Deaths of Prisoners in Custody or on Temporary Release for the period 1st January 2012 to 11th June 2014* (Inspector of Prisons 2014)

¹⁴⁶ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A on 15th January 2014 while on temporary release* (2014/A , Inspector of Prisons 2014)

are published at the discretion of the Minister for Justice. Table Seven shows that reports can go unpublished for over 31 months. Therefore, issues raised in such reports cannot be tackled in a timely and efficient manner to ensure they do not occur again. Nor can lessons to be learned from the report be rolled out to ensure future safety if reports are not published in a timely manner.

The report into the death of Prisoner C 2012, who died in January 2012, was completed by the Inspector in August 2014, 31 months after the death of Prisoner C. The report was only published in January 2015, 36 months after the death of Prisoner C. Highlighted in the report are some tensions between the prison staff and the wife of the deceased in relation to his release on compassionate grounds due to failing health. It also referred to interdepartmental and inter-institutional communication problems regarding how an application for compassionate release should be dealt with and who had final authority on such a decision. Tension between the wife of the deceased and the prison administration documented in the Inspectors report perhaps shines a light on a possible reason why this report was delayed. The issues highlighted in the report could not be addressed or evaluated due to the fact it went unpublished for 36 months. As illustrated in Tables 8 and 11 a considerable amount of deaths occurred, and issues arose, from the time of the death and the completion of the report. A large amount of time also elapsed, five months, between the completion of the report into the death of Prisoner C and the publication of the report by the Minister of Justice on the Inspectors website. In the preceding 31 months to the publication of the report

similar issues may have arisen for other prisoners that did not result in death, but could have been subject to the same bureaucratic system of deliberation, without swift and appropriate remedy as could have been received had the report been published and acted on within a reasonable time frame.

The reports of Prisoners B and K of 2012 were delayed by 25 and 17 months respectively. Both reports concerned matters relating to prisoners with substance abuse problems and access to mental health services. In both cases, the Inspector highlights that less than adequate records were kept in relation to access to mental health services in prison. Both relate to requests for access, but no documentation relating to appointments kept or scheduled were available to the Inspector. This highlighted a serious deficiency in service provision. These reports went unpublished for between one and a half and two years which allowed for similar situations to occur in two cases in 2013.¹⁴⁷ The lack of swift and immediate publication of reports has the effect of situations repeating themselves.

Although the Inspector states throughout his reports that he has been granted unrestricted access to material and evidence requested, material is not always provided in a swift and timely manner. The Inspector's reports are thorough and detailed. They are extremely useful not only for analysing trends

¹⁴⁷ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner J on 18th September 2013 while on temporary release* (2013/J, Inspector of Prisons 2014); I Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner N in Wheatfield Prison on 29th December 2013* (2013/N, Inspector of Prisons 2014)

in deaths and contributory factors but they also give a glimpse of a cross-section of the prison population of prisons. Factors such as contact with psychiatric services, drug use/addiction, and prison guard culture regarding observation of prisoners and responses to incidents can be extracted from his reports.

3.1 Tables of data

Table One

<u>Sex of Deceased</u>	<u>Number of Deaths</u>	<u>Location of Death</u>	<u>Number of Deaths</u>
Male	31	Prison	9
Female	1	Temporary release	23

Table Two

<u>Prisoner's Origin</u>	<u>Deaths from that Area</u>
Dublin	14
Rest of Leinster	5
Munster	9
Connaught	2
Other	2

Table Three

<u>Age of Deceased</u>	<u>Number of Deaths</u>
20 – 29	12
30 – 39	12
40 – 49	1
50 – 69	6
70 +	1

Table Four

<u>Cause of Death</u>	<u>Number of Deaths</u>
Suicide/Self-harm	13
Natural/Medical	9
Accident	2
Violent	3
Overdose/Drugs	5

Table Five

<u>Location of Hospital Death</u>	<u>Number of Deaths</u>
Mater	2
St. Mary's	1
St. James'	1
Midwestern	1
Undisclosed	1

Table Six

<u>Location of Prison Death</u>	<u>Number of Deaths</u>
Mountjoy	5
Wheatfield	1
Limerick	1
Cork	2

Table Seven

Year	Date of death	Date report completed by Inspector	Number of months between death and report completion
2012			
Prisoner A	17/1/12	16/10/13	21 Months
Prisoner B	21/1/12	26/2/14	23 Months
Prisoner C	30/1/12	26/8/14	31 Months
Prisoner D	1/2/12	29/10/13	20 Months
Prisoner E	15/2/12	29/10/13	20 Months
Prisoner F	4/4/12	29/10/13	18 Months
Prisoner G	16/4/12	29/10/13	18 Months

Year	Date of death	Date report completed by	Number of months
2012		Inspector	between death and report completion
Prisoner H	12/5/12	29/10/13	17 Months
Prisoner I	18/3/12	31/10/13	19 Months
Prisoner J	20/5/12	31/10/13	17 Months
Prisoner K	10/9/12	14/2/14	17 Months
Prisoner L	29/10/12	26/11/13	13 Months
Prisoner M	18/11/12	31/10/13	11 Months
Prisoner N	2/12/12	7/11/13	11 Months

Year	Date of death	Date report completed by	Number of months
2012		Inspector	between death and report completion
Prisoner O	8/11/12	5/11/13	12 Months
Prisoner P	28/12/12	31/10/13	10 Months

Year 2013	Date of death	Date report completed by Inspector	Number of months between death and report completion
Prisoner A	27/1/13	15/11/13	10 Months
Prisoner B	No Information Available	No Information Available	No Information Available
Prisoner C	25/2/13	26/11/13	9 Months
Prisoner D	6/4/13	14/2/14	10 Months
Prisoner E	16/4/13	31/3/14	11 Months
Prisoner F	10/5/13	26/8/14	15 Months
Prisoner G	3/6/13	6/12/13	6 Months

Year 2013	Date of death	Date report completed by Inspector	Number of months between death and report completion
Prisoner H	30/8/13	10/6/13	10 Months
Prisoner I	14/9/13	10/6/14	9 Months
Prisoner J	18/9/13	14/2/14	5 Months
Prisoner K	11/10/13	21/3/14	5 Months
Prisoner L	5/12/13	24/3/14	3 Months
Prisoner M	18/12/13	10/6/14	6 Months
Prisoner N	29/12/13	26/8/14	8 Months

Year 2014	Date of death	Date report completed by Inspector	Number of months between death and report completion
Prisoner A	15/1/14	31/3/14	2 Months
Prisoner B	23/2/14	26/8/14	6 Months
Prisoner C	No Information Available	No Information Available	No Information Available
Prisoner D	6/5/14	26/8/14	3 Months

Table Eight

<u>Reason Next-of Kin not Contacted</u>	<u>Number of Cases</u>
Family declined meeting	2
Family did not respond	4
Phone conversation	2
Criminal investigation	4
Medical/age related death	2

Table Nine

<u>Interaction with Services</u>	<u>Number of Prisoners from reports</u>	<u>Percentage of Prisoners from Reports</u>
Drug/Alcohol Therapeutic Services	18	56%
Psychiatric Services	8	25%

3.2 Issues arising from the reports

Through analysis of the Inspectors reports a number of issues can be identified:

- There appears to be inconsistencies between aftercare services, not only between prisons, but amongst prisoners within the same prison.¹⁴⁸
- There was a high instance of drug and alcohol misuse documented in the reports.
- There were a greater number of deaths while on temporary release than deaths within prison. A death on temporary release includes temporary release to hospital for specialised care and treatment for prisoners with terminal and serious illnesses.
- There was a high rate of prisoners availing of psychiatric services prior to committal documented within the reports; six out of twenty-nine reports. One report alluded to the fact that a prisoner, who had psychiatric issues known to the family, was not given psychiatric treatment within prison.¹⁴⁹ This was due to the fact that concerns were not communicated to the Prison Service. Within the report it was suggested by the family that the prisoner had exhibited signs of psychological distress. These continued to go untreated during the prisoner's incarceration.

¹⁴⁸ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner G on 16th April 2012 while on temporary release* (2012/G, Inspector of Prisons 2013); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner H on 12th May 2012 while on temporary release* (2012/H, Inspector of Prisons 2013); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner I on 17th/18th March 2012 while on temporary release* (2012/I, Inspector of Prisons 2013)

¹⁴⁹ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A In Mountjoy Prison on 17th January 2012* (2012/A, Inspector of Prisons 2013)

3.3 Issues of follow up services while released on temporary release

Some prisoners on reviewable temporary release were supported to a very high level and when released put in contact with support and therapeutic services, drug and alcohol addiction services, and mental health services.¹⁵⁰ Other prisoners were not; a fact highlighted by family questions put to the Inspector to investigate.¹⁵¹ While there had been support services offered to some of the temporary release prisoners, more often they had been placed in environments that were hostile to recovery, or continued recovery. 56 per cent of the prisoners in the Inspectors reports had been engaged in drug rehabilitation programs while in prison, as highlighted by Table Nine, while 25 per cent had engagement with psychiatric services, also highlighted in the same table. Of these prisoners all of those who had accessed psychiatric services were dual prognosis, meaning that they had both drug/alcohol addiction problems and having mental health problems.

Another issue highlighted from the reports was the lack of maintenance to CCTV cameras within prisons; some CCTV cameras or recording

¹⁵⁰ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A on 15th January 2014 while on temporary release* (2014/A, Inspector of Prisons 2014)

¹⁵¹ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner L on 29th October 2012 while on temporary release* (2012/L, Inspector of Prisons 2013); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A on 27th January 2013 while on temporary release* (2013/A, Inspector of Prisons 2013); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner J on 18th September 2013 while on temporary release* (2013/J, Inspector of Prisons 2014)

equipment were not working.¹⁵² This poses security risks for staff and prisoners. It also hindered the ability of the Inspector to properly review footage in some cases.

