Report of the

National Steering Group

on Deaths in Prisons

Contents

Chapter 1

Introduction

Establishment of National Steering Group

1.0 The Minister for Justice announced in May 1996 the establishment of the National Steering Group on Deaths in Prison comprising of representatives of various disciplines involved in the care of prisoners. The terms of reference of the Group are:

(a) to review deaths in custody since 1991,

(b) to look at the recommendations contained in the Report of the Advisory Group on Prison Deaths published in August 1991, and

(c) to make whatever further recommendations, if any, deemed necessary.

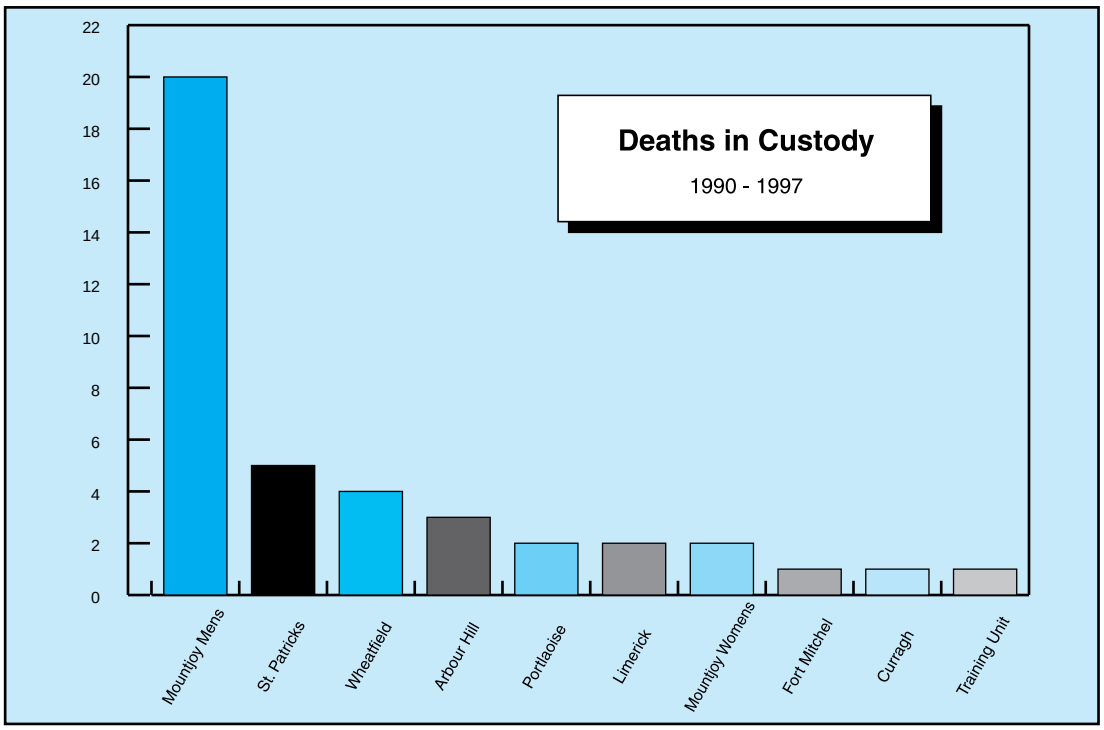
Membership of the Group

1.1 The membership of the Group is as follows:

Mr. James Woods	Governor Operational Co-Ordination (Chairperson)
Mr. Dan Scannell	Governor Loughan House
Fr. Fergal McDonagh	Head Chaplain, Arbour Hill Prison
Dr. Enda Dooley	Director of Prison Medical Services
Dr. Charles Smith	Medical Director, Central Mental Hospital
Mr. David McAuliffe	Higher Executive Officer, Department of Justice
Ms. Marieva Coughlan	Clinical Psychologist, Department of Justice
Mr. Derek Murphy	Prison Officers Association
Mr. Terry Boyle	Assistant Principal, Probation & Welfare Service (from Feb 1998)
Mr. Sean Aylward	Principal Officer, Department of Justice (until May 1997)
Mr. Tom Maguire	Principal Officer, Department of Justice (May/June 1997)
Mr. Michael O'Neill	Assistant Principal, Department of Justice (Dec 1997)
Mr. Chris Morris	Assistant Principal, Probation & Welfare Service (retired late 1997)
Ms. Sheila McGrath	Prison Officer/Secretary to Group

Approach to the Work

1.2 The Group met on 14 occasions between June 1996 and February 1998. They studied information on all deaths in custody from 1990 to 1997 inclusive.



A detailed breakdown is provided in Appendix A, page 37.

The Group also examined statistics on deaths in custody both in the United Kingdom and Wales, and in Scotland. These are outlined in Appendix B, page 40.

The Group also examined statistics on suicides in the general community. These are outlined in Appendix C, page 41.

In addition, representatives of the Group attended two Seminars in the United Kingdom as follows:—

(1) ''Listening Scheme'' which operates in some of the prisons there (page 19), and

(2) ''Deaths in Custody and Beyond'' (page 20).

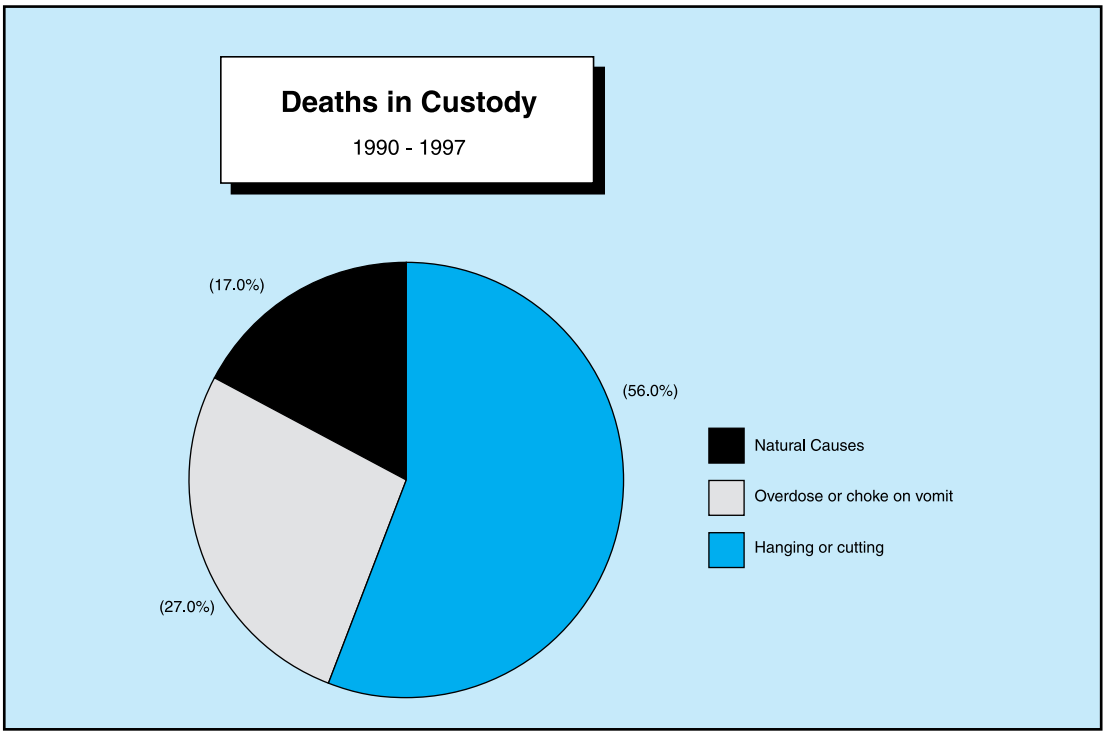
Scope of this Report

1.3 To assist the Group in undertaking this work, deaths occurring in prison were divided into three categories as follows:—

(a) suicides

(b) deaths due to drug overdose, and

(c) deaths due to natural causes



While deaths adjudged to be ''suicides'' form the bulk of all deaths occurring in prison, there has been a noticeable increase in recent years in both the numbers of deaths due to natural causes and to drug overdoses. This reflects both the increase in the numbers of older people being committed to prison (particularly for sex offences) and the large number of prisoners with a background of current or recent opiate abuse also being committed to prison. It is estimated that approximately 30-40% of the overall prison population come into this category while, in the Dublin prisons the percentage may be as high as 60-70%.

It has only been since the enactment of the Criminal Law (Suicide) Act, 1993 (which abolished the crime of suicide) that coroners have been allowed to accept this particular verdict. Previous suicides were couched in other terms. Notwithstanding this, the Group for statistical and analysis purposes, use the term ''suicide'' for all deaths considered or adjudged as such.

The Group found it difficult to establish if those who took their own lives fully intended to carry out the act or if it was a ''call for help''. The only exception was in those cases where the deceased left a note explaining why they were going to take their own lives.

