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

Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary

Tel: + 353 67 42210
Fax: + 353 67 42219
E-mail: info@inspectorofprisons.gov.ie
Web: www.inspectorofprisons.gov.ie

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

Presented to the Minister for Justice and Equality pursuant to Part 5 of the Prisons Act 2007

Judge Michael Reilly
Inspector of Prisons

11th June 2014

Contents

Chapter 1

Introduction

1.1 This omnibus report covers my investigations into the death of prisoners in custody or while on temporary release for the period 1st January 2012 to 11th June 2014. In this period 34 deaths occurred. Of the 34 deaths 15 occurred in prison or when prisoners were admitted to hospital following a serious life threatening incident in prison and 19 while prisoners were on temporary release. I have completed my investigations into 27 of the deaths and submitted my reports to the Minister for Justice and Equality (hereinafter referred to as the "Minister"). 23 reports have been published by the Minister. I am currently investigating the remaining 7 deaths of which 5 occurred in custody and 2 while on temporary release.

1.2 In Chapter 2, I outline the reasons why an independent investigation of deaths of prisoners is important. I outline why I am involved in the investigation process and finally my *modus operandi*. To fully understand Chapter 2 same must be read in conjunction with Chapter 7 of my Report titled – ***An Assessment of the Irish Prison System*** dated 20th May 2013 (hereinafter referred to as my "Assessment Report").

1.3 In Chapter 3, I refer to relevant findings outlined in my reports to date. I refer in general terms to my recommendations.

Of particular concern are my findings that, <u>in a number of investigations</u>, (a) a line management structure either did not exist or was deficient which would have adequately supervised the proper implementation of relevant Standard Operating Procedures, Governors' or Chiefs' Orders, (b) relevant Standard Operating Procedures, Governors' or Chiefs' Orders were not followed and (c) proper records, including medical records were not adequately maintained.

The management of all prisons should study carefully all reports and pay particular attention to findings and recommendations because, while

these relate to individual prisons, they have general application across the whole prison system.

1.4 Data regarding deaths of prisoners either in custody or on temporary release are minimal. I have decided to gather data for all deaths occurring since 1st January 2012. In order that such data is of relevance and can be used for comparative purposes with data from other jurisdictions I sought assistance from the University of Limerick. In Chapter 4, I give brief details of the research to be undertaken by the University, the material which will form part of the research and other matters. I would like to express my appreciation to Professor Shane Kilcommins and Dr. Eimear Spain of the Law School at the University for their generous offer of assistance. In my next omnibus report on deaths of prisoners I will be in a position to set out the results of the research and detail the data being gathered.

1.5 In paragraph 7.30 of my Assessment Report I stated:-

> "*As the procedure for investigating deaths of persons in prison custody or on temporary release is new in this Country I will revisit my procedures in the light of experience. I would also welcome any constructive suggestions in this regard. If necessary, I will revisit my procedures and in that eventuality will publish such revised procedures.*"

1.6 **I wish to point out that my investigations of and reports on deaths of persons either in prison custody or while on temporary release are not and do not purport to answer all questions surrounding a death. My investigations are part of a three pronged process – the other elements being the investigation by An Garda Síochána and the investigation and Inquest conducted by the Coroner.**

1.7 **I am satisfied that the combination of a Garda inquiry and the Coroner's investigation and Inquest coupled with my investigation and subsequent report means that this Country 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.

Chapter 2

Independent Investigations

Reason for Investigations

2.1 In Chapter 7 of my Assessment Report I pointed out that the then procedures, taken together, for the investigation of deaths in prison custody did not meet the criteria of an independent investigation which would satisfy the elements of Article 2 of the European Convention on Human Rights.

2.2 In Chapter 3 of my Report titled- ***Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody*** dated 21st December 2010 (hereinafter referred to as the "Deaths in Prison Custody Report") I outlined in detail the elements necessary to satisfy Article 2 of the European Convention on Human Rights. I referred to relevant decisions of the European Court of Human Rights in order to put in context the ingredients necessary for the proper investigation of all deaths in prison custody.