Where footage was available, irregular checks were carried out by prison officers on prisoners who were either under protection/supervision or out of their cells.¹⁵³

The reports highlighted a number of incidences where prisoners under supervision were not checked every 15/20 minutes as required by prison guidelines.¹⁵⁴ In some instances there were gaps of several hours between checks.¹⁵⁵

Medical records were not being thoroughly completed, or systematically kept. Nurses and doctors were not documenting requests for specialised treatment or assessments.¹⁵⁶ Within the reports, the Inspector

¹⁵² Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner F in Cork Prison on 10th May 2013* (2013/F, Inspector of Prisons 2014)

¹⁵³ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A In Mountjoy Prison on 17th January 2012* (2012/A, Inspector of Prisons 2013)

¹⁵⁴ A Governor's Order dated 29th July 1998

¹⁵⁵ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A In Mountjoy Prison on 17th January 2012* (2012/A, Inspector of Prisons 2013); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner B in Limerick Prison on 21st January 2012* (2012/B, Inspector of Prisons 2013); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner F in Cork Prison on 10th May 2013* (2013/F, Inspector of Prisons 2014); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner N in Wheatfield Prison on 29th December 2013* (2013/N, Inspector of Prisons 2014)

¹⁵⁶ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner K on 10th September 2012 while on temporary release* (2012/K, Inspector of Prisons 2013)

alluded to the fact that false information had been supplied to him on more than one occasion.¹⁵⁷

The Inspector asked that information received by him must be accurate and true. There had been instances where he had tried to verify information supplied to him, and it had been proven to be false.

Though the Inspector of Prisons is officially independent in his or her role, the requirement to submit his reports to the office of the Minister for Justice prior to publication reduces his independence. The Inspector is reliant on prisons to supply information necessary to conduct the investigation. The Inspector makes recommendations based on information supplied in good faith that the information received is accurate and true. Compliance with the recommendations and observations is low, as demonstrated by the Report into the Death of Prisoner F 2013. The Inspector stated that he had brought it to the attention of the management of Cork Prison that the lack of CCTV in D Block was problematic and unsafe over the past number of years. His recommendations went unheeded making it very difficult to investigate the death of a prisoner where there was no CCTV footage of the time leading up to and surrounding the death. Prison rules and procedures are in place for the protection of prisoners and prison officers. The Inspector suggested that these

¹⁵⁷ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner J on 18th September 2013 while on temporary release* (2013/J, Inspector of Prisons 2014); Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner N in Wheatfield Prison on 29th December 2013* (2013/N, Inspector of Prisons 2014)

rules and procedures were not being adhered to due to staffing issues and overcrowding.¹⁵⁸

3.4 Thematic problems arising from reports

Table Ten

Themes from reports	Description
Inadequate notes kept	Relating to both access to mental health services and notes in relation to record keeping of checks on prisoners
Gaps in communication between An Garda Síochána and the Prison Service	Where prisoners on temporary release have broken the conditions of release and are unlawfully at large. Such information is not related to the Prison Service
Lack of follow up services on temporary release	Where access to follow up services on release from prison and while being

¹⁵⁸ Judge Michael Reilly, *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner A In Mountjoy Prison on 17th January 2012* (2012/A, Inspector of Prisons 2013)

Themes from reports	Description
	reintegrated into society is inconsistently applied. Some prisoners are not linked with services. Some prisoners being released are not released to accurate addresses and can become homeless
CCTV footage and equipment inadequate	Some CCTV cameras are maladjusted; others do not function at all. Issues surrounding this have been raised by the Inspector numerous times according to his report into the death of Prisoner F 2013 in Cork Prison.
Procedures relating to Special Observation Prisoners (SOP) not correctly followed	The standard practice of checking a SOP is every 15/20 minutes. This was not being adhered to with gaps being as high as hours between checks
Problems in the community reintegration schemes with drug taking	The absence of random drug screening as a part of these schemes can mean that those who have gone through substance abuse rehabilitation/ accessed

Themes from reports	Description
	therapeutic services are exposed to drugs in an unmonitored/ uncontrolled environment
Issues with crime scene protection	Bodies were removed before the arrival of An Garda Síochána or the Coroner. Large groups of people gathered in the area of the death and potential contamination of the scene
Media supplying unsubstantiated information to the public	Raised during interviews with families was the fact that some media sources had been supplied with information that the Inspector could not verify as true to the family causing upset and confusion

Areas such as:

- aftercare while on renewable temporary release,
- drug and alcohol rehabilitation services inside prison,
- mental health services within prison and within the community, and
- the over reliance on medication within prisons,

were also all highlighted in the Inspector of Prison's reports. A high rate of mental health issues among those mentioned in the reports indicates the need to address how prisons deal with mental health issues. It is widely accepted that those with mental health issues are often found housed in prisons,¹⁵⁹ which are not hospitable environments for the treatment of mental illnesses.

3.5 Mental Illness Statistics

Kennedy et al found in their analysis of prisons in Ireland that drug and alcohol dependence and harmful use was present among 61-79% of their study group.¹⁶⁰ For all mental illnesses combined they found that:

- 16% of male committals
- 27% of sentenced males, compared with
- 41% of female committals and,
- 60% of sentenced females,
- had mental health issues.

¹⁵⁹ Gary Culliton, 'When prison is no substitute for Hospital' *Irish Medical Times* (Dublin, 25 July 2012); HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

¹⁶⁰ The survey samples were: 1. Males admitted to the prison population (referred to as receptions or committals), whether sentenced or remanded into custody. They interviewed 7% of all adult males committed in a year, divided equally between remand and sentenced committals. 2. A cross-sectional survey of male remand prisoners. They interviewed 50% of men remanded in custody. 3. A stratified random survey of 15% of all sentenced men in the Irish prisons population. 4. Newly committed women prisoners. They interviewed approximately 9% of female committals per year. 5. A cross-sectional study of all female prisoners. They interviewed approximately 90% of female prisoners, of whom 24 were on remand and 68 were sentenced.

It was estimated that:

- 3.7% of male committals,
- 7.5% of males on remand,
- 2.7% of sentenced males and,
- 5.4% of female prisoners,

should have been diverted to psychiatric services. As many as 20% of male committals and 32% of female committals needed to be seen by a psychiatrist. This would have required approximately 376 transfers from prison to hospital per annum, and between 122 and 157 extra secure psychiatric beds, in addition to extra mental health in-reach clinics.¹⁶¹ There has been analysis since the 2004 study by Kennedy et al. These statistics highlight that a considerable amount of people who are in need of assistance for their mental health are placed in prison rather than being redirected into psychiatric and mental health facilities. The demand for such services is high, but there is a limited capacity and few facilities. The National Forensic Mental Health Service is the main service provider for those in need of secure mental health services. Prisons are not designed to house, nor are they equipped to deal with, those who have psychiatric or mental health needs.¹⁶² The IPRT has called for those in need of mental health assessment to be diverted to services outside of the

¹⁶¹ HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

¹⁶² Irish Penal Reform Trust, *Preliminary Briefing on Mental Health in Prisons*, (2009), <http://www.iprt.ie/files/IPRT_Preliminary_Briefing_on_Mental_Health_November_2009.pdf>, last accessed 25/12/2014

current forensic mental services such as the practice in Cloverhill Prison.¹⁶³ In Cloverhill there is a Prison In-reach and Court Liaison Service (PICLS), that aids the diversion of persons with psychiatric illnesses, held on remand, to non-forensic mental health settings.¹⁶⁴

Access to Mental Health Services

The expense of extending services to meet the needs of those who require it in the current economic environment means those such needs will not be met in the foreseeable future. Current societal attitudes to those in prison are quite negative.¹⁶⁵ Levels of political will for change are increasing,¹⁶⁶ but the incentives to re-evaluate how prisons are used comes though the hard work of a handful of political actors.

The Inspectors reports highlight the fact that numerous inmates either identified as having accessed mental illness services prior to committal or accessed the services within the prisons. Some prisoners who had accessed the internal services within the prison, and were eligible for temporary release, had gained access to community mental health services. Monitoring of rates of compliance with attendance at these services was inconsistent and not universal.

¹⁶³ *ibid*

¹⁶⁴ *ibid*

¹⁶⁵ Anne-Marie Allen, '*Drug-related knowledge and attitudes of prison officers in Dublin prisons*', (Trinity College Dublin 2001 31)

¹⁶⁶ Ivana Bacik, 'Radical reform of our penal system will lead to a safer society for us all' *Irish Independent* (Dublin (28 March 2013); Kevin Warner, 'Review of prison system fails to tackle endemic problems' *Irish Times* (23 October 2014)

Community Reintegration Schemes

Inmates who had successfully completed drug and alcohol rehabilitation services, and were eligible for temporary release, were enrolled in community reintegration schemes. These schemes are not hospitable environments for persons recovering from addiction. As suggested in the Inspectors reports, relapses and drug taking had often recommenced due to increased access to drugs and less strict/controlled supervision. The highlighted issues need to be addressed in order to reduce recurrence of mental health issues, drug misuse, and recidivism rates. Those on temporary release in need of follow up services should be referred to the appropriate services. The services provided should be linked to the “signing on” procedure, (where a prisoner on temporary release needs to regularly sign on with An Garda Síochána in a Garda station and within the prison). By linking these, the chances of relapsing and reoffending may be reduced.