Present Position

1.4 As regards the present position within the Irish Prison Service in relation to suicide awareness the Group found that :–

- there are good policies in place,
- there is a good level of awareness by staff
- many possible deaths are saved by the alertness and vigilance of staff,
- every death in custody has a significant effect on other offenders and on staff,
- there has been a significant increase in the prison population since the original Report of the Advisory Group on Prison Deaths,
- there has been an increase in the number of offenders committed with drug dependency and other related problems,
- there has been an increase in the number of female offenders committed to prison on remand, and
- there has been an increase in the number of deaths in custody resulting from drug overdoses.

Priority Issues

1.5 The Group identified the following priority issues:—

(1) The establishment of a high support type facility in each of the closed institutions for offenders exhibiting suicidal tendencies,

(2) The establishment of an assessment centre. The Group welcomes the inclusion of such a centre in the new prison in Cloverhill. A suicide awareness strategy should be put in place prior to its opening.

(3) the co-ordination of information from:—

(a) The local Suicide Awareness Groups within each institution, and

(b) Inter-Governmental agencies — Gardai/Courts/Hospitals/Prisons.

(4) Bunk beds should be manufactured with a protective barrier on the top bunk to ensure that it is not possible to tie a ligature to it.

(5) Additional Pharmacists should be appointed to oversee the control and dispensing of drugs in addition to the appointment of qualified nurses.

Chapter 2

Current Practice

Overview

2.0 The Group is satisfied that there is now a much more active policy in operation to prevent deaths in custody than prior to the 1991 Report from the Advisory Group on Prison Deaths.

The Group found that staff saved a considerable number of lives by a combination of good observations and fast reactions when finding a self-injury in progress. These events – unlike a death in custody – rarely if ever attract media attention.

The Group also found that there were strategies and plans in place for the prevention of suicides in all institutions. However, unless there is to be a total denial of all personal privacy to offenders at all times, the possibility of suicides in custody cannot be precluded no more than it can be precluded in the wider community. There exists however in all institutions a great level of awareness and care in the prevention, insofar as is possible, of suicide.

Routine Measures

2.1 Offenders are regularly observed/supervised/checked 24 hours per day, 365 days per year from their time of committal to their time of discharge. They are observed/checked both in cell and out of cell.

Some are checked/observed more frequently than others while in cell. Those whose names appear on ‘‘Special Observation Lists’’ are checked every 15-20 minutes while in cell. Names are placed on these lists for several reasons (*see page 14*) including for example, if information becomes available to staff that offenders are in danger of doing harm to himself/herself or it is observed that an offender is upset, depressed or anxious as result of a distressing visit. Reasons might also include receipt of a letter containing bad news, a court appearance or refusal of temporary release. Staff coming on different tours of duty are informed accordingly.

Samaritans

2.2 The Samaritans visit a number of institutions regularly. In some institutions there is a special telephone facility available to offenders to contact the Samaritans if they so wish. Offenders may also write to the Samaritans on a confidential basis.

Staff Training

2.3 All newly recruited staff to the Prison Service receive training in suicide awareness. Certain other staff have also been selected to receive additional training from the Samaritans.

Local Suicide Awareness Group

2.4 A Suicide Awareness Group has been established in each institution. These Groups are chaired by the Governor and include representatives from the various services; Doctor, Psychiatrist, Psychologist, Chaplain, Welfare, Education and Prison Staff. They meet quarterly or more often if necessary. They also meet after a death occurs to review and discuss the full facts of the particular incident.

Effects of a death in custody

2.5 The Group noted the effects of suicide on the family of the deceased, fellow offenders and staff. It was noted that an offender's death in the women's prison can have a greater effect among the offenders there in comparison to an offender's death in a male prison. This may be due to the fact that the women's prison is so small and offenders there get to know each other much better. Deaths in such circumstances could be regarded as being somewhat similar to the death of a close family member.

Chapter 3

The Wider Context

Increase in prison population

3.0 The prison population has increased dramatically in the period reviewed – 1990 to 1997. While the number of committals each year has almost doubled, the daily average in custody has also increased significantly in that period.

Daily Average in Custody 1990 – 1997
Daily average in custody 1990 – 2,108 Daily average in custody 1997 – 2,539

Committals in Custody 1990 – 1997
Total committals in custody 1990 – 6,406 Total committals in custody 1997 – 11,620

Approximately 10% of the total male population are now on remand or awaiting trial at any one time. There is a different trend in the female population however in that approximately 70% of female offenders in custody in recent times are on remand.

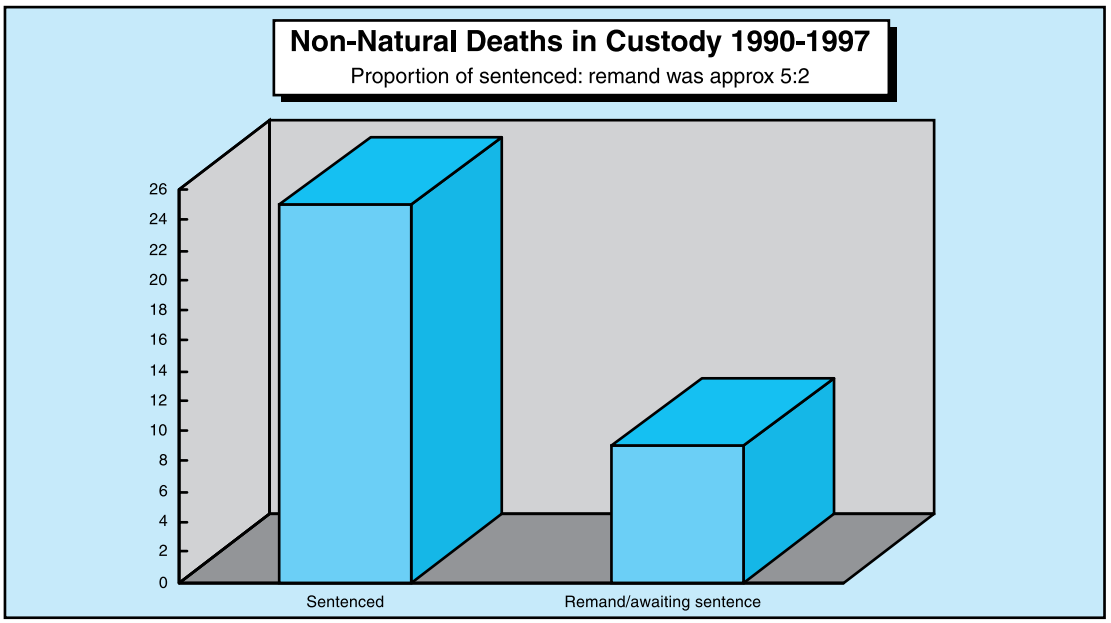
Overall these trends reflect a more transient prison population passing through the system more rapidly. In the context of suicide prevention, it has become increasingly difficult for staff to develop and maintain the quality of relationship which is necessary to accurately identify those most at risk of suicide or self-injury.

Increase in number of drug dependent offenders

3.1 It is noted that there has been a significant increase in the number of offenders with drug dependency problems. Eight of the deaths in the period reviewed were as a result of drug overdoses. Almost all those who died in custody in 1995 and 1996 were known to have had a heroin addiction.

Most vulnerable stages of custody

3.2 The previous Group found that suicides were more likely to occur in the cases of offenders who were on remand, awaiting trial, awaiting sentence or at the early stages of a sentence. This was consistent with the findings of international research.



However, the present Group found no clear pattern regarding the stage of custody at time of suicide. 24% of all deaths were on remand. 26% of non-natural deaths were on remand.

It is possible that improved suicide prevention procedures since the last report have resulted in fewer suicides at those stages of custody which are normally considered high risk.