2.3 I stated in paragraph 4.5 of the Deaths in Prison Custody Report that:-

> "*The European Court of Human Right's current position is that the procedural obligation may be satisfied through a combination of processes. The requirements do not need to be satisfied through a single process. I am satisfied that provided the investigation processes taken as a whole fulfil the* ***Jordan*** *requirements the procedural aspect of Article 2 should not be violated."*

2.4 I have stated at paragraph 1.6 that one of the elements of an investigation is the investigation by An Garda Síochána. An Garda Síochána fulfils two roles, namely, a criminal investigation if same is warranted and the collection of evidence on behalf of the Coroner in order that he/she can fulfil his/her obligations as set out hereunder at paragraph 2.5. However, where there is no criminal element the gathering of evidence for the Coroner is limited.

2.5 The Coroner's Inquest will establish the identity of the deceased, where the death took place, when the death took place and how the death occurred (if possible). Therefore, if for reasons of sensitivity, I do not include some of these details in my reports this does not render my reports incomplete as my reports are one prong of a three pronged process.

2.6 I pointed out in my Assessment Report that the investigations by An Garda Síochána and the Coroner were and are robust, independent and meet best international practice.

2.7 In my Assessment and Deaths in Prison Custody Reports I stated that in order to satisfy all the elements of Article 2 of the European Convention on Human Rights it would be necessary that an investigation broadly based around the activities of the prison, the care taken of the prisoners who had died and other relevant matters should be carried out.

In this context I stated at paragraph 7.6 of my Assessment Report that the then internal investigation by the Governor was - **"*neither robust, independent nor transparent".***

Minister's Announcement

2.8 On 19th April 2012 the Minster announced the setting up of an independent further process for the investigation of all deaths of prisoners either in prison custody or on temporary release which would be in addition to the existing investigations by An Garda Síochána and Coroners in the following terms:-

> "*The Minster for Justice, Equality and Defence Mr. Alan Shatter T.D. announced that, following consultations with Judge Reilly, Inspector of Prisons, it had been decided that the death of any prisoner in the custody of the Irish Prison Service shall be the subject of an independent investigation by the Inspector of Prisons. This is in addition and without prejudice to existing mechanisms in place for the investigation of deaths including Garda investigations and inquests by Coroners.*

All deaths of prisoners, including those arising from natural causes or suicide, will be the subject of an independent investigation by the Inspector. This will apply to prisoners who are in the custody of the Irish Prison Service, whether or not the death actually occurs within the prison walls, and to prisoners who have recently been let out on temporary release. In the context of his investigations, the Inspector will consult, as appropriate, with members of the family of the deceased. Under Part 5 of the Prisons Act 2007, the Inspector of Prisons is independent in the performance of his functions and there is an obligation to publish his reports."

The Minister, in a press statement, expressed confidence that the Irish Prison Service and other relevant public sector agencies would cooperate with and indeed welcome my involvement in this area.

2.9 At this juncture I feel it important that I should point to Section 31(7) of the Prisons Act 2007 which states as follows:-

"Governors and other prison officers, other persons employed in prisons and prisoners shall, as far as reasonably practicable, comply with any request for information that the Inspector may make in the performance of his or her functions."

The Investigation Process

2.10 I have investigated or am in the process of investigating all deaths as defined in the Minister's statement referred to in paragraph 2.8 which have occurred since 1st January 2012 in so far as these relate to the activities of the prison, the care taken of the prisoners who have died and other relevant matters.

2.11 In layman's terms my investigations referred to in paragraph 2.10 must ascertain whether or not the prison environment, the prison conditions, the prison regimes or the actions or non actions of prison management, staff or

others working within the prison system contributed in any way to the death of the prisoner.

2.12 In addition to being notified of a death of a prisoner in the custody of the Irish Prison Service I am provided with documentation by the Governor, in accordance with protocols agreed between my office and the Irish Prison Service, which sets out, *inter alia*, relevant details of the deceased, reports generated by Governors, senior staff etc, confirmation that all CCTV has been saved, names of officers and others who had contact with the deceased in the previous 72 hours and other relevant information that assists me in commencing my investigation. In the case of deaths occurring while prisoners are on temporary release I am provided with all assessments carried out prior to the release of the particular prisoner and other relevant information. In all cases whether the deaths occur in prison or otherwise in addition to examining all documentation provided I carry out my own investigations and in this connection examine the relevant area or areas, scrutinise the CCTV and interview relevant persons. 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.** This has contributed to delays in my investigations and significantly increased my workload. In this connection I would like once again to reiterate the provisions of Section 31(7) of the Prisons Act 2007 as referred to in paragraph 2.9 of this Report.