Record Keeping

Another area that had been highlighted from the Inspectors reports was record keeping. Medical records, especially pertaining to requests to access mental health services within prison, and referrals to mental health professionals or services were not meticulously kept. Numerous reports from the Inspector stated that a prisoner had requested evaluation. This was noted, but whether a prisoner gained access or not was not noted in certain cases. Meticulous record keeping, especially in relation to access to medical assessment requests, is vital for ensuring all necessary steps are taken to ensure

compliance with Rule 33 of the Prison Rules 2007. Rule 33 states; prisoners are entitled to primary healthcare of at least the same standard as available to medical card holders. Prisons are also obliged not to put a person's health at risk¹⁶⁷ which can refer to mental health needs, as well as their physical needs.

It has been suggested that the suicide rate in Irish prisons, which is about twice the figure for the rest of rest of the population,¹⁶⁸ is a reflection of a more general societal problem,¹⁶⁹ Kennedy et al argue that the large number is due to the fact that prison populations consist largely of young men with drug and alcohol issues.¹⁷⁰ As there is not a study of drug addiction among males of the general population it is difficult to ascertain whether there is a larger concentration of drug addicted males in prison than in the general population.

Rates of Psychosis

The high rate of psychosis (among the cross section of) male remand prisoners (7.4%) is striking, particularly since it is so much higher than averages in other countries, (identified by Fazel and Danesh).¹⁷¹ A possible explanation for this higher rate of psychosis is that those with serious mental illness are more likely

¹⁶⁷ Mulligan v Governor of Portlaoise Prison [2010] IEHC 269

¹⁶⁸ Before correction for age and sex

¹⁶⁹ HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

¹⁷⁰ HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

¹⁷¹ S Fazel, J Danesh, 'Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys' (2002) 359 Lancet 545

to be remanded in custody. Taylor and Gunn found this to be the case for mentally ill individuals, even when charged with relatively minor offences.¹⁷²

As highlighted previously, prisons are not designed to be substance abuse rehabilitation clinics, nor are they designed to be mental health service providers. The reality is that through the pursuit of a wholly punitive system, those who are in need of specialised medical care for addiction or mental illness are placed within prisons rather than secure medical facilities where the assistance they need is available to them. This is due to a lack of funding for secure medical facilities, which means there is less space for those who are in need of it. The only alternative seems to be incarceration, which can have a negative impact on persons with mental illnesses. This is an area that has attracted careful and serious re-examination by those who seek penal policy review.

The need for adequate restructuring of drug rehabilitation and the over-use of medication requires immediate attention. The high rates of methadone use, on entry and prior to entry, and the over prescription of benzodiazepines facilitates abuse.¹⁷³ The issue is exacerbated through transference, substituting one substance for another equally addictive substance, thus continuing dependence rather than trying to tackle dependence.

¹⁷² P Taylor, J Gunn, 'Homicides by people with severe mental illness: myth and reality' (1999) 174 (4) *British Journal of Psychiatry* 82

¹⁷³ HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

Adequate staffing levels are paramount to ensure:

- An incident such as that which occurred in the Gary Douch case cannot happen again.
- That adequate supervision is given to those in special observation units within all prisons and,
- Regular checks occur on those who are high risk prisoners.

As aforementioned, a common theme arising from the Inspectors reports is that regular checks are not being carried out, and when checks are being carried out they are not thorough enough and can result in in-cell deaths by suicide, overdose or natural causes (as highlighted in the Inspectors reports).

Table of Inquest Verdict Terms¹⁷⁴

Table Eleven

Accidental death.	Deaths deemed accidental
Death by misadventure.	The verdict of misadventure is applied to a wide variety of deaths which might generally be described as the unintended outcome of an intended action. For example, a heroin addict injects him/herself with heroin and unintentionally overdoses. It also includes those whose deaths arise from engagement in potentially dangerous sports or activities.
Medical misadventure	Medical misadventure is where there is an unintended outcome of an intended action in a medical context or where complications arising from a medical procedure cause death.

¹⁷⁴ Coroners Rules, *Report*, (Department of Justice and Equality)

<p>Suicide/self-inflicted death/deceased took their own life.</p> <p>In returning a verdict of suicide the Coroner/juror must be sure:</p> <p>The deceased took his or her own life</p> <p>The deceased was intent on taking his life</p> <p>There is proof beyond reasonable doubt that the injuries sustained were self-inflicted and the deceased had such intention.</p>	<p>In addition to “suicide” it was agreed that the term ‘self-inflicted death’ or a narrative such as ‘deceased took his own life’ are acceptable wordings of this verdict.</p>
<p>Unlawful killing.</p>	<p>In returning a verdict of unlawful killing the Coroner/jury must confirm that:</p> <p>No criminal proceedings are pending</p>

	<p>Where the evidence is inconclusive and the DPP may have to re- examine the case</p> <p>Where there is insufficient evidence to record another verdict.</p>
Narrative	<p>A narrative verdict is a verdict where the circumstances of a death are recorded without attributing the cause to a named individual</p>

3.6 Mountjoy Committal Unit and Best Practice

The prison reception or committal process is predominately seen as a way of assessing risks of violence by and between prisoners, with physical and mental health needs often lower in priority than security and good order within the prison. This can mean that prisoners may not have the same level of access to healthcare as those in the community.¹⁷⁵

Mountjoy Prison has introduced the first night or Committal unit (opened December 2010), and the High Support Unit (HSU). They were established in

¹⁷⁵ Gary Culliton, 'When prison is no substitute for Hospital' *Irish Medical Times* (Dublin, 25 July 2012); HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

response to the Gary Douch case. The two units were created to provide a pathway of care¹⁷⁶ and to relieve some of the pressure being newly committed can have on a prisoner.

In the first year of operation 96 prisoners passed through Mountjoy's HSU nine-bed unit and the study by Culliton noted a 59 per cent reduction in the average monthly use of special observation cells compared to the year before the HSU opened.¹⁷⁷ This brought Mountjoy into line with international practice and guidelines.¹⁷⁸ The HSU project was driven by two needs. The first was a requirement to reduce the use of special observation cells in the prison without any increase in injuries or self-harm. The second was for step-down accommodation for sentenced prisoners with major mental illnesses who had been transferred to the Central Mental Hospital,¹⁷⁹ where they had responded well to treatment. If returned to prison to serve out the remainder of their sentence, Culliton suggests that they would be prone to relapse due to the ready availability of drugs in the prison, and the stresses of overcrowding and interacting with other inmates.¹⁸⁰

¹⁷⁶ *ibid*

¹⁷⁷ Gary Culliton, 'When prison is no substitute for Hospital' *Irish Medical Times* (Dublin, 25 July 2012); HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

¹⁷⁸ *ibid*

¹⁷⁹ Now known as the National Forensic Mental Health Service,

¹⁸⁰ Gary Culliton, 'When prison is no substitute for Hospital' *Irish Medical Times* (Dublin, 25 July 2012); HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, *Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners* (National Forensic Mental Health Service 2004)

The introduction of these units within Mountjoy coupled with close proximity to mental health facilities has been a positive development. Such services should be rolled out nationwide to all prison campuses in Ireland. The only impediments to success are proximity to regional Mental Health Services, resource allocation to allow for the implementation and setting up of such units within prison campuses, and staffing levels to allow for proper supervision of such units.

Four - England and Wales

Since 2002 there have been 2,448 deaths in prisons in England and Wales. 987 of these deaths (40.3%) were classified as self-inflicted. Within the same timeframe there were 394 deaths in police custody.¹⁸¹

The two bodies charged with investigating deaths that occur within the criminal justice system, immigration, or revenue and customs detention, are the Office of the Prisons and Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC).

The PPO is wholly independent of the National Offender Management System, the UK Border Agency and the Youth Justice Board. They are operationally independent of the Ministry of Justice although they sponsored by them.

The IPCC are completely independent of the police and the government.

4.1 The Office of the Prisons and Probation Ombudsman (PPO)

The Office of the Prisons and Probation Ombudsman (PPO) investigates deaths due to any cause (including suicide and natural causes). Their remit includes deaths which occur in prisons; young offender detention centres;

¹⁸¹ <http://www.inquest.org.uk/statistics/31.03.15>

approved premises (residential units which house offenders in the community) and immigration detention centres.

The PPO was officially created in 1994 following the Woolf report¹⁸² as The Office of the Prisons Ombudsman. Its original function was to consider complaints from applicants who had not achieved satisfaction through internal prison complaints systems. In 2001 the Office's remit was extended to include complaints from those under probation supervision; and was re-named to reflect this change. A fatal incidents function was introduced in 2004, adding to the Ombudsman's remit the requirement to investigate all deaths in prisons; probation approved premises; immigration detention facilities and secure training centres.

The Ombudsman can also investigate the death of someone who has recently been released from custody if he/she feels there are issues in relation to the care provided.¹⁸³

4.2 Investigative process of the Prisons and Probation Ombudsman

- Once the relevant prison or detention centre informs the PPO that a death has occurred, an investigator is assigned to lead the investigation and a family liaison officer is appointed to liaise with the bereaved family.

¹⁸² Woolf H and Tumim S, *Prison Disturbances, April 1990: Report of an Inquiry*, Cm 1456, London, HSMO, 1991 (Woolf Report)

¹⁸³ Terms of Reference of the Office of the Prisons and Probation Ombudsman

- The investigator gathers evidence about the circumstances leading up to and at the time of the person's death. This includes examining all the relevant records and policies, and conducting interviews with relevant staff and prisoners or residents, if required.
- Information is sought from the NHS England in order to commission an independent clinical review of the health care provided to the deceased prior to their death.
- When the investigation is complete, a draft report is produced outlining the investigation findings. It may also recommend changes to improve the quality of care given by the prison or detention centre.
- A copy of the draft report is then sent to the bereaved family and to the relevant prison or detention centre, accompanied by annexes which include the review of healthcare given to the prisoner, records of interviews, and other relevant documents.
- The bereaved family and the prison authorities may comment on the factual accuracy of the draft report before the final version is issued.
- The reports often include recommendations focusing on what could be done to prevent similar situations in the future. The relevant authority must provide the Ombudsman with a response on whether they accept the recommendations and indicate the steps that they will take to implement them.
- After comments have been considered, the Ombudsman produces the final report. This is sent to the bereaved family and the relevant

detention centre. It is also sent to the Coroner who conducts the inquest to establish how the person died.