Introduction of new laws limiting the right to bail

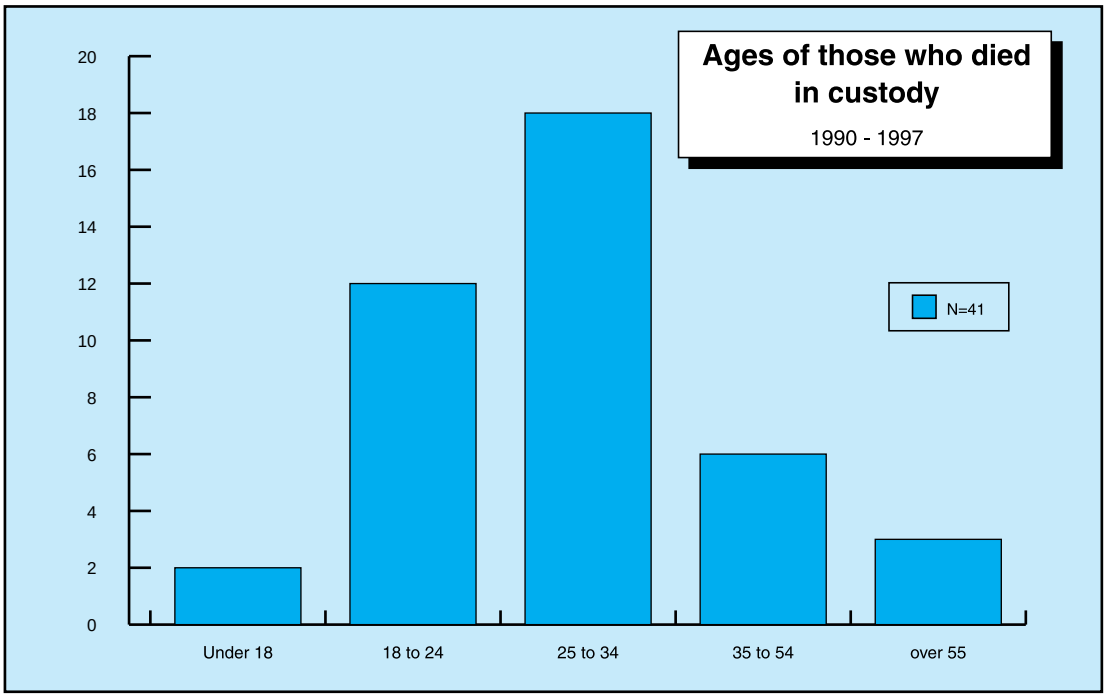
3.3 The likelihood is that there will be a substantial increase in the number of offenders committed to prison on remand with the introduction of the new bail laws. The Group strongly advise that the management of the new assessment centre at Cloverhill should be alerted to this fact and have a suicide awareness strategy in place (local committee etc.) prior to its opening.

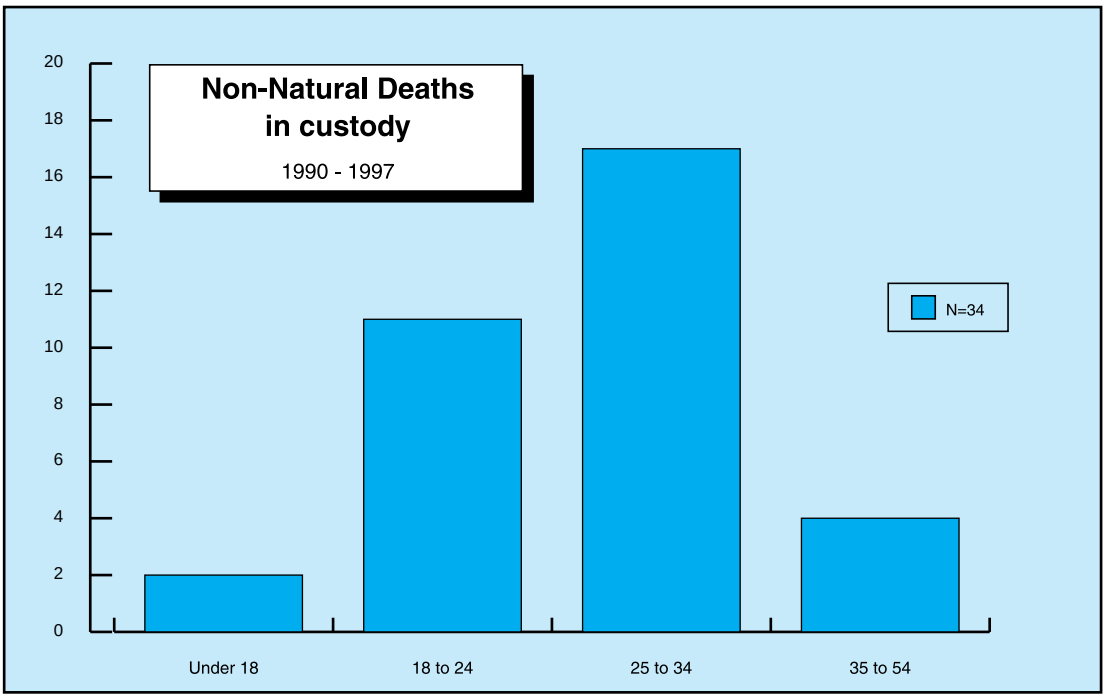
Increase in number of suicides in the general community

3.4 The number of officially recorded suicides in the general community also increased (see Appendix C, page 41, for totals and age profile). There was an average of 356.5 deaths per year recorded officially in the 5 year period 1990-1995. In the years 1980-1985 there was an average of 245 recorded deaths per year.

The average age of male offenders who take their own lives is mid 20's. There are few offenders in custody over the age of 45. Less than 3% of the total prison population at any one time are female offenders. The age profile of suicides in custody is therefore not comparable with the general community.

The following graphs give an indication of the age profile of those who died in custody.





Chapter 4

Observations regarding current practices and facilities

Medical Files/Records

4.0 The Group were informed that, in some cases where an offender was being transferred from one institution to another, that the offender's medical file was not always transferred with him/her. In the circumstances it could be several days before it arrived at the new prison.

The Group also found that some prisons do not maintain medical records on file but that information is retained in a large medical journal. It is understood that there is a reluctance by some prison medical officers to extract and up-date information from this journal for individual medical file records.

The Group understands that plans are in train to introduce computerisation of medical records in an effort to overcome these difficulties and looks forward to its speedy implementation.

Recommendation: The computerisation of medical records should be introduced as soon as possible.

The Group were informed of existing arrangements where the medical orderly on duty completes a specially designed form on the committal of an offender into custody. This form details the offender's medical history (as given by the offender), any history of hospitalisation, self mutilations etc. The medical orderly may also include observations such as whether the offender was in an agitated state or appeared to be under the influence of drugs or alcohol etc. It was also found that this procedure is not strictly followed in all cases. This situation must be addressed.

Recommendation: The completing of specially designed forms by medical orderlies/nurses on committal should be carried out at all times.

Prison Medical Officers

4.1 The Group recommend that now that the new contract for prison medical officers has been agreed with the IMO (the Doctor's representative body) that the whole medical area should be examined with a view to ensure that:—

(a) all offenders have adequate time with medical officers,

(b) medical files are completed and up-dated, and

(c) medical officers are available for management meetings and to give advice when required.

The Group found that, in some institutions, the number of offenders who attended some of the medical officers in the time span in which the medical officers were in the institution, would indicate that each offender received approximately one minute of the medical officers examination time.

The Group considered it necessary for medical officers to attend management meetings including suicide awareness meetings and in particular to attend discussions concerning offenders with medical or psychiatric problems and where such offenders are being considered for transfer, release or work.

Contribution of Medical Orderlies

4.2 The Group discussed the contribution of medical orderlies and agreed that they perform their duties very well and have given great service to their institutions over the years. Their functions are varied in that they perform para-medic duties in addition to other duties including disciplinary ones. It is therefore difficult for medical orderlies to be regarded by offenders as listeners or carers and simultaneously as supervisory officers. The Group agreed that qualified nurses would be more suitable and welcomes their proposed introduction into the service.

Medical Orderly cover after final lock-up in Mountjoy Prison (Female)

4.3 The Group were informed that no medical orderly cover was available in the Women's Prison after 8pm each night. If an emergency arose, a medical orderly from Mountjoy Men's Prison or St. Patrick's Institution would have to be called. Their arrival could be delayed due to the number of security gates which have to be opened to allow access. This problem has been highlighted previously.

Recommendation: The Group recommend that there should be 24 hour medical orderly/nursing cover in the Women's Prison.

Single Cell Occupancy

4.4 The Group examined the issue of single cell and multiple cell occupancy. The typical suicide in a "closed" institution usually occurs when the offender is alone in the cell and the most common method employed is hanging.

The Group agreed that single cell occupancy was a preferred option for an offender from a privacy, bullying or sexual harassment point of view. From a suicidal viewpoint where an offender has no companionship and a greater degree of loneliness in a single cell situation, the option of a shared occupancy cell should be available to both offenders and management. Where shared cell occupancy is a recommended option each offender should have their own single bed. In the Group's view, bunk beds no matter how good their design, provides an increased risk factor for self-injury.

The fact that someone is in a shared cell does not necessarily guarantee that they will not attempt suicide or self-injury or that cell mates will be in each others company at all times. An offender in such a cell can be on their own for different reasons at various times during the day and evening e.g. while their companion is at work, visits, education or recreation etc. There have also been a number of examples over the years where suicides have occurred despite the presence of other offenders in the same cell.

Recommendation: The option of shared occupancy cell should be available to both offender and management from a suicide viewpoint. In such circumstances each offender should have their own single bed as, bunk beds no matter how good their design, provide an increase risk factor for self injury.