2.13 An important part of all investigations is that the family of a deceased prisoner should be consulted and issues that they wish to have addressed should be so addressed. In all of my investigations I endeavour to contact the family in order that I might address any concerns that they may have. In certain cases the next of kin do not respond and I fully understand their position in this regard.

2.14 Each investigation is different but my *modus operandi* in each is explained in my individual reports.

2.15 Subsequent to my presentation of my reports to the Minister but before their publication I again meet with the members of the family of the deceased prisoner for the purpose of explaining to them, in advance of the publication of the relevant report, in general terms my findings and my recommendations (if any). I also inform them in layman's terms what is detailed in the particular report.

Content of and Publication of Reports

2.16 Depending on the circumstances of the death and whether same has occurred in prison custody or on temporary release my reports will differ in content. However, the majority of the following general points are covered in all reports:-

- General background information on the deceased.
- Relevant sequence of events if the death occurred in prison detailing, where necessary and relevant, contact by the prisoner with the medical and therapeutic services in the prison.
- An examination of relevant CCTV footage.
- Circumstances relating to the finding of the deceased prisoner.
- Details of relevant Prison Rules, Standard Operating Procedures, Governors' or Chiefs' Orders.
- The circumstances relating to the release of a prisoner on temporary release to include specifically any assessments carried out, procedures put in place as a result of such assessments and the circumstances of the release of the prisoner.
- My contact with the family.
- Addressing the concerns of the family.
- My findings.
- My recommendations.

2.17 In my Reports I identify each deceased prisoner by letter only in order to respect the privacy wishes of the families as in **all** my contacts with family

members of deceased prisoners their wishes have **always been** that they would like my reports to be anonymous. I also remove names of any persons who are mentioned in my reports. This practice of anonymising reports has found favour in other jurisdictions and does not take from the veracity and substance of my reports.

2.18 When completed I submit my reports to the Minister. The Minister, having considered such reports, publishes same. The timeframe for such publication is approximately 6 weeks from the date of my presentation of my reports to the Minister.

2.19 In my reports I make findings of fact.

Obligations on State Authorities

2.20 **It is for the Prison Authorities and other State Authorities, if relevant, having examined the evidence adduced in any criminal proceedings or Coroners' proceedings and the contents of my reports to initiate any procedures that they might deem appropriate.**

2.21 In support of my observations referred to in paragraph 2.20, I wish to draw attention to the following:-

- The case of **Jordan -v- United Kingdom** (Judgment of 4th May 2001) where the European Court of Human Rights, when examining the relevant elements of an application under Article 2 of the European Convention on Human Rights, observed at paragraph 105 that:-

  "*……the essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State Agencies or bodies, to ensure their accountability for deaths occurring under their responsibility".*

- Article 13 of the European Convention on Human Rights was considered by the European Court of Human Rights in the case of **Erji -v- Turkey** (Judgment of 28th July 1998) where the Court explained that the requirements of Article 13 are stricter than those of Article 2 stating at paragraph 98 that *"the effectiveness"* of the remedy must be assessed by reference to the serious nature of an allegation under Article 2 of the Convention, and that:-

  "the notion of an effective remedy for the purposes of Article 13 entails, in addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible and including effective access for the relatives to the investigatory procedure. Seen in these terms the requirements of Article 13 are broader than a contracting State's procedural obligation under Article 2 to conduct an effective investigation."

- The fact that an individual can pursue a civil claim in relation to a death (that engages Articles 2 or 3 of the Convention) does not discharge the State of its Article 2 procedural obligation to investigate the particular death. In **Jordan -v- United Kingdom** the European Court of Human Rights explained at paragraph 141 that:-

  "Civil proceedings would provide a judicial fact-finding forum, with the attendant safeguards and the ability to reach findings of unlawfulness, with the possibility of damages. It is however a procedure undertaken on the initiative of the applicant, not the authorities and it does not involve the identification or punishment of any alleged perpetrator. As such, it cannot be taken into account in the assessment of the State's compliance with its procedural obligations under Article 2 of the Convention."