- After the inquest has concluded the report can be published on the PPO's website.
- All reports published before September 2014 have been completely anonymised, but from September 2014 the Ombudsman no longer removes the name of the deceased from the reports, although other names, such as those of prison staff, continue to be redacted.

4.3 The Independent Police Complaints Commission (IPCC)

The Independent Police Complaints Commission (IPCC) investigates deaths or serious injuries where as a result, a person has died or sustained serious injury and:

at the time of death or serious injury the person had been arrested by a person serving with the police and had not been released, or was otherwise detained in the custody of a person serving with the police;
or

at, or before, the time of death or serious injury the person had contact of any kind (whether direct or indirect) with a person serving with the police who was acting in the execution of his or her duties and there is

an indication that the contact may have caused (whether directly or indirectly) or contributed to the death or serious injury.¹⁸⁴

The IPCC has its own investigators who carry out independent investigations. They are supported by a team including lawyers, press officers and support staff. Investigations are overseen by an IPCC Commissioner who has ultimate responsibility for the investigation. Commissioners come from a range of backgrounds and can never have worked for the police.¹⁸⁵

Investigative process of The Independent Police Complaints Commission (IPCC)

- Initially, staff from the IPCC attend at the scene of the death and liaise with local police force about securing the scene and obtaining evidence from officers and staff involved.
- The investigation then commences with IPCC investigators assessing questions from the family or complainant, agreeing the terms of reference of the investigation and collecting and analysing evidence. This may include witness statements, CCTV and other technical data, policies, forensic evidence, and independent expert evidence.
- They interview witnesses/suspects, including police, (under the Police and Criminal Evidence Act 1984 if applicable).

¹⁸⁴ Section 12, Police reform Act, 2002

¹⁸⁵ Section 9(3), Police reform Act, 2002

- Throughout the investigation they liaise with and provide updates to the person's family, the Crown Prosecution Service (CPS), the Coroner and sometimes with the Health and Safety Executive.¹⁸⁶
- When the investigation is complete a report is produced setting out findings and conclusions. The conclusions, outline whether there is a case to answer for misconduct or poor performance.
- If they think a police officer or member of police staff may have committed a criminal offence, the report is passed to the Crown Prosecution Service. The CPS is then responsible for deciding whether the person should be prosecuted.
- The IPCC considers whether particular action could be taken to prevent a similar matter happening again and whether lessons could be learned by the police.
- Where an inquest is to be held, the report and evidence is provided to the Coroner for consideration at the inquest.
- The report also is sent to the police force concerned, who may be required to take disciplinary action, and the report is also given to the family.
- The investigation report will be published after an inquest; prosecution and/or disciplinary action is completed.

¹⁸⁶ A guide to IPCC independent investigations, November 2013, www.ipcc.gov.uk

4.4 Interactions between investigations

The IPCC has an investigative remit over the police but there are times where the both IPCC and the PPO will be investigating the same incident. The IPCC and the PPO have a memorandum of understanding regarding how they will work with each other in these types of cases.¹⁸⁷ For example, if someone was in police custody and then went to prison and died by suicide, the IPCC may investigate whether the police passed on all information about the individual to the prison. The PPO would investigate what the prison staff did to manage any identified risks effectively. An example of this is the case of Christopher Shapley.¹⁸⁸

Investigation by IPCC into the actions of South Wales Police (SWP) prior to the transfer of Christopher Shapley into the care of the court and prison service

Christopher Shapley died on 20th Sept 2013 in HM Prison Cardiff. He had been arrested three days previously at his home address following a domestic argument. He was taken to the custody unit at Merthyr Tydfil police station, where he was charged and remanded in custody. Two days later, on 19 September 2013, Mr Shapley appeared in Court following which he was

¹⁸⁷ Statement by Lindsay Harvey, Policy and Engagement Officer, IPCC (Personal Communication 11 November 2014)

¹⁸⁸ <https://www.ipcc.gov.uk/investigations/christopher-shapley-south-wales-police>

transferred to HM Prison Cardiff. The next day, 20 September 2013, he was found dead in his cell by prison officers.

South Wales Police(SWP) made a referral to the IPCC who carried out an investigation focusing on:

- What information SWP officers had available to them in respect of Christopher's risk of self-harm;
- How SWP officers obtained information during Christopher's detention, how they recorded this and disseminated it;
- What action SWP officers took to communicate the information they had to HMP Cardiff;
- Whether SWP officers followed the force policies and procedures.

When Mr. Shapley was taken into custody, his family had highlighted to SWP two previous incidents involving Christopher's safety and a possible risk of self-harm. The investigating officer assessed these, spoke to Christopher about them and was satisfied that they were not indications of attempts at self-harm. He did not, therefore, pass this information on to the custody officer. In hindsight, these incidents should have been recorded regardless of Christopher's explanation. The investigation found no evidence of any misconduct by SWP officers. The IPCC found that the officers had complied with the force's policies and procedures for completing risk assessments on a person in custody and followed up with care plans that were appropriate to Mr Shapley's needs based on risks identified while he was in custody. However, the investigation did identify issues with the Person Escort Record (PER) form. A PER form is used by police forces across Wales and England

when a person is being transferred between different institutions to relay any concerns about a detained person's risk of self-harm.

SWP ticked the box on the PER form to record concerns about Mr Shapley's risk of self-harm but there was not sufficient space to include any further information. A sheet with additional information was stapled by the custody sergeant onto the PER booklet but this sheet became separated and was never found.

Speaking about the investigation, the IPCC Commissioner for Wales, Jan Williams, said; "Christopher's death has highlighted the need for an informed and thorough risk assessment of an individual's risk of self-harm, and a robust means of communicating this information to all authorities with responsibility for people in custody."

She also added that the loss of the additional risk information "was most unfortunate for Christopher, and we will never know what might have happened if it had not gone astray".¹⁸⁹

¹⁸⁹ IPCC issues findings from investigation into South Wales Police actions prior to Christopher Shapley's death, 14th July, 2014 <www.ipcc.gov.uk> accessed on 05.01.15

4.5 Suicide and Mental Health Issues

A worrying trend in UK custody deaths and one that is subject of much media debate at the moment is the alarming rise in suicides in prisons. In the period September 2013-2014, suicides rose by 38% on the previous 12 month period and are up 52% since 2011-2012.¹⁹⁰

Individuals with mental health issues can be particularly vulnerable. When placed in a custodial setting, separated from families and support systems, their illnesses can often be exacerbated.

The PPO's fatal incident reports into self-inflicted deaths will nearly always list recommendations in relation to suicide and self-harm procedures. Recommendations have been made that staff should receive further training in how to care for prisoners with mental health concerns and how to identify risk factors. Recommendations are also quite often made in relation to communication, information sharing, and consideration of the content of documents. Although it is not always possible to prevent a person from taking their own life, it is essential that prison staff are aware of all information in relation a prisoner so that they can devise an appropriate care plan.

On 6th February 2014 an independent review was announced into self-inflicted deaths in custody of 18-24 year olds. The report is due later this year and the review is being led by Lord Toby Harris, Chair of the Independent

¹⁹⁰ <https://www.gov.uk/government/collections/safety-in-custody-statistics>

Advisory Panel on Deaths in Custody. The aim of the review is to make recommendations to reduce the risk of future self-inflicted deaths in custody.

There has been considerable criticism in the media¹⁹¹ of the current Justice Minister, Chris Grayling, and his refusal to link the current crisis with cuts to staffing levels and overcrowding.¹⁹² The Chief inspector of Prisons, Mr. Nick Hardwick, has even stated it was 'not credible' for the Government to deny a link between pressures on the prison system and the rise in self-inflicted deaths.¹⁹³

4.6 Equality and Human Rights Commission Enquiry

The Equality and Human Rights Commission have recently published the findings of an inquiry entitled: *Preventing Deaths in Detention of Adults with Mental Health Conditions*.¹⁹⁴ The Commission examined available evidence about non-natural deaths of adults with mental health conditions in prisons, police custody and hospitals between 2010 and 2013. A principal aim of the inquiry was to establish if the organisations responsible for managing individuals in custody, were meeting their obligations under Article 2 ECHR.

¹⁹¹Charlie Gilmore, 'Chris Grayling, how do you account for these prison suicides?' *The Independent* (London 16 November 2014)

¹⁹² Paul Peachey, 'Chris Grayling denies there is a prison crisis amid soaring suicides' *The Independent* (London 19 August 2014)

¹⁹³ Oliver Wright, 'Rise in prison suicides being fuelled by staff shortages, warns watchdog' *The Independent* (London 11 August 2014)

¹⁹⁴ Equality and Human Rights Commission 'Preventing Deaths in Detention of Adults with Mental Health Conditions' [2015] <www.equalityhumanrights.com> accessed 05.03.15

Main findings from the Inquiry:

Framework

The inquiry published a two page framework based on human rights case law which can act as a checklist to assist organisations holding adults in detention in meeting their obligations under Article 2 ECHR. It is divided into two sections - obligations to protect; and obligations to investigate.