Bunk Beds

4.5 The Prisons Building Planning Section of the Department of Justice, Equality and Law Reform also showed the Group a drawing of a proposed type of bunk bed which was to be installed in Wheatfield, Place of Detention. The Group recommended that the protective bar on the top of bunk beds should be ''closed in'' with metal or steel sheet so that a ligature could not be tied to it. This also applies to the steps provided at the end of the bed to allow access to the top bunk. The back of the steps and siding should also be closed in with a metal or steel sheet to prevent any offender tying something to it. **Under no circumstances should suicide prevention be used as justification for prison overcrowding.**

Televisions in Cell

4.6 The Group examined the boredom and loneliness factors in being locked up in a single cell for up to 14 hours a day. Some offenders cannot read or write. Some are serving very long sentences. Offenders are allowed to have a small radio/cassette in their cells while a few long term offenders have purchased their own battery operated television set to be used in their cells. The Group were informed that there were a number of such T.V.'s already in use in certain circumstances in Arbour Hill

Prison. Their use had brought about a reduction in the number of self mutilation incidents and had a calming influence on offenders there. The opportunity of watching T.V. was also beneficial in giving offenders and their visitors a common subject of discussion.

The Group recommend that a portable T.V. be installed in some cells in selected institutions as part of a pilot project. The criteria for determining who should be allowed have a T.V. should include the length of sentence being served and behaviour in custody. Their provision should be on the clear understanding that it is a privilege and not a right. Any breach of prison rules or misuse or damage to a T.V. should lead to it's withdrawal by the Governor. The benefits of such a project could be reviewed after a suitable time period – perhaps a year.

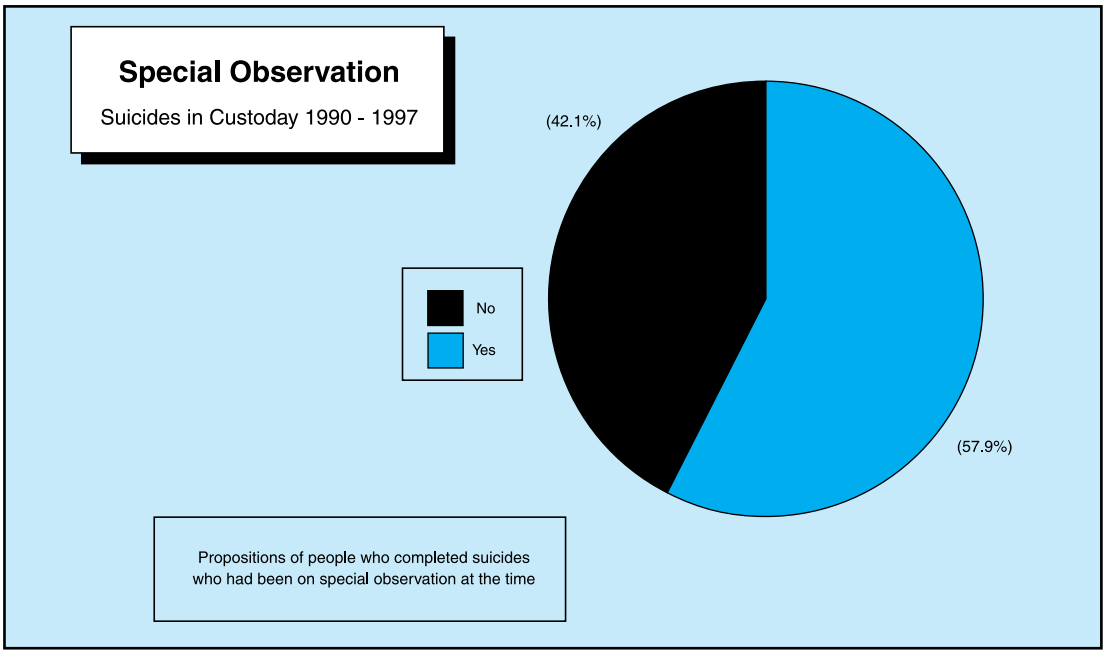
Cell Windows

4.7 The most commonly used method of suicide was with a ligature from bars in cell windows. It is almost impossible to manufacture a window which will allow ventilation and at the same time be made absolutely suicide proof. Even if the design is such that the vent is free of bars a make-shift catch can be manufactured by those determined to commit such an act. There are numerous articles of waste material In prison workshops which can be converted into a hook from which a ligature can be tied. Even cell cutlery such as a knife or fork have been jammed in window frames or surrounds and used to support a person hanging. Minimising opportunities to tie ligatures to cell windows helps reduce death by hanging among those who self-injure impulsively.

A review was carried out of windows in Mountjoy Women's Prison after a suicide had taken place there. These windows were only installed in recent years and were considered, at the time to be the most suitable in terms of suicide prevention. However, redesigned windows are now going to replace those which will have perspex covering the bars and a long letter box type flap to allow air into the cell. The bars are not accessible from the cell. The glazing is a single sheet of polycarbonate with bars on both sides which are flush with the glass. The Prisons Building Planning Section of the Department of Justice, Equality and Law Reform displayed a drawing of a new prison to the Group incorporating the new designs and it is intended that these type of windows will be used in all new future refurbishments.

Special Observations

4.8 The Group had detailed discussions on the use of "special observation lists" of offenders. The purpose of these lists is to check specific named offenders in cell every 15/20 minutes during the hours of lock-up. The lists are available to all staff on various tours of duties i.e. at breakfast, dinner, tea lock-up times and when night duty staff take up duty.



Several points were raised concerning the lists, such as

(a) The list was too long making it almost impossible to check each person every 15/20 minutes,

(b) Some names were placed on the list and never reviewed or removed from it,

(c) It was not always clear as to why some offenders were placed on the list in the first place (e.g. medical, suicidal or security reasons), and

(d) Regular review of all those on the list is needed.

The Group noted that special observation lists often represented 60% of the total prison population in some institutions and even up to 74% in others. The need for such lists is obvious but they should be managed in a better way. The policy of placing all categories e.g. security, medical etc, on the same observation list may not be the most appropriate system. If a list known as ''Special Care'' were introduced, it could place more focus on those needing medical care and this would allow resources to be channelled towards specific offenders during their time of crisis. When the crisis had passed, their names could then be removed from the list.

There should be a review system in each institution to enable those offenders listed for security reasons to be reviewed every 2-3 months. Those on the list for medical or psychiatric reasons should be reviewed by the appropriate medical personnel and management on a daily basis. In this way it should be possible to reduce the number of names on the lists.

Recommendations:

(1) Those on special observation lists for security reasons should be reviewed every 2-3 months,

(2) Those on the special observation lists for medical or psychiatric reasons should be reviewed on a daily basis, and

(3) A list known as ''Special Care'' should be introduced specifically for offenders who are identified as currently experiencing a crisis situation. When the crisis is over their names should be removed.

Cladded or Strip cells

4.9 The practice of these cells being used when offenders were upset or depressed was discussed. It was agreed that placement in such a cell helped an offender to get over the crisis but did not cure the problem. While being held in these cells the offender was very isolated, at times did not know night from day, and had no reading materials or audio devices available to him/her. It left a feeling of hopelessness and loneliness. It is also accepted that there are rules in force as to when and how these cells are to be used. Those detained there must be seen by the doctor the next day and on a daily basis thereafter.

Some offenders become violent and have to be placed there for the overall good of the management of the institution. The fact that such offenders are placed there may give the general impression that such cells are for punishment only and not for offenders own good and safety. An offender who is feeling suicidal may think that the cladded cells are only for punishment purposes. The present lack of other suitable areas for violent or very aggressive offenders leaves little alternatives to their use. The Group agreed that the use of cladded or stripped cells was still necessary because of the lack of appropriate alternatives such as an observation type setting attached to the landings or wings of prisons.

High Support Type Facility

4.10 The possibility of a high support type facility in the wings or landings of a prison should be examined. These are in use in the United Kingdom. It was considered that this type of facility would be a more suitable setting to hold offenders exhibiting suicidal tendencies rather than the existing practice of placing them in isolation in special or cladded cells.

Recommendation: The Group recommend that this type of support should be provided in each closed institution and it should be located in a central area where staff other than those working in the area frequently pass by.

Offenders with Behavioural and/or Psychiatric Difficulties

4.11 The Group noted that a considerable number of offenders held in custody have behavioural/psychiatric difficulties. This gives rise to the question of whether prison

is a suitable place to hold such people. Some are clearly in need of hospitalisation which is not available within the prison setting. If an offender needs such treatment, he/she is usually transferred to the Central Mental Hospital. There are on-going difficulties in getting offenders transferred to the Central Mental Hospital due to the apparent shortage of beds there. Offenders awaiting transfer to the Central Mental Hospital are normally held in cladded cells and could remain there for several days prior to a transfer. The Group found this to be unacceptable. Despite on-going discussions over several years between the Department of Health and Children, the Eastern Health Board and the Department of Justice, Equality and Law Reform little progress appears to have been made on this front.

Recommendation: The Group recommend that offenders deemed by the medical personnel to require Psychiatric hospitalisation should transfer to such hospitals immediately.