2.22 **The Garda investigation, the Coroner's investigation and my investigation into any relevant death are initiatives on behalf of our State Authorities. I am satisfied that the combination of all three <u>followed, where appropriate, by action as referred to in paragraph 2.20</u> means that this Country can be in compliance with its national and international obligations and meet 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.**

General comments

2.23 I make reference in a number of my reports of my investigations into the deaths of prisoners while on temporary release to the obligations owed to prisoners by the management of prisons to ensure, *inter alia*, that proper assessments are carried out prior to release, that vulnerable prisoners are linked to appropriate services in the community and that the prisoners being released have accommodation.

2.24 **My comments in paragraph 2.23 <u>must not</u> be construed as suggesting that prisons are the only agency responsible for the wellbeing of a prisoner released on temporary release. In my view prisons can only go so far. Other statutory and non statutory agencies must play their part and if found wanting accept their responsibilities.**

Chapter 3

Summary of Findings

3.1 In this Chapter I give a flavour of findings that I have made to date. These findings refer to failures to observe procedures, inaction or a lack of understanding of basic principles. **The more serious disclose disturbing facts**.

3.2 In order to have a complete picture of all findings which include factual findings in all cases that are not controversial one must refer to my individual reports which are published on my website – www.inspectorofprisons.gov.ie

3.3 The following are my main adverse findings:-

- A line management structure either did not exist or was deficient which would have adequately supervised the proper implementation of relevant Standard Operating Procedures, Governors' and Chiefs' Orders particularly relating to the checking of prisoners during periods of lock down.
- Prisoners on Special Observation not checked in accordance with Standard Operating Procedures.
- Appropriate risk assessment not carried out prior to prisoners being released on temporary release.
- Incomplete records including medical records.
- Not possible to determine from the medical records provided whether the psychiatry services were provided to or availed of by prisoners.
- A prisoner, whose vulnerability in prison and in the community was know to all services and who should have been supervised in the community post his release, was released on temporary release without formal arrangements being in place for such supervision.
- Governors' and Chiefs' Orders not being complied with.
- CCTV coverage not adequate.
- Availability of drugs, mobile telephones and other contraband in prisons.

- Deceased was homeless and vulnerable. No assessment carried out prior to release. Not linked with any agency on his release. Released to an address that was not available to him. Prisoner profile details not correct and/or current.

3.4 **For balance it is necessary that I point out that I have made many positive findings in my Reports.** In the majority of reports no significant concerns are disclosed. These findings must be taken as an acknowledgment of the positive attitude being adopted in relevant prisons.

3.5 In appropriate cases I have made recommendations in my reports. Such recommendations are based on my findings. I maintain a log of all recommendations that I have made. While these recommendations are made in specific cases and are referable to particular prisons many of them have general relevance throughout the prison estate. **Therefore, I would consider it a serious matter if published recommendations, having been made in one case, were not universally followed in all prisons. The responsibility for ensuring that recommendations are followed rests with the Governor and senior staff of each individual prison.**

General comment

3.6 My comments in paragraph 3.5 should not be interpreted as suggesting that Governors and senior staff of prisons only assume responsibility for deficiencies in their prisons when such deficiencies are pointed out by me in my reports. **They have responsibility for ensuring that their prisons are run correctly, that orders are carried out, that prison rules are adhered to and that the lawful and human rights of prisoners and staff are vindicated.**

Chapter 4

Research

4.1 I have stated in paragraph 1.4 that data relating to deaths of prisoners either in custody or on temporary release are minimal. I intend producing detailed data for all deaths occurring since 1st January 2012 and then building on such material. Research is being undertaken by the University of Limerick in this regard. I would again like to thank Professor Shane Kilcommins and Dr. Eimear Spain for their generous assistance.

4.2 An important aspect of this study will be the compilation of a compressive data set on deaths of prisoners while in the custody of the Irish Prison Service. This will include deaths while prisoners are under the care of the prison service but not physically detained in prison, for example, when receiving medical care off site or while on temporary release. In line with best international practice, this data set will include basic demographic details, prisoner characteristics, the period of detention and the cause of death.

4.3 The School of Law at the University of Limerick has also been commissioned to conduct an extensive literature review on deaths in custody and to design and populate a database based on international best practice. The benefits of gathering data include allowing Professor Kilcommins's and Dr. Spain's team to:-

- test mortality rates relative to the general population and to prison populations in other jurisdictions
- identify risk factors within the Irish prison system and compare to international risk factors
- point to appropriate remedial steps, if any, which may be taken to reduce the number of deaths of prisoners in the custody of the Irish Prison Service.