Recommendations

- 1) A structured approach should be established for implementing improvements from previous deaths and narrowly avoided death. This should include a statutory obligation on institutions to respond to recommendations from inspectorate bodies
- 2) Individual institutions should have a stronger focus on ensuring they meet their responsibilities to keep those in custody safe. This can be achieved by improving staff training.
- 3) Increased transparency and the full involvement of families
- 4) The Human Rights framework should be adopted and used as a practical tool.

4.7 Next –of-kin

Involvement in investigations

In a PPO investigation, a family liaison officer contacts the family within four weeks of the death occurring. They are in regular contact with the family throughout the investigation to keep them updated. Families have a chance to comment on the factual accuracy of the draft report before the final version is issued.

In an IPCC investigation, the investigators liaise with the family, although it does not appear that they have any scope to comment on the report before it is issued.

Inclusion in policy formation

A three tier Ministerial Council on deaths in custody was established in July 2008 with a shared purpose of bringing about a continuing reduction in the number and rate of deaths in all forms of state custody in England and Wales.

The three tiers consist of the:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

Families are encouraged to join the Practitioner and Stakeholder Group in order to have their views heard on whether the focus of the Council's work is effective in meeting families' needs.

The Independent Advisory Panel (IAP) held two family listening days – in March 2010 and September 2011, in order to hear from families whose family members had died in custody.

Following the family listening day in September 2011 the IAP made a number of recommendations for improvement in the delivery of family liaison by Mental Health Trusts following the family listening day in September 2011, which focused on families of individuals who had died whilst detained under the Mental Health Act.

In 2013, The IAP published the family liaison common standards and principles,¹⁹⁵ which were communicated to practitioners in each of the organisations to be incorporated into existing policies. In 2014 launched a new guide for bereaved families, 'Guide to Coroner Services' which explains simply to bereaved people how the inquest process works.¹⁹⁶

INQUEST

INQUEST is a small charity providing free advice to people bereaved by a death in custody and is entirely independent of government. It was founded in 1981 and the only organisation in England and Wales that provides a specialist, comprehensive advice service to bereaved people, lawyers, other

¹⁹⁵ IAP 'Family Liaison Common standards and Principles' www.iapdeathsincustody.independent.gov.uk> accessed 05.03.15

¹⁹⁶ IAP 'Guide to Coroner Services' www.iapdeathsincustody.independent.gov.uk> accessed 05.03.15

advice and support agencies, the media, MPs and the wider public on contentious deaths and their investigation. Co-director Deborah Coles has worked with the IAP on how to bring about improvements in family liaison practice in the custodial sectors and investigative bodies and helped develop the family liaison common standards and principles

www.inquest.org.uk

Five - Scotland

The Crown Office and Procurator Fiscal Service (COPFS) is Scotland's independent prosecution service. It is headed by the Lord Advocate, the ministerial head of COPFS, who has a responsibility to investigate all sudden, suspicious and unexplained deaths in Scotland.

The Lord Advocate is a Minister of the Scottish Government and acts as principal legal advisor, but decisions made by him about criminal prosecutions and the investigation of deaths are taken independently of any other person. In that way, he is not subject to the ordinary rules about collective ministerial decisions. Procurators Fiscal are legally qualified prosecutors who are employed by the COPFS and who act on the instructions of the Lord Advocate. They work in specialist units and offices around Scotland. They investigate all sudden and suspicious deaths and handle criminal complaints against the police.

When a person dies in custody in Scotland, their death is subject to a Fatal Accident Inquiry (FAI) under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. When a death in custody occurs the relevant

detention centre will advise Police Scotland, the Scottish police force, of the death and report the death to the Procurator Fiscal to investigate.¹⁹⁷

5.1 Fatal Accident Inquiry

A Fatal Accident Inquiry (FAI) is a form of inquest unique to the Scottish legal system and is conducted by a Procurator Fiscal. It is a type of court hearing which publically enquires into the circumstances of a death. It is presided over by a Sheriff and is normally held in the Sheriff Court. An FAI will usually be held for all deaths in custody, but they can also be held in other circumstances if it is thought by COPFS to be in the public interest to do so. COPFS will seek to hold an FAI as soon as practicable after a death.

The purpose of an FAI is to assess the circumstances surrounding the death and to identify any issues of public concern or safety and to prevent future deaths or injuries. The Procurator Fiscal has responsibility for calling witnesses and leading evidence at an FAI, although other interested parties may also be represented and question witnesses. At the end of an FAI, a Sheriff will make a determination.

The determination will set out:

- where and when the death occurred
- the cause of death

¹⁹⁷ Statement by Annette Dinning, Scottish Prison Service (Personal communication 5 November 2014)

- any precautions by which the death might have been avoided
- any defect in systems that caused or contributed to the death
- any other facts which are relevant to the circumstances of the death

FAI cannot make any findings of fault or blame against individuals.

The Sheriff will decide whether or not to publish the determination. Although there is no requirement for him or her to do so, they are usually published and placed on the Scottish Courts

Next-of-kin

During the FAI process, the Procurator Fiscal will liaise with family members of the person who died 'to ensure that they are kept fully informed of any progress and to ensure their views are carefully considered when any decisions are being made'¹⁹⁸

¹⁹⁸ "The role of the Procurator Fiscal in the investigation of deaths" information booklet available at www.copfs.gov.uk/

Families Outside

Families Outside is an independent charity which has been helping prisoners' families in Scotland for over 20 years.

It is the only national charity in Scotland that works solely to support the families of people affected by imprisonment.

They work closely with the Scottish Prison Service, and are involved in the various groups around death in custody. They link in with the support teams (senior staff, family contact officers, chaplaincy, health centre etc) within the prisons when someone dies in custody.

www.familiesoutside.org.uk

5.2 Suicide and mental illnesses

In Scottish Prisons, there are similar issues to those in England and Wales in relation to prisoner suicides. Research conducted by the Scottish Inquirer newspaper (now known as 'The Ferret') found 'serious breaches of official policy' when 27 Fatal Accident Inquiry reports dating from 2007 to 2014 were analysed.¹⁹⁹

Although the Scottish Prison Service (SPS) has a system in place for identifying prisoners at risk, called 'Act2Care', 16 of the reports examined by

¹⁹⁹ Billy Briggs, 'Scottish Prisons fail to protect inmates at risk of suicide' *The Ferret* (Scotland 4th March 2014)

the Scottish Inquirer highlighted issues in relation to the system not being properly followed. The “Act2 Care” system was enacted in 1998 and reviewed in 2005. The policy states that communication is vital to prevent suicides. However, communication issues emerged as a major concern, with the FAI reports detailing instances where information was not passed from one agency to another. In the case of two deaths by suicide in HMP Perth,²⁰⁰ both less than a year apart, information that the prisoners had been prescribed drug withdrawal medication in police custody was not passed on to the prison authorities. Had the prison staff been made aware of this information they could have taken extra precautions to protect the prisoners concerned.

In another death by suicide, that of Matthew Kirk, details of a suicide attempt in police custody and previous attempts of suicide were not made available to officer assessing him under the Act2care system.²⁰¹ Similar situations arose in the case of Stuart James Rose and James Bell, who had attempted self-harm in police custody and was identified as being at risk. However, the Prison Escort (PER) form which highlighted this was not available to prison staff who accessed him when he arrived in prison.²⁰²

²⁰⁰ Inquiry under the Fatal Accident and Inquiries (Scotland) Act 1976 into the sudden death of Lee Russell (21 May 2009) <www.scotcourts.gov.uk> accessed 10.01.15

²⁰¹ Inquiry under the Fatal Accident and Inquiries (Scotland) Act 1976 into the sudden death of Lee Russell (8 May 2012) <www.scotcourts.gov.uk> accessed 10.01.15

²⁰² Inquiry under the Fatal Accident and Inquiries (Scotland) Act 1976 into the deaths of Stuart James Rose and James Bell (31 January 2014) <www.scotcourts.gov.uk> accessed 10.01.15

The system failures highlighted in the FAI reports show that there staff need to be held more accountable so that robust communication systems between courts, police, escorting officers and prison staff are implemented at all times. The presiding sheriff in the FAI inquiry into the death of another prisoner Stephen Cobb stated that that “ACT 2 Care is a robust and well regarded system; that all SPS staff have been trained in it; and that they are fully aware of how the policy ought to work in practice”²⁰³ This is perhaps a suggestion that despite correct policies and procedures being in place, the onus is on the staff implementing these procedures to ensure that a duty of care is afforded to all prisoners.

²⁰³ Inquiry under the Fatal Accident and Inquiries (Scotland) Act 1976 into the sudden death of Stephen Robert Thomas Cobb (19 January 2010) <www.scotcourts.gov.uk> accessed 10.01.15

Six - Northern Ireland

Under the terms of the Good Friday agreement in 1998, over 400 political prisoners were released from Northern Ireland's prisons. The closure of the Maze prison followed in 2000. With the prison population demographic in Northern Ireland changing dramatically within a very short time scale, tensions rose among the remaining prisoners. Protests staged in HM Maghaberry Prison in relation to safety concerns prompted the Secretary of State to commission a review of staff and prisoner safety.

The 2003 review was led by Sir John Steele, who was a former head of the Northern Ireland Prison Service from 1987 to 1992.

One of Sir Steele's principal recommendations from the review was the introduction of an independent Prisoner Ombudsman for Northern Ireland. It was stated that such an ombudsman would "make a valuable contribution to defusing the tensions which are bound to arise in prisons in Northern Ireland".²⁰⁴

Following proposals in April 2004, and a period of public consultation during April and May 2004, the Prisoner Ombudsman's Office was set up and opened in Belfast City centre on 3rd May 2005.