The Group also found that, if an offender had previously been treated in a psychiatric hospital, the prison medical staff were usually not aware of this unless the offender volunteered this information. There is clearly a need for a system of inter-institutional exchange of information to deal with this situation.

Recommendation: The Group recommends that co-ordination of information from Courts, Garda and Hospitals concerning an offender's psychiatric history is essential and that the Department of Justice, Equality and Law Reform should write to the Department of Health and Children and the Garda Commissioner seeking their assistance in having same implemented.

Reporting of Incidents

4.12 The Group also found a lack of consistency among all institutions in the procedures of reported self inflicted mutilations, attempted suicides and overdoses. This information should be submitted on a specifically designed form to the Department of Justice, Equality and Law Reform but all incidents are not being reported. It is not clear why this procedure is not being complied with. It can only be assumed that some incidents may be considered too trivial in nature by local management to report.

Recommendation: The Group recommends that all incidents of self-injury must be reported on the relevant form.

Procedures if a death occurs in custody

4.13 The Group considered that certain necessary enquiries to establish facts must be undertaken in the event of a death in custody. While such investigations are essential for management purposes, it was felt that in general they could be approached more sensitively. The discovery of an offender who has committed suicide should never be regarded as a routine aspect of a prison officer's work. It is, of course, necessary to have all reports and facts available as early as possible after a death. A standardised form outlining all information required could be devised to assist in this

regard. A debriefing session for staff who have been directly involved in the discovery of a completed suicide in custody should become routine practice.

Samaritans

4.14 Two members of the Irish Samaritans attended a meeting of the Group and outlined the services provided by them to the prison service i.e.

(a) They make weekly visits to some prisons and offenders can correspond with them uncensored.

(b) In some institutions they provide a mobile phone service with a direct link to Samaritans. This is frequently used although in some prisons the telephone set was abused and altered so that calls other than to the Samaritans could be made from it. This practice has since ceased, and

(c) They provide training for selected Prison Staff.

The Samaritans made the following recommendations:

1) They recommend that as a pilot project a Samaritan representative be invited to attend the meetings of the Suicide Awareness Committee of a selected Institution, and if successful, this be extended to all prisons where a Samaritan Team operates.

2) That Samaritan Branches who are involved in Prison Befriending Schemes be invited to provide support for prisoners, officers and staff in the immediate aftermath of a suicide.

3) That opportunities for extending the Officer Training Programme, currently provided by the Samaritans be examined.

It is the Group's view that local institutions should consider and apply these recommendations as appropriate to their own situation.

The Samaritans also spoke of the listening scheme which their English counterparts operate in UK. prisons and were supportive of such a scheme here if it was considered worthwhile. Further discussions would however be required before this could be implemented. The listening scheme is explained further in the next chapter.

Chapter 5

Presentation and Reports from Seminars attended

Listening Scheme

5.0 The Group received a report from the representative who attended a Seminar in the United Kingdom on 17/18th February 1997 concerning a Listening Scheme which operates in some of the prisons there. Two other group members attended a workshop about the UK Listening Scheme as part of a conference about deaths in custody.

The UK Listening Scheme is monitored and run by the Samaritans. Offenders are selected and trained by the Samaritans and operate as an extension of the Samaritan Services within the landings of the prison. As with the Samaritans the Listening Scheme is totally confidential. If a selected offender is found to have breached confidentiality, he/she is removed from the scheme and generally transferred to another prison. The offender selected and trained is known to other offenders as a Listener. If a fellow offender is feeling depressed or suicidal he can go to the Listener's cell or room and he/she will listen, support him/her over his/her crisis. The Listener may, if required, also share a cell with the offender in crisis while he/she is feeling low.

The Listener Scheme requires offenders of trustee status who are serving long sentences, have no substance addictions/dependencies and are available when required. It also needs a large institution with a panel of suitable offenders to operate correctly. An important factor in the success of the Scheme is the support Listeners offer each other. To this end weekly structured Group sessions facilitated by someone from the Samaritans are held for all Listeners in an institution. Thus at least 10 – 12 suitable offenders were needed to set up a Listening Scheme. The Group considered that it might be difficult to find the required numbers with the necessary experience as we would be selecting from a much smaller base number.

The scheme was opposed by prison staff in the UK at first but is now very much accepted and widely used there.

Recommendation: The Group recommends that the scheme is worth examining further with a view to developing a model suited to the Irish Context.

Conference attended

5.1 Three representatives of the Group attended a Conference in England on ''Deaths In Custody and Beyond''. They reported to the Group that the Conference's main emphasis was on deaths in Police Custody. They attended workshops about the listening scheme, suicide prevention at Cornton Vale Women's Prison, Scotland, and self harm reduction at Broadmoor in England.

As well as information regarding the listening scheme outlined above the following points were considered the most relevant from the other workshops:—

— Multi disciplinary teamwork involving stated shared objectives, regular team meetings, systematic information sharing and clear definition of roles maximises the potential of any prison to reduce instances of self-injury.

— For female offenders a key worker system has proved effective at Cornton Vale especially as a way of building relationships with repeat petty offenders who spend regular but short periods in custody.

— Staff morale was identified as being critical to the success of suicide prevention. This can be eroded by;

(a) the systems failure to monitor significant changes in the type of offenders coming into custody and their life problems,

(b) Intrusive and insensitive media coverage following a completed suicide,

(c) failure to maintain a pleasant working environment,

(d) poor communications, and

(e) poorly attended/infrequently convened team meetings.—At Broadmoor self-injury incidents were noted to increase significantly at "Anniversaries" (deaths, relationships, child birthdays, etc) and at times when particular staff were on leave. The introduction of a system which anticipates and plans for these events has significantly reduced the level of self injury among women there.

Visiting Committees

5.2 The Group wrote to the Visiting Committee in each institution and requested their views and observations on deaths in custody and other related matters. Some responses made particular reference to the urgent requirement for a review of the dispensing and control of drugs. The views of those who responded have been taken into consideration in the recommendations contained in this Report

National Task Force on Suicide

5.3 The Group acknowledged the recommendations of the Report of the National Task Force on Suicides issued by the Department of Health and Children (Report January 1998, Page 33, Paragraph 2.10).

The Task Force Recommendations with direct relevance to Prisons were as follows:

(a) that the mentally ill in prison be given appropriate treatment,

(b) that in view of the marked association between drug abuse and both self-injury and death (including suicide) in prison, particular effort and resources be devoted, in conjunction with community strategies, towards addressing the drug dependency problems of prisoners,

(c) that the medical and caring services within prison be developed to a level which would ensure equivalence with similar community services,

(d) that prison officers receive appropriate training in the recognition and response to suicidal behaviour, and

(e) that every effort be made to prevent access to illicit drugs in prisons.

Chapter 6

Review of the 57 recommendations contained in the Report of the Advisory Group on Prison Deaths published in August 1991

Overview

6.0 The Group considered that of the 57 recommendations contained in the Report of the Advisory Group on Prison Deaths that:—

—34 were fully Implemented,

—15 were partially Implemented, and

—8 were not Implemented.

Fully Implemented	1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 21, 23, 25, 26, 30, 33, 34, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 57.
Partially Implemented	3, 5, 14, 19, 20, 24, 28, 32, 47, 49, 50, 51, 52, 53, 56.
Not Implemented	15, 22, 27, 29, 31, 35, 54, 55.

Review of Status of Each Recommendation

6.1 **Recommendation No. 1**

The Department issue a Circular now to Prison Governors setting out suicide prevention policy and procedures and that up-dated versions of the circular be issued as appropriate.

This recommendation has been implemented. The Group agreed that the circular was useful and should be up-dated by the Department of Justice, Equality and Law Reform if and when changes in the system required this.

Recommendation No. 2

A Suicide Prevention Group be established in each prison.

This recommendation has been implemented. Groups have been established and

are operating for many years in each prison. Co-ordination of information from the different groups is however both desirable and necessary and an annual forum should be established to facilitate information sharing.

Recommendation No. 3
The questionnaire for use in relation to all prisoners arriving in the reception area include questions in relation to suicide risk and that the completed questionnaire be used by the doctor in his examination of each newly arrived prisoner.
This recommendation has not been fully implemented. The Group consider that difficulties have been experienced in some institutions in completing the forms. There have also been occasions when these forms did not accompany the offender's file on transfer.

Recommendation No. 4
In training courses for prison officers stress be laid on the need to note at reception stage any indications that a person may be a suicide risk and that these indications be recorded.
This recommendation has been implemented but the Group considers that the environment in which the forms are completed may not be conducive to truthful answers.

Recommendation No. 5
Training courses in suicide prevention be organised for custodial officers.
This recommendation has not been fully implemented. The Group consider that training courses for staff on the issue of suicide prevention should make staff aware of the Circular in Recommendation No. 1. All new entrants to the prison service have received training in suicide awareness since publication of the Report of 1991.

Recommendation No. 6
Rule 114 (2) be re-drafted in a more positive vein.
This recommendation has been implemented.

