OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Ms O 2019

AGED 27

WHILE ON REVIEWABLE TEMPORARY RELEASE
FROM MOUNTJOY WOMEN'S PRISON (DÓCHAS CENTRE)

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GLOSSARY

Act	Prisons Act 2007
DG	Director-General
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
Office	Office of Inspector of Prisons
UAL	Unlawfully at large
RTR	Reviewable Temporary Release

PREFACE

The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Minister has requested the Inspector of Prisons to investigate deaths in prison custody. In 2018, clarification was received that the Inspector is also requested to investigate the death of any person which occurs within one month of their temporary release from prison custody. The Office is completely independent of the Irish Prison Service (IPS). The Inspector of Prisons and staff of the OIP are civil servants, however, they are independent of the Department of Justice in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations are disseminated in the interest of transparency, and in order to promote best practice in the care of prisoners.

Objectives

The objectives for Inspector of Prisons investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;

- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in future;

- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and

- Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Act in relation to accessing healthcare/medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Next of Kin (NoK). This inevitably leads in some instances to a failure to review healthcare/medical records where NoK is unknown, cannot be located, or refuses to provide consent. It was not deemed necessary to access the healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to Ms O's Reviewable Temporary Release (RTR) on 8 July 2019 and following receipt of RTR.

A standardised checklist of information requirements from the IPS to assist an investigation into deaths in custody (while on Temporary Release) is in place. The IPS Operations Directorate provided the OIP with all relevant information requested.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

The OIP contacted Ms O's NoK, her mother, by telephone in December 2019. The role of the OIP in relation to the investigation of her daughter's death was explained. Ms O's mother did not wish to meet with the OIP and said she had no concerns she wished to raise. She confirmed she had been contacted before Ms O's release from the Dóchas Centre and she had confirmed that Ms O could reside with her.

Although this report will inform the Minister for Justice and several interested parties, it is written primarily with Ms O's family in mind. I offer my sincere condolences to them for their sad loss.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
31 MARCH 2021

FINDINGS

Ms O was aged 27 years. She was committed to Mountjoy Women's Prison (Dóchas Centre) on 8 March 2019. She had a remission date of 6 September 2019.

Ms O was approved Reviewable Temporary Release (RTR) with effect from 8 July 2019.

The necessary arrangements were made in advance for Ms O to reside with her mother who confirmed to the OIP that she had been contacted before Ms O was released and had expressed her willingness for Ms O to reside with her.

We received confirmation from the IPS that a place in a drug treatment clinic had been confirmed for Ms O in advance of her release.

Ms O met with the Welfare Officer in relation to social welfare payments on 2 July 2019.

She was released from the Dóchas Centre on RTR on 8 July 2019.

One of the conditions attaching to Ms O's RTR was to sign on weekly at the Dóchas Centre. Ms O failed to return to the prison on 15 July 2019 to sign on and was unlawfully at large (UAL) from that date.

On the 13 August 2019 the Operations Directorate were notified by the Prison Chaplain that Ms O had passed away on 12 August 2019.

The cause of Ms O's death is a matter for the Coroner.

RECOMMENDATIONS

There are no recommendations in this report. In sanctioning Ms O's temporary release the necessary arrangements were made in advance for Ms O to reside with her mother and receive addiction support.