²⁰⁴ *'Review of Safety at HMP Maghaberry'*, (The Steele Report) August 2003

Since the Office opened in 2005 there have been 48 deaths in prison custody.

6.1 Prisoner Ombudsman for Northern Ireland

The Prisoner Ombudsman has two specific functions: to investigate and report on Complaints from prisoners and their visitors; and to investigate and report on Deaths in Custody.

The current Prisoner Ombudsman is Tom McGonigle. He is supported in his work by two senior investigating officers, five investigating officers and other support staff.

The Prisoner Ombudsman investigates the circumstances of the deaths of prisoners including those held in young offender institutions. This includes persons temporarily absent from the establishment but still in custody (e.g. under escort, at court or in hospital).

They do not generally investigate the deaths of persons released from custody. However, the Ombudsman has discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.

The aims of each Ombudsman investigation (as per the terms of reference) are to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual.

- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the Department of Health, Social Services and Public Safety & the Prison Service, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights

6.2 Investigative Process

- The Ombudsman will act on notification of a death from the Prison Service and will decide on the extent of investigation required depending on the circumstances of the death.
- An investigator is appointed and they will meet with the deceased's family and will liaise with the family as necessary throughout the investigation
- The investigator will examine the circumstances surrounding the death and investigate any clinical issues relevant to the death. This will be done in conjunction with the South Eastern Trust, who has responsibility for healthcare within prisons, and the Prison Service.
- Once the investigation is complete; the Ombudsman sends the draft report to the Prison Service.

- If the Ombudsman considers it necessary they will send the draft report in whole or part to one or more of the other parties e.g. family, health service.
- The Service has 28 days to respond and they may draw attention to factual inaccuracies or material that should not be disclosed; include comments from identifiable staff or include a response to any recommendations.
- Once any responses have been received, the Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.
- The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage the report will include background documents.
- The report may be revised if necessary in light of any further information or representations, e.g. if new evidence emerges at the inquest.
- The Ombudsman then issues a proposed published report to the Prison Service, the Coroner, the family of the deceased and also to the Inspectorate of Prisons and the Minister for Justice (or appropriate representative). The proposed published report will not include background documents and may be anonymised so as to exclude the

names of individuals and other sensitive information in the report may need to be removed.

- If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.
- Since 2008, all reports have been published on the Prisoner Ombudsman Office's website – www.niprisonombudsman.com
- If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister for Justice.

6.3 Interactions between investigations (as per terms of reference)

A criminal Investigation by the police will take precedence over the Prisoner Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police.

If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service.

If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings

6.4 Independence of process

Prisoner Ombudsman

Unlike the Prison and Probation Ombudsman in England and Wales, the Prisoner Ombudsman Office has never had its own statutory basis. Instead the Prisoner Ombudsman is an "Independent Statutory Office Holder," currently appointed by the Minister of Justice.

The Prisoner Ombudsman is accountable to the Northern Ireland Assembly through the Minister of Justice, and acts independently of the Prison Service. There has been much campaigning for the Office to be placed on a statutory footing with the current Ombudsman acknowledging that he is "the third prisoner ombudsman who has had the notion of placing this office in statutory footing since it was established ten years ago".²⁰⁵

McGonigle, among others, is of the opinion that the current legislation which the office falls under is not the appropriate place for the Ombudsman's office. Currently in order to seek access to documents from the South Eastern Trust, the Ombudsman's office must seek consent from the deceased next-of-kin. He is of the opinion that other statutory bodies would have "more confidence in dealing with another statutory body and will make the process of them agreeing to share such information with us much easier."²⁰⁶ He stated

²⁰⁵ Niall McCracken, 'Prison watchdog criticises lack of progress following jail deaths' (22 January 2015)

<www.thedetail.tv/investigations/prisons > accessed 10.01.15

²⁰⁶ Ibid

that "Our own statutory footing would mean the perceptions of this office in terms of its independence would be heightened which is very important."

The Hillsborough Castle Agreement published in February 2010 outlined that "The powers of the Prisoner Ombudsman should be reviewed "in light of experience elsewhere". This led to a consultation document to place the office on a statutory footing issued to Justice Committee members on 19th September 2013; and a 12 week public consideration process which ended on 28th January 2014. The current situation is that the Department of Justice intends to legislate for the proposals within the forthcoming Fines and Enforcements Bill by the end of the current Assembly mandate in April 2016.

6.5 Suicides and Mental Illnesses

Unfortunately the same issues regarding mental illness and suicides arise in Northern Ireland's prisons as they do in the rest of the United Kingdom. The Prisoner Ombudsman wrote to the Justice Minister and Health Minister in November 2013 to highlight his "increasing concern" that changes are not being made following prison deaths.²⁰⁷ His letter was obtained and published on the detail.tv, which is a Belfast based not-for-profit news and analysis website.

²⁰⁷ Prisoner Ombudsman letter to the Justice Minister and the Health Minister, Niall McCracken, 'Prison watchdog criticises lack of progress following jail deaths' (22 January 2015) <www.thedetail.tv/investigations/prisons > accessed 10.01.15

McGonigle highlights in his letter that 31% of the recommendations made in 10 death in custody reports had previously been made. Some of the recommendations dated back to 5 years previously and featured issues including inadequate record keeping of healthcare staff and failure to comply with Supporting Prisoner at Risk (SPAR) procedures.

6.6 Next-of-Kin

The Prisoner Ombudsman or a member of his staff meets with the deceased's family after the death and will be in contact with them throughout the investigative process as necessary. An aim of the investigation as listed on the terms of reference is to provide insight and explanations for the deceased's family.

6.7 The Police Ombudsman's Office

A death which occurs while the person is in the custody of the Police Service Northern Ireland (PSNI) is investigated by The Police Ombudsman. It is normal protocol for the Police Ombudsman to investigate if an individual dies within 24 hours of police contact. Established in November 2000 its primary function is to provide "independent, impartial investigation of complaints about the police in Northern Ireland."²⁰⁸ The Police Ombudsman's Office is entirely independent of the PSNI. It was created as a body through the Police (Northern Ireland) Act 1998.

²⁰⁸ www.policeombudsman.org/About-Us

Since its establishment the Police Ombudsman's Office has investigated 18 deaths in custody or following police contact. Of the 18 investigations, four were in respect of deaths that occurred while detained in custody.²⁰⁹

When investigating death in custody Police Ombudsman investigators will make all suitable enquiries, have the power to seize any evidence and examine all CCTV footage and police logs. They can also make criminal or misconduct recommendations in relation to individual officers, as well as policy recommendations to the Police Service Northern Ireland (PSNI).²¹⁰

²⁰⁹ <http://www.policeombudsman.org/investigations>

²¹⁰ As per personal communication with Andrew Ruston, Police Ombudsman Office, 23rd February, 2014.

Seven - Canada

The rationale for the inclusion of Canada in this report as a comparative jurisdiction is based on the following factors. Canada is a common law jurisdiction similar to Ireland. Canada has two official languages, French and English. There is a body of research available in the English language on investigations into deaths in custody. Canada is a Western country with similar traditions as Ireland and faces similar issues with regard to penal policy.

In Canada responsibility for prisons is divided between the federal government and provincial/territorial governments. The Correctional Service of Canada (CSC) is responsible for offenders serving a sentence of two or more years in a federal prison.²¹¹ The CSC is mandated to:

- provide for the care and custody of inmates;
- provide programs that contribute to the rehabilitation of offenders and to their successful reintegration into the community;
- prepare inmates for release;
- provide a system of parole, statutory release supervision and long-term supervision of offenders; and
- maintain a program of public education about the operations of the Service.²¹²

²¹¹ Part 1, Corrections and Conditional Release Act 1992.

²¹² Section 5, Corrections and Conditional Release Act 1992.

This section reviews the investigative processes for deaths in custody in federal prisons only. On average there are 163,000 adult offenders in the Canadian correctional system on any given day. Historically Canada has placed convicted offenders under community supervision, usually on probation. During 2010/2011 only 23 percent were incarcerated. In this same period 89 percent of the prison population comprised of men, 62 percent were single and 24 percent were under 25 years of age. Twenty percent of prisoners are Aboriginal people, almost seven times the proportion of Aboriginal people (3 percent) in the adult population as a whole.²¹³

Canada does have a Prison Ombudsman in the form of the Office of the Correctional Investigator (OCI). This office was established following the Kingston Penitentiary Riot of 1973. In response to 'repressive and dehumanising' conditions the inmates took five officers hostage in a siege that culminated in local authorities storming the prison. Two prisoners died, 13 were injured and a portion of the prison was destroyed. A Commission of Inquiry recommended the establishment of the OCI for the purpose for investigating prisoner complaints and deaths in custody.²¹⁴

²¹³ M. Dauvergne, 'Adult Correctional Statistics in Canada 2010/2011' (Statistics Canada 2012).

<<http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11715-eng.htm>> accessed 07 February 2015

²¹⁴ H. Saper, 'Aging, Disordered and Aboriginal Offenders in Canadian Federal Corrections' (The Office of the Correctional Investigator and Human Rights 2010).