Recommendation No. 7
The correct attitude to suicide investigations be promoted among prison staff and management in the proposed circular and at training courses.
This recommendation has been implemented. The circular should be re-drafted so that it includes a checklist. It should also highlight the need for care to be given to front-line staff and offenders following a death in custody.

Recommendation No. 8
The practice of placing prisoners considered suicide risks in association cells should continue but that such placements be kept under review and should be of short duration.
This recommendation has been implemented.

Recommendation No. 9
The practice of placing prisoners considered a suicide risk in a special cell as a

last resort be continued but that such placements continue only while they are active suicide risks.

This recommendation continues to be implemented. The Group however expressed regret that there was no other option and considered that Recommendation No. 9 should be linked to Recommendation No. 54.

Recommendation No. 10

That the practice of placing prisoners on the Special Observations List be continued.

This recommendation has been implemented. The Group stated that it was contrary to policy for a person who was on special observations for medical reasons to remain on observations for more than 14 days without being jointly reviewed by the Governor and Psychiatrists/Psychologist/Doctor.

Recommendation No. 11

The Director of Prison Medical Services consult with Governors and Medical Officers of closed prisons with a view to criteria for the placing of prisoners on the special observations list and their being taken off the lists.

This recommendation has been implemented. A reminder from the Director of Prison Medical Services should be re-issued to Governors and Medical Officer with a request that the list be checked regularly and not later than fortnightly.

Recommendation No. 12

The sequence in which officers look into the cells of prisoners on the special observations list should be varied.

This recommendation continues to be implemented. The Group considered that although the practice is of limited use it should remain.

Recommendation No. 13

Telephone facilities be provided to enable prisoners to contact their families or friends.

This recommendation has been implemented. The Group were informed that telephone facilities are available to offenders now and that card operated telephones are to be installed shortly in most prisons/institutions.

Recommendation No. 14

An effective written system be provided in each prison in which day staff going off duty would note any information in relation to prisoners which might indicate that they would be a suicide risk and that this would be communicated to staff coming on duty at night.

The Group felt that Recommendation No. 14 has not been fully implemented but should remain and that a direction should be sent out from the Department of Justice, Equality and Law Reform stating that this recommendation should be actively implemented as it is not operating in some prisons at present.

Recommendation No. 15
A system be established through which information outside the prison which might indicate that a prisoner could be a suicide risk and which is available to staff such as Courts, Gardai or Hospital staff would be transmitted to the prison authorities.
This recommendation has not been implemented as it is outside the control of prison management. The Group recommends that the Department of Justice, Equality and Law Reform write to the Department of Health and Children and the Garda Commissioner seeking their assistance in having same implemented.

Recommendation No. 16
The circular from the Department of Justice outline in detail the procedures to be followed by prison staff in the event of a suicide in progress being discovered.
This recommendation has been implemented but staff should be reminded again of the existence of the circular.

Recommendation No. 17
A survey be carried out in each closed prison into the length of time it takes to gain access to a cell in an emergency at different times around the clock, with a view to reducing the time involved as much as is practicable.
This recommendation has been implemented and reports have been furnished to the Department of Justice, Equality and Law Reform concerning same from both open and closed prisons.

Recommendation No. 18
Resuscitation packs be provided at strategic points in all closed prisons.
This recommendation has been implemented.

Recommendation No. 19
All custodial staff receive training in resuscitation techniques.
This recommendation has not been fully implemented. The Group recommended that all custodial staff receive training as only a small number have received same so far.

Recommendation No. 20
The arrangements for GP services in all prisons be reviewed by the DPMS with a view to ensuring (a) that all newly committed prisoners are seen by a doctor on the day of their committal or the next day (providing that the prisoner had gone through the reception process and had been seen by the medical orderly (b) that those requesting to see the doctor are given more thorough consideration by the doctor.
These recommendations were not fully implemented but discussions are on-going.

Recommendation No. 21
The existing GP arrangements for female prisoners and for HIV prisoners in Mountjoy Prison be continued.
This recommendation has been implemented.

Recommendation No. 22

The psychiatric services in the prisons be reviewed by the DPMS with a view to improving where possible the existing psychiatric services for prisoners. Consideration should be giving to sharing some future psychiatric appointments between the prison service and the Forensic Services in Dundrum.

This recommendation has not been implemented but discussions are on-going.

Recommendation No. 23

Medical orderlies be on active duty in all of the closed prisons for twenty four hours a day seven days a week and that the issue of their duties be examined.

This recommendation has been implemented except for Mountjoy Women's Prison and the Training Unit as there are no medical orderlies on night duty in either centres. Recruitment of qualified nurses is now being actively considered and the building of the new women's prison should ensure its own staffing including 24 hour medical cover. The Group insist that while awaiting the completion of the *New Women's* prison's that there should be 24 hour medical orderly cover in the present Women's Prison at Mountjoy.

Recommendation No. 24

The level of training of medical orderlies be improved.

This recommendation is in the process of being implemented. Recommendation No. 24 is linked to Recommendation No. 23 and outcome of discussions of one depends on the other. (Arrangements for the recruitment of qualified nurses are now in train).

Recommendation No. 25

Increased psychological services be made available by way either of appointing additional full time psychologists to the staff of the Department or by employing them on a sessional basis.

This recommendation has been implemented. The Group were informed that the number of psychologists employed by the Department of Justice, Equality and Law Reform had doubled from 3 to 6 since publication of the Report. The Group consider that there is a need for more to be employed.

Recommendation No. 26

The services of a female psychologist should be made available to the female prisoners.

This recommendation has been implemented.

Recommendation No. 27

Additional Probation & Welfare Officers be employed in the prisons.

This recommendation was not implemented. The Group recommended additional welfare officers be appointed to the prisons and a structured roster implemented to facilitate an officer being available for call-in on 24 hour basis in cases of emergency.

Recommendation No. 28

The DPMS evaluate the present services available for drug and alcohol abusers with a view to their improvement and their integration with one another.

This recommendation was not fully implemented. Some counselling is taking place but is insufficient to meet demand. The Group recommended that selected prison officers be provided with appropriate training to complement and support existing counselling services to offenders.

Recommendation No. 29

Work, educational, and recreational facilities be made available for all prisoners to occupy their out-of-cell time.

This recommendation was not implemented. In the Group's opinion the position is worse now than when the recommendation was made particularly in the light of the increase in the prison population. The availability of more accommodation may ease the situation.

Recommendation No. 30

The Samaritans be facilitated in working with prisoners and that their involvement with prisons be extended from the present two to all prisons.

This recommendation has been implemented.

Recommendation No. 31

The number of offenders in any prison be limited to the number that would ensure one prisoner per single cell but allowing for doubling up where that is done for acceptable reasons.

This recommendation has not been implemented. The Group agreed that the problem was worse now than in 1991 when the recommendation was made. They considered that the recommendation was valid and should remain.

Recommendation No. 32

The practice of slopping out be eliminated and that access to toilet and wash-up facilities be made available to all prisoners on a 24 hour basis as soon as possible.

This recommendation is not fully implemented. The Group agreed that progress had been made in Arbour Hill Prison, St. Patrick's Institution, Mountjoy Women's Prison, Fort Mitchel, Mountjoy Separation Unit and the New Medical Unit. The Group recommended that all new cellular buildings should have internal sanitation and that every effort should be made to have in-cell sanitation in all prisons by year 2000. In the meantime they recommended that 24hr cover should apply to those prisons which do not have such a facility.

Recommendation No. 33

The Sentence Review Group continue to review the sentence of long term prisoners and that the outcome of reviews be notified to prisoners as soon as possible.

This recommendation has been implemented. The Group recommended that the

Sentence Review Group should review offenders earlier in their sentence rather than at the 7 years stage.

Recommendation No. 34
Review meetings be held on a regular basis and that the cases of all prisoners be considered at them.
This recommendation has been implemented except for those offenders convicted of sexual offences.

Recommendation No. 35
Liaison meetings be held as often as is necessary having regard to the number of prisoners whose cases are suitable for consideration at those meetings.
This recommendation has not been implemented. The Department of Justice, Equality and Law Reform's 5 year plan if implemented would help.

Recommendation No. 36
Prisoners continue to be granted temporary release for family occasions, where such is justifiable having regard to the safety of the public, and that decisions on such applications be conveyed to prisoners at the earliest possible date.
This recommendation has been implemented.

Recommendation No. 37
A Study Group of Prison Management Staff be set up to examine the arrangements for supervision of prisoners during lock-up-times.
This recommendation has been implemented and a report on same has been furnished to the Department of Justice, Equality and Law Reform.

Recommendation No. 38
Psychological counselling and any other counselling considered appropriate, be provided on a formalised bases for prisoners and staff who may be affected by a prison suicide.
This recommendation has been implemented. Psychological counselling has been put on more formal basis than in 1991 and the psychological service is reviewing its post incident care at present.

Recommendation No. 39
Governor's give thorough consideration to the procedures that are necessary to ensure that he and his staff give all possible help to the family and that he takes personal responsibility for such help being given.
This recommendation has been implemented.

Recommendation No. 40
An information booklet on what he can expect by way of services etc. in the prison should be made available to each prisoner on his arrival in prison.
This recommendation has been implemented and information booklets are available to all offenders on committal.

Recommendation No. 41

In any new prison being built, windows should be so designed as to minimise the risk of suicide.

This recommendation has been implemented as far as is possible. All new prisons have lower risk windows installed except the Health Care Unit in Mountjoy which does not comply with this recommendation.

Recommendation No. 42

Specially designed windows that would reduce the risk of suicide be provided as far as practicable as replacements for existing windows in all prisons, should it emerge that a ''ligature free'' window can be designed.

This recommendation has been implemented as far as is possible.

Recommendation No. 43

A small number of cells, to be used as special cells, be provided in closed prisons with no access to the window bars.

This recommendation has been implemented.

Recommendation No. 44

The possibility of obtaining furniture which, if broken up by the prisoner, could not be used by him to injure himself or others should be investigated.

This recommendation has been implemented insofar as a Senior Architect from Board of Works attended a meeting with the Group and outlined the type of built-in furniture being considered for new prisons. This furniture will be as domestic in style as possible.

Recommendation No. 45

The installation of a cell-call system in Mountjoy Prison be completed as soon as possible.

This recommendation has been implemented.

Recommendation No. 46

Changes be made to any cell which do not enable a prison officer to see all parts of the cell when he looks in through the viewing aperture.

This recommendation has been implemented.

Recommendation No. 47

Enquiries be made concerning an alternative system of lighting that would not have the disadvantages of the present system: if such a system is available that it be installed in prison cells if feasible.

This recommendation is not fully implemented. The Group were informed by a Senior Architect from the Board of Works that this matter will be referred to the Services Engineer Board of Works and that special cells in new buildings will have low light left on at all times thus eliminating the problem in those special cells.

Recommendation No. 48

The Chief Trades Officer of each prison carry out a survey of cell accommodation to identify any structural features that could assist a prisoner in committing suicide and that the necessary adaptations be made.

This recommendation has been implemented and the Group agreed that such checks should be carried out regularly.

Recommendation No. 49

A programme of refurbishing and brightening of all prisons buildings and exercise yards be embarked upon.

This recommendation has not been fully implemented. Some of the refurbishing has been carried out. The issue of suitable paint and colouring was discussed. The Group recommends that consideration of the need for colour variety and the impact of colour on people who live and work in prison environments be taken when ordering paint supplies.

Recommendation No. 50

A form as at Appendix 5 be used by the Department and the Prison Service and copies completed in respect of each suicide attempt or incident of self-mutilation by a prisoner — one copy should be kept in the prison and another forwarded to the Department of Justice.

This recommendation has not been fully implemented. It is completed in some prisons very thoroughly while in others it is done less frequently. The Group recommended that this form be reviewed and re-designed by the Director of Prison Medical Services to make it more relevant to present day management of offenders.

Recommendation No. 51

Prisons and the Department of Justice analyse the data collected in relation to attempted suicides and instances of self-mutilation with a view to discerning trends and salient factors and taking any action that may seem appropriate from such analysis with a view to preventing suicide and instances of self-mutilation.

This recommendation has not been fully implemented. The Group felt that it was not being done nationwide and recommended that local suicide awareness group be made aware of such incidents and that a record of self mutilations be held in each prison by the medical orderlies/nurse who deals with the incident. The Department of Justice, Equality & Law Reform should also receive a copy.

Recommendation No. 52

A Committal Assessment Centre be established in Dublin in which all newly committed offenders would be accommodated and assessed during the initial days in prison, and that arrangements be made in Cork, Limerick and Portlaoise Prisons to ensure that committals to those prisons would receive a service on a par with that in the centre in Dublin in the initial days of their imprisonment.

This recommendation has not been fully implemented. The Group considered that prior to the opening of the new Assessment Centre at Cloverhill there should be planning between the various groups involved in its operations in order to establish

its regimes and in particular to put in place a suicide prevention strategy *before* the prison opens. This recommendation applies equally to other proposed new prisons and places of detention.

Recommendation No. 53
In the long term a new female secure prison be provided and also an open centre for females.
This recommendation has not been fully implemented. The Group agreed that the women's secure prison is being built and that an open centre for female offenders is urgently required.

Recommendation No. 54
The provision of a ward for non-violent psychiatrically disturbed prisoners either in a prison or a hospital setting be discussed between the Departments of Justice and Health and the Central Mental Hospital.
This recommendation has not been implemented. The Group were informed that discussions are on going at present between the three mentioned agencies. This provision is essential and it is imperative that agreement be reached soon.

Recommendation No. 55
A unit to cater for psychiatrically disturbed violent prisoners be established.
This recommendation has not been implemented. No unit has yet been established. The Group agreed to change the wording ''to establish a special unit to cater for people with serious behavioural/or psychiatric difficulties''.

Recommendation No. 56
The arrangements for dispensing controlled drugs in the prisons be reviewed by the DPMS and that the employment of Pharmacists be considered.
This recommendation was implemented and one Pharmacist was appointed since the publication of the Report. However, since August 1997, the Pharmacist resigned her position and has not been replaced to date. The need for additional pharmacists and qualified trained staff in order to meet legal requirements is also being looked at on an on-going basis by DPMS. A number of pharmacists should be employed to dispense controlled drugs in the prisons and these appointments be made without delay.

Recommendation No. 57

(a) that greater use by made of surveillance cameras in visiting areas in all prisons, and

(b) where a prisoner has been caught smuggling drugs into any prison he be allowed only restricted visits for a specified period thereafter.

This recommendation has been implemented.

Chapter 7

Conclusions

Summary of the Group's Review

7.0 The findings of the Group's review of the Report of the Advisory Group on Prison Deaths are summarised below:—

1. Co-ordination of information from the Suicide Awareness Groups in each institution is necessary and an annual forum should be established to facilitate this. (ref Recommendation No. 2)

2. All prison staff should be made aware of the Suicide Prevention Circular issued by the Department of Justice, Equality and Law Reform when receiving training in suicide prevention. (ref Recommendation No. 5)

3. The circular on suicide investigation should be re-drafted so that it includes a checklist and it should highlight the need for care to be given to front-line staff and offenders following a death in custody. (ref Recommendation No. 7)

4. A reminder from the Director of Medical Services should issue with a request that the list of those offenders on special observations for medical reasons be checked regularly and not later than fortnightly. (ref Recommendation No. 11)

5. A letter should issue from the Department of Justice, Equality and Law Reform to all Governors about the necessity of having an effective written system in place so that information on those offenders considered to be at risk is shared by all staff. This is not operating in each institution at present. (ref Recommendation No. 14)

6. The Department of Justice, Equality and Law Reform should write to the Department of Health and Children and the Garda Commissioner seeking their assistance in having information relevant to suicide risk forwarded to the prison authorities. (ref Recommendation No. 15 and page 17)

7. All prison staff should be reminded of the existence of the circular on procedures to follow in the event of finding a suicide in progress. (ref Recommendation No. 16)

8. All prison staff should receive training in resuscitation techniques. (ref Recommendation No. 19)

9. There should be 24 hour medical orderly/nursing cover in Mountjoy Women's Prison. (ref Recommendation No. 23)

10. More psychologists should be employed by the Department of Justice, Equality and Law Reform. (ref Recommendation No. 25)

11. Additional Probation and Welfare Officers should be appointed to the prisons and a structured roster implemented to facilitate one officer being available for call-in on a 24 hour basis in cases of emergency. (ref Recommendation No. 27)

12. Selected prison officers should be provided with appropriate training to complement and support existing counselling services to offenders. (ref Recommendation No. 28)

13. All new cellular prison buildings should have in-cell sanitation and every effort should be made to progress this objective. 24 hour cover should apply to those prisons who don't have such facility. (ref Recommendation No. 32)

14. The Sentence Review Group should consider the cases of offenders at an earlier stage in their sentence than the present 7 years. (ref Recommendation No. 33)

15. Consideration of the need for colour variety and the impact of colour on people who live and work in prison environments be taken when ordering paint supplies. (ref Recommendation No. 49)

16. The existing form for reporting incidents of self mutilation should be reviewed by the Director of Prison Medical Services to make it more relevant to the present day management of offenders. (ref Recommendation No. 50)

17. The local Suicide Awareness Group in each institution should be made aware of such incidents as referred to in the last recommendation and a record of all self mutilations be held in each institution by the medical orderlies/nurses who deal with the incidents. Copy should be forwarded to Department of Justice, Equality and Law Reform. (ref Recommendation No. 51)