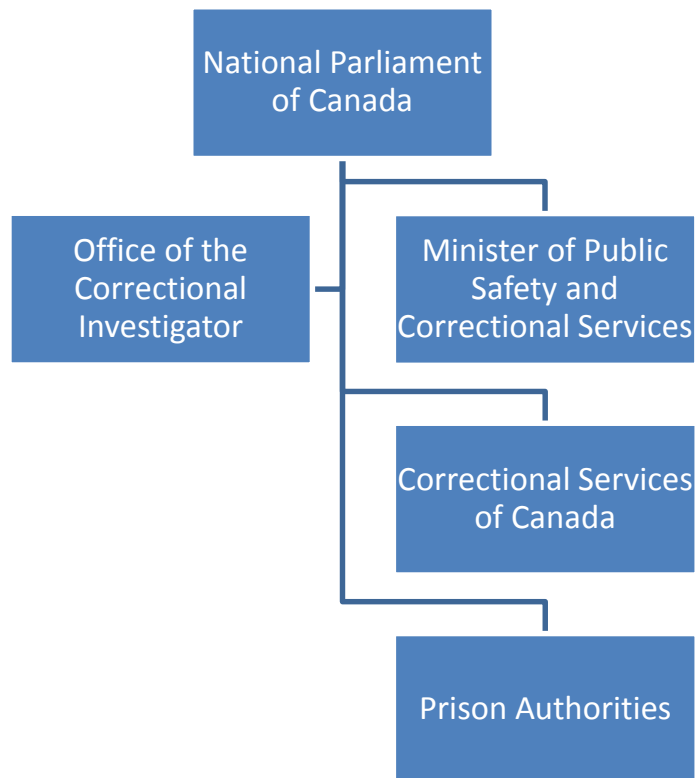
<http://www.theioi.org/downloads/ftvle/Wellington%2520Conference_44.%2520Working%2520Session%20> accessed 07 February 2015.

An annual vigil for prisoners who have died in custody is held on August 10th (Prisoner's Justice Day), in response to the death of Edward Nolan on that date in 1974. Mr. Nolan, a mentally ill prisoner, was kept in isolation in conditions described as 'grossly inadequate' and died by suicide after multiple attempts.²¹⁵

Between 2002 and 2013, 536 deaths were recorded in federal prisons in Canada. Of these 70 percent were attributed to natural or expected causes. The average age of the prisoners involved was 60 years. The leading cause of death was cancer followed by cardiovascular disease.²¹⁶ The exact cause of death, whether it was a natural cause or unexpected, determines which form of investigative process will be used to examine the circumstances surrounding the death.

²¹⁵ John Howard Society of Canada, *Prisoners' Justice Day, Aug 10th: 40 Years Since Edward Nolan Committed Suicide in Solitary Confinement in Millhaven Penitentiary Backgrounder* <<http://www.johnhoward.ca/media/Prisoners%20Justice%20Day-Backgrounder.pdf>> accessed 27 November 2014.

²¹⁶ Remarks for Howard Saper. Conference *Healthy Beyond Bars: Towards Healthy Prisons in Canada* February 2014.
< <http://www.oci-bec.gc.ca/cnt/comm/presentations/presentations20140221-eng.aspx>> accessed 07 February 2015.



7.1 The Office of the Correctional Investigator

The Office of the Correctional Investigator (OCI) acts as an ombudsman for federally convicted offenders serving a sentence of two years or more. It was set up on a statutory footing by Part III of the Corrections and Conditional Release Act 1992 to conduct investigations into prisoner problems related to

decisions, recommendations, acts or omissions of the Correctional Service of Canada (CSC).²¹⁷

The OCI acts independently of the Minister of Public Safety and the Correctional Service as an oversight body, reporting directly to the National Parliament of Canada. Included in the remit of the OCI is the review of all incidents and CSC investigations of inmate deaths, regardless of the cause of death.²¹⁸

Where a death in prison or other custodial situation occurs, the head of the institution is under a duty to submit a situation report within 72 hours to the Regional Deputy Commissioner and CSC National Headquarters. Upon receipt of the report, the Deputy Commissioner of the CSC, in consultation with the Director General of the Incident Investigations Unit, will issue a convening order to proceed with either a Board of Investigation or a Mortality Review Process. The investigation should be completed within six months of the convening order. Upon completion of the investigation a closure memo shall be sent to the OCI advising of the decision to close the investigation and detailing all actions taken.²¹⁹

Section 19 of the Corrections and Conditional Release Act provides:

²¹⁷ Part 3, Corrections and Conditional Release Act 1992.

²¹⁸ Remarks for Howard Saper. Conference *Healthy Beyond Bars: Towards Healthy Prisons in Canada* February 2014.
< <http://www.oci-bec.gc.ca/cnt/comm/presentations/presentations20140221-eng.aspx>>
accessed 07 February 2015.

²¹⁹ Commissioner's Directive 041 *Incident Investigations* (Corrections Service of Canada 2010).

'Where an inmate dies or suffers serious bodily injury, the Service shall, whether or not there is an investigation under section 20, forthwith investigate the matter and report thereon to the Commissioner or to a person designated by the Commissioner.'²²⁰

7.2 Board of Investigation

The purpose of the Board of Investigation is to ensure that an appropriate action is taken following a fatality; that any lessons learned from a review are integrated into operational practices; and that responsibility, accountability and transparency are demonstrated.²²¹

The Board of Investigation produces a report describing the events prior to and after the incident leading to the death. It reviews policy and legal compliance. Its findings are reported to the Office of the Correctional Investigator. A Board of Investigation, under Section 19 investigates unexpected deaths such as suicide, homicide, overdose or unknown cause. Suicides comprise of 20 percent of all deaths in federal prisons in Canada.²²²

The Board of Investigation consists of three members, one of whom is independent of the Correctional Services of Canada (CSC). It is convened within 15 days of the death and is mandated to investigate long standing risk factors, medical and health issues, the security classification of the inmate

²²⁰ Section 19, Corrections and Conditional Release Act 1992.

²²¹ Office of the Correctional Investigator Correctional Service of Canada's Response to Deaths in Custody (2010).

²²² Office of the Correctional Investigator A Three Year Review of Federal Inmate Suicides (2011-2014) (2014).

involved, presence of staff in the area when the fatality occurred, and the level of medical care provided. The Board must prepare a chronology of events, a profile of the inmate and a statement of findings. It may also issue recommendations aimed at preventing a reoccurrence.

The completed report accompanied by key findings and recommendations is submitted to the prison warden and to regional and national authorities, who may either accept or reject its conclusions. If accepted, the recommendations will form the basis of an action plan. If rejected it is usual for the authorities to explain why. The report will be presented and signed off by the CSC executive committee.²²³

7.3 Mortality Review Process

The CSC originally established a Board of Investigation for all in-custody deaths. This changed in 2005 and deaths by natural causes are now investigated by a Mortality Review Process in order to streamline the investigative procedure.²²⁴

The Mortality Review Process investigates deaths from natural causes. It consists of one member, a registered nurse working at the Clinical Services Branch, National Headquarters. The health care provided and the circumstances leading up to the death are reviewed. The report produced

²²³ Office of the Correctional Investigator An Investigation of the Correctional Service of Canada's Mortality Review Process (2013).

²²⁴ Remarks for Howard Saper. Conference Healthy Beyond Bars: Towards Healthy Prisons in Canada February 2014.

following the process includes a statement of the cause of death, details of any risk factors that contributed to the death, medical care provided related to cause of death, and whether such care was in accordance with CSC policy and accepted professional standards of care.²²⁵ When compared with a Board of Investigation the Mortality Review Process has been criticised for lacking independence and reviewing only medical reports without offering lessons learnt or recommendations.²²⁶

The Office of the Correctional Investigator has been skeptical of the Mortality Review Process since its inception. It maintains that a medical file review, even one thoroughly and qualitatively completed does not constitute an investigation. It lacks interviews with staff or management, relying solely on medical charts, which may not be a complete record of the circumstances surrounding the death. Mortality reports claim, without exception, that the medical care received by the prisoner meet professional standards. The OCI has raised concerns about requiring registered nurses to evaluate the diagnostic procedures of physicians and whether it is appropriate for one professional group to comment on the work practice of another professional group.²²⁷

Any death in custody or prison must also be investigated by a coroner. The role of coroner is to examine and control the body at the place of death

²²⁵ Office of the Correctional Investigator (n 13).

²²⁶ Ibid.

²²⁷ Ibid, 15-16.

and to arrange for a post mortem to be carried out by a pathologist. If the death is the subject of a criminal investigation, the coroner assists the police and crown attorney.²²⁸

7.4 Statistics of Cases

Elderly Prisoners

The average age of an inmate during 2013 and 2014 from natural causes was 60 years. This is significantly lower than the life expectancy of the Canadian population (males 78.3 years and females 83 years).²²⁹ The Office of the Correctional Investigator has accepted that the aging process is accelerated by as much as ten years or more in an institutional setting.²³⁰ This would account for the higher mortality rate when compared with the general population. Canada has an aging prison population. One in five federal prisoners are aged 50 years or older, while one quarter of the prison population is serving a life or indeterminate sentence.

The Office of the Correctional Investigator has criticised the quality and adequacy of the health care provided in the Prison Service. Release on compassionate grounds for terminally ill prisoners is provided for by the Royal Prerogative of Mercy or section 121 of the Corrections and Conditional

²²⁸ James Payner-James , Anthony Busuttill and William Smock (eds) *Forensic Medicine: Clinical and Pathological Aspects* (Cambridge University Press 2003), 117.

²²⁹ Annual Report of the Office of the Correctional Investigator 2013-2014.

²³⁰ Remarks for Howard Saper. Conference *Healthy Beyond Bars: Towards Healthy Prisons in Canada* February 2014.

Release Act. However, between 2008 and 2013, only thirteen prisoners applied, seven were rejected, and just four granted.²³¹

Prisoners with Mental Illness

Canada has been criticised for systematically failing prisoners with mental illness. *Antonowicz* and *Winterdyk* note that prisons have become warehouses for the mentally ill who, due to lack of funding and staff shortages, receive inadequate care.²³² The John Howard Society of Canada estimate that the percentage of prisoners with mental illness doubled between 1997 and 2008. It has condemned the practice of placing prisoners deemed to be 'difficult or problematic' in solitary confinement.²³³ The Canadian Human Rights Commission notes the deinstitutionalisation of psychiatric services has taken place over 40 years. Many psychiatric hospitals were closed and patients discharged into the community. Insufficient assistance in housing and community support resulted in many people falling through the cracks.²³⁴ It argues that a prison is not a suitable environment for a person with a mental health issue.