18. An open centre for female offenders is urgently required. (ref Recommendation No. 53)

19. The wording in Recommendation No. 55 in the original Report of August 1991 ''that a unit to cater for psychiatrically disturbed violent prisoners be established'' should be amended to now read ''that a special unit to cater for people with serious behavioural/or psychiatric difficulties be established''. (ref Recommendation No. 55)

20. The appointment of a number of Pharmacists to dispense controlled drugs in the prisons should be made as a matter of urgency. (ref Recommendation No. 56)

New Recommendations

7.1 The Group made the following new recommendations:—

1. All incidents of self injury must be reported on the relevant form to the Department of Justice, Equality and Law Reform. (P. 17 ref)

2. An examination of medical procedures/services/requirements in each institution should be undertaken in the context of the implementation of the new contract for prison doctors. (P. 12 ref)

3. A high support facility be provided in each closed institution for offenders exhibiting suicidal tendencies. (P. 16 ref)

4. The dispensing and control of drugs should be urgently reviewed. The employment of Pharmacists and qualified nurses should facilitate this. (P. 20 ref)

5. The option of shared occupancy cell should be available to both offenders and management from a suicide viewpoint. In such circumstances each offender should have their own single bed as bunk beds no matter how good their design provide an increase risk factor for self injury. (P. 13 ref)

6. A portable T.V. should be installed in some cells in selected prisons as part of a pilot project. (P. 13 ref)

7. Where a bunk bed is used the protective bar on the side of top bunk beds should be ''closed-in'' with metal or a steel sheet to ensure that — in as far as is possible — a ligature cannot be tied to it. The same should apply to the steps provided at the end of the bed. (P. 13 ref)

8. (a) A listening scheme – based on that run by the Samaritans in the United Kingdom – should be set up here on a pilot basis and reviewed after 18 months – 2 years in operation and modelled to suit an Irish Prison Context. (P. 19 ref)

   (b) Local institutions should consider the Samaritans recommendations and apply them as appropriate to their own situation. (P. 18 ref)

9. Computerisation of medical records should be introduced as soon as possible. (P.11 ref)

10. On committal medical orderlies/nurses should complete specially designed forms at all times. (P.11 ref)

11. Offenders deemed by the medical personnel to require psychiatric hospitalisation should be transferred to such hospitals immediately. (P.16 ref)

12. Those on special observation list for security reasons should be reviewed every 2-3 months. Those on special care list for medical or psychiatric reasons should be reviewed daily. A list known as ‘‘special care’’ should be introduced placing more focus on offenders experiencing crisis situations. Their names should be removed from the list when the crisis is over. (P.15 ref)

Appendix A

All Deaths 1990 – 1997	Deaths From Natural Causes 1990 – 1997
1990 - 4 1991 - 5 1992 - 5 1993 - 3 1994 - 5 1995 - 3 1996 - 9 1997 - 7	1990 - 0 1991 - 0 1992 - 1 1993 - 0 1994 - 0 1995 - 0 1996 - 3 1997 - 3

Date of Death	Age & Sex of Deceased	Committal & Release Date	Place of Custody	Cause of Death
06/03/90	19 yrs. (F)	13/05/89 27/05/90	Mountjoy	Hanging
04/04/90	26yrs. (M)	13/11/86 serving life P.S.	Mountjoy	Hanging
26/11/90	16 yrs. (M)	22/09/90 21/10/91	St. Patrick's Institution	Hanging
26/12/90	38 yrs. (M)	05/03/90 06/09/91	Mountjoy	Choked on own vomit
26/09/91	23 yrs. (M)	22/10/87 30/01/93	Mountjoy	Overdose
20/07/91	31 yrs. (M)	13/06/86 25/06/92	Limerick	Hanging
25/07/91	34 yrs. (M)	24/07/91 Remand	Mountjoy	Hanging
21/08/91	30 yrs. (M)	16/08/91 Remand	Mountjoy	Hanging
12/12/91	31 yrs. (M)	18/11/91 03/07/92	Mountjoy	Hanging
19/02/92	45 yrs. (M)	14/03/91 13/12/94	Portlaoise	Heart Attack
18/03/92	19 yrs. (M)	30/12/91 Remand	St. Patrick's Institution	Hanging

Date of Death	Age & Sex of Deceased	Committal & Release Date	Place of Custody	Cause of Death
22/03/92	28 yrs. (M)	11/01/90 11/10/93	Training Unit	Cut his own throat
17/06/92	21 yrs. (M)	29/01/92 17/05/94 also awaiting trial	Wheatfield	Hanging
12/08/92	34 yrs. (M)	04/06/92 30/09/93	Mountjoy	Overdose
04/03/93	18 yrs. (M)	07/10/92 05/10/93	Wheatfield	Hanging
28/03/93	28 yrs. (M)	18/11/92 for sentence	Mountjoy	Overdose
08/11/93	30 yrs./ (M)	09/04/92 28/01/98	Mountjoy	Overdose
28/04/94	26 yrs. (M)	01/05/89 Life P.S.	Arbour Hill	Hanging
13/04/94	41 yrs. (M)	27/10/93 03/07/97	Mountjoy	Overdose
16/07/94	35 yrs. (M)	19/05/93 31/08/94	Mountjoy	Choked on vomit
03/12/94	17 yrs. (M)	18/10/94 25/12/94	Fort Mitchel	Hanging
15/12/94	33 yrs. (M)	14/05/94 Remand	Mountjoy	Hanging
29/01/95	24 yrs. (M)	16/06/94 15/02/96	Mountjoy	Overdose
01/07/95	26 yrs. (M)	30/05/95 Remand	Mountjoy	Hanging
22/07/95	31 yrs. (M)	06/02/94 15/09/97	Mountjoy	Overdose
01/03/96	27 yrs. (M)	24/02/96 Remand	Mountjoy	Hanging
28/03/96	20 yrs. (M)	17/01/96 17/10/96	St. Patrick's Institution	Hanging
29/03/96	28 yrs. (M)	22/02/96 23/05/98	Mountjoy	Overdose
23/05/96	21 yrs. (F)	22/05/96 Remand	Mountjoy	Hanging

Date of Death	Age & Sex of Deceased	Committal & Release Date	Place of Custody	Cause of Death
23/06/96	20 yrs. (M)	22/06/96 Remand	St. Patrick's Institution	Hanging
10/06/96	31 yrs. (M)	23/06/94 03/10/96	Mountjoy	Natural Causes
26/07/96	35 yrs. (M)	12/04/94 23/07/96	Wheatfield	Natural Causes
25/08/96	30 yrs. (M)	19/01/96 03/05/97	Portlaoise	Hanging
10/10/96	78 yrs. (M)	23/05/96 22/05/2001	Arbour Hill	Natural Causes
17/07/97	20 yrs. (M)	09/01/97 14/08/98	St. Patrick's Institution	Hanging
21/02/97	60 yrs. (M)	28/01/97 Remand	Arbour Hill	Natural Causes
21/05/97	35 yrs. (M)	10/10/89 30/05/2002	Mountjoy	Overdose
27/07/97	25 yrs. (M)	03/09/96 22/01/2004	Wheatfield	Hanging
22/08/97	70 yrs. (M)	21/03/97 21/03/2006	Curragh	Natural Causes
18/10/97	22 yrs. (M)	24/07/96 12/08/99	Mountjoy	Natural Causes
21/11/97	25 yrs. (M)	20/03/96 14/05/2003	Limerick	Hanging

Appendix B

In the years 1990 — 1996 there were 366 prison suicides in England and Wales (9 of whom were female)

Suicides in Prisons in England and Wales in 1996
(Source C.S.O.)
(Prison Population of approx. 55,000 — 60,000)

Total 64

22% were aged 21 and under
36 were on remand
2 were females

Scotland's Prison Service
(Prison Population approx. 5,500)

In Scotland's prison service there were 17* suicides in prisons from 01/04/96 — 31/03/97.

* (subject to Fatal accident inquiry)

Of 17 suicides: 12 were on remand
3 were females
2 sentenced

Statistics for self-inflicted deaths over the last five years in the Scottish Prisons are as follows:

1992/93	7
1993/94	7
1994/95	16
1995/96	8
1996/97	17 *Subject to Fatal accident inquiry

Appendix C

In the Irish "General" Community for years 1990-1995 deaths recorded were as follows: (Source Central Statistics Office)		
Year	**Suicides**	**Undetermined**
1990	334	48
1991	346	38
1992	363	22
1993	361	26
1994	353	12
1995	383	9

Age profile of suicides in General Community for year 1995: (Source C.S.O.)							
Male Total 305							
0-14 yrs.	15-24	25-34	35-44	45-54	55-64	65-74	75 plus
3	72	70	64	38	23	27	8
Female Total 78							
0-14 yrs.	15-24	25-34	35-44	45-54	55-64	65-74	75 plus
1	10	16	19	14	7	9	2

Wt. P63510. 1,000. 4/99. Cahill. (M33940). G.Spl.