²³¹ Ibid.

²³² D Antonowicz & J Winterdyk, 'A Review of Deaths in Custody in Three Canadian Provinces' (2014) *Canadian Journal of Criminology and Criminal Justice*, 98.

²³³ John Howard Society of Canada, Prisoners' Justice Day, Aug 10th: 40 Years Since Edward Nolan Committed Suicide in Solitary Confinement in Millhaven Penitentiary Backgrounder <<http://www.johnhoward.ca/media/Prisoners%20Justice%20Day-Backgrounder.pdf>> Accessed 27 November 2014.

²³⁴ The Canadian Human Rights Commission, Submission to the Committee against Torture, April 2012 <http://www.chrc-ccdp.ca/sites/default/files/cat_cct-eng.pdf> Accessed 27 November 2014.

Studies have shown the effects of solitary confinement on mental health.²³⁵ The majority of prisoners experience insomnia, confusion, feelings of hopelessness and despair, hallucinations, distorted perceptions and psychosis.²³⁶ The OCI has identified physical isolation as an important risk factor for prison suicide and as a result has recommended that the long term segregation of mentally disordered inmates at risk of suicide or self-injury should be prohibited.²³⁷

7.5 Next-of-Kin

On the death of a prisoner while in custody the next-of-kin are informed by the Institutional Head or District Director who must liaise with the family regarding funeral arrangements.²³⁸ The OCI has criticised the Morality Review Process as falling short of best practice in having no provision for liaison with family members of the deceased. The OCI has recommended that the Mortality Review Process findings should be shared with the family upon request.²³⁹

When a non-natural death of an inmate occurs, the Director General of the Incident Investigations Unit must inform the next-of-kin or designated person of that a Board of Investigation has been convened. The next-of-kin

²³⁵ Sharon Shalev, *A Sourcebook on Solitary Confinement*, (Mannheim Centre for Criminology 2008).

²³⁶ *Ibid* 14.

²³⁷ Office of the Correctional Investigator *A Three Year Review of Federal Inmate Suicides* (2011-2014) September 2014, 16.

²³⁸ Commissioner's Directive 530 of 2013, *Death of an Inmate: Notifications and Funeral Arrangements*, <<http://www.csc-scc.gc.ca/politiques-et-lois/530-cd-eng.shtml>> Accessed 30 December 2014.

²³⁹ Remarks for Howard Saper. Conference *Healthy Beyond Bars: Towards Healthy Prisons in Canada* February 2014.

may request a copy of the final report. This also applies in cases where a prisoner suffers serious bodily injury.²⁴⁰

When a death occurs by natural causes the Director General of the Clinical Services must inform the next-of-kin or designated person that a Mortality Review Process has been convened. The next-of-kin may request a copy of the final report.²⁴¹

7.6 Statistics

The CSC has been criticised for failing to keep detailed information on in-custody deaths.²⁴² The Canadian Centre for Justice Statistics is responsible for collecting information on deaths in federal and provincial custody, but is restricted to reporting the number of deaths and a broad outline of the cause of death.²⁴³ The OCI notes the CSC has stopped producing an Annual Inmate Suicide Report. This contained an overview of all inmate suicides in CSC facilities, a description of the suicides that occurred throughout a given year, location, psychological background, suicide risk pre-indicators and a summary of recommendations from the CSC Board of Investigation reports. The OCI has recommended that they recommence production of this report.²⁴⁴

²⁴⁰ Commissioner's Directive 041 *Incident Investigations* Corrections Service of Canada (2010).

²⁴¹ Ibid.

²⁴² D Antonoxicz & J Winterdyk, 'A Review of Deaths in Custody in Three Canadian Provinces' (2014) *Canadian Journal of Criminology and Criminal Justice*, 98.

²⁴³ D Antonoxicz & J Winterdyk A Review of Deaths in Custody in Three Canadian Provinces (2014) *Canadian Journal of Criminology and Criminal Justice*.

²⁴⁴ Office of the Correctional Investigator A Three Year Review of Federal Inmate Suicides (2011-2014) September (2014), 4.

Eight - Recommendations

General recommendations

Definition of a 'Death in Custody'

- An agreed national/international definition of a 'death in custody,' broad enough to include deaths resulting from conditions in custody, is required.

Duty of Care owed whilst in Custody

- Clarification is needed in relation to the extent of the duty of care owed to a person in custody, on temporary release, or upon release.

Legislation

- The Coroners Bill 2007 should be reintroduced to the Oireachtas without delay.
- The Optional Protocol to the Convention Against Torture (OPCAT) should be ratified in accordance with the current Programme for Government.

Prison Conditions

- Research into over-crowding in prisons as a contributory factor to custodial deaths should be undertaken and the findings publicly disseminated.
- Single cell occupancy in prisons should be the rule, not the exception.

- Prisoners on protection require the highest standard of care and should only ever be placed in single cells or in dual occupancy cells where monitoring and vigilance is of a high standard.
- The allocation of cells to prisoners should be based on robust risk assessment.

Alternatives to Prison Custody

- A range of alternatives to prison custody should be explored, where appropriate, to reduce over-crowding in prisons.

Personnel

Inspector of Prisons

- The Inspector of Prisons should be appointed following a public competition.
- The remit of Inspector of Prisons should be extended to include investigation of all non-natural deaths in custody.
- The Inspector of Prisons should have statutory power to compel witnesses and for disclosure of documents relevant to the investigative process.

The Coroner

- The range of verdict options open to a Coroner should be widened to include a 'narrative verdict'.

- Coroner's reports on deaths in custody should be classified separately in the Coroner's Court in order that data is more easily accessible.

Next-of-Kin

- Legal Aid should be made available for next-of-kin representation at an inquest.
- A standard procedure should be established for contacting next-of-kin/families following a death in custody.
- The family of a prisoner who dies in prison custody should be treated with due respect, care and compassion.
- The Prison Governor should be fully accountable for any breach in his/her duty to notify the family.
- A family liaison worker should be appointed to advise and support a family following a custodial death.

Long-term objectives

- The establishment of a Prison Ombudsman on a statutory basis, with power to investigate prisoner complaints, could prevent deaths in custody.

Prison Ombudsman

- A Prison Ombudsman should be independent and directly accountable to the Oireachtas rather than to the Minister for Justice, to ensure impartiality.

- The Office of the Prison Ombudsman should be funded directly from exchequer funds and not through the Prison Service budget.

Institutions

Accountability

- A prison governor should be statutorily obliged to respond to the recommendations made by the Inspector of Prisons in his/her reports.
- A prison governor should be required to present evidence of how he/she has followed through on any recommendations made in the Inspector of Prisons reports.
- Recommendations from an Inspector/Ombudsman's report should contain very clear actions to be taken by prisons which should include a timeline thus ensuring accountability of prison staff (as per the Prison Ombudsman for Northern Ireland reports).

Irish Prison Service

- Prison staff should receive regular ongoing training regarding risk assessment and management of prisoners who have additional health challenges.
- Procedures for reporting prison deaths should be standardised across the Irish prison system.
- Record keeping by prison officers should be comprehensive.
- At risk prisoners should be monitored at the recommended intervals.

Reports

Commissions of Investigation

- Commissions of investigation should be held in public and the terms of reference decided by the Oireachtas.

Publication of Investigative Reports

- Publications of investigative reports should be prompt. Systemic delays in publishing investigative reports on deaths in custody need to be addressed urgently along with a reluctance to permit public access to such reports.
- Publication should not be subject to Ministerial approval and should occur within a specific time frame. Publication timelines should be set in all investigative processes.

Preventative recommendations

Human Rights

- Overcrowding in Irish prisons must be addressed as a matter of urgency
- In accordance with the recommendations of the Committee for the Prevention of Torture, 23-hour-lock-up should be used as a temporary measure only.
- The practice of 'slopping out' should be immediately discontinued in accordance with the recommendations arising from the CPT 2011 visit and Article 3 of the ECHR.

Care

- Efforts should be made to reduce the use of pharmacological treatment for prisoners with mental health issues through greater use of alternative forms of treatment such as counselling.
- Drug treatment facilities such as detox programmes should be available throughout the Irish Prison Service.
- Structured aftercare to be rolled out (training programmes, housing made available, etc.) to reduce the risk of death occurring on temporary release.
- Adequate medical treatment should be provided to prisoners. Requests by prisoners for extra medical treatment, and the response thereto, should be fully documented.
- The educational budget for the Prison Service should be increased to ensure productive activities are available for prisoners to engage in.

Prison Visiting Committees

- Role of visiting committees should be strengthened and put on a statutory footing.
- The Visiting committee appointments process must be open to public competition.
- Powers of visiting committees to be enhanced so that such committees have access to prisoner complaints from all complaint categories.

Long Term Recommendations

Research

- The Office of the Ombudsman for Prisons (when established) should have a research and policy section capable of conducting research into deaths in custody.
- Statistics on prison population should be publicly available to encourage research into the operation of the penal system in Ireland.
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Appendix One: Britain - Prison facts

	England and Wales	Scotland	Northern Ireland
Number of prisons	131	15	3
Number of people incarcerated	88,205 (27/02/15) 148 per 100,000	7434 (12/01/15) 146 per 100,000	1743 (27/02/15) 101 per 100,000
Deaths in 2014	242	24	4
Deaths 2002 - date	2448	269	57

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