



OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Ms S 2019

AGED 38

On 20th December 2019

WHILE ON REVIEWABLE TEMPORARY RELEASE

FROM MOUNTJOY WOMEN'S PRISON (DOCHAS CENTRE)

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<u>CONTENTS</u>	<u>PAGE</u>
GLOSSARY	03
PREFACE	04
SUMMARY	06
FINDINGS	07

GLOSSARY

Act	Prisons Act 2007
CAP	Care After Prison
CSS	Community Support Service
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 by the Department of Justice 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; 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.
- Identify areas that may be pivotal in achieving or obstructing progress of the Department of Justice 2021 to 2023 Strategy to create a 'Safe, Fair and Inclusive Ireland' (Goals 2 and 3).

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 surrounding Ms S's Reviewable Temporary Release (RTR) on 7 October 2019 and breaches of the conditions of her 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.

Although this report will inform the Minister for Justice and several interested parties, it is written primarily with Ms S's family in mind. Our Office contacted Ms S's NoK by telephone and explained the role of the OIP in relation to a death in custody investigation. The NoK did not wish to meet with the OIP. I offer my sincere condolences to the family for their sad loss.

A handwritten signature in cursive script that reads "Patricia Gilheaney".

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
16 February 2022

SUMMARY

Ms S was committed to the Mountjoy Women's Prison (Dóchas Centre) on 8 July 2019 and she had a remission date of 13 January 2020. Ms S was approved RTR to engage with the Community Support Scheme and attend appointments arranged by the community support worker attached to Care After Prison.

After serving a period of 3 months she was approved RTR with effect from 7 October 2019. Following a breach of the terms of her conditions, she was taken back into custody in the prison 10 days later on 17 October 2019 and released on RTR on 18 October 2019 as the prison occupancy was very high. Ms S was again placed back in custody on 25 October 2019 and approved RTR again on 31 October 2019 as the occupancy of the Dóchas Centre was well beyond its capacity.

On 14 November Ms S was due to 'sign on' at the Dóchas Centre, however, as she was in the custody of An Garda Síochána at that time this did not occur. She attended the Dóchas Centre the following day, 15 November 2019 and she was taken back into prison custody. Three days later, on 18 November 2019, she was again, for the fourth time in the space of a little over a month, released on RTR as An Garda Síochána confirmed she was not subject to new charges.

Ms S complied with the requirement placed on her to sign on in the Dóchas Centre on 16 December 2019. She was due to return to sign on again on 23 December 2019. This did not occur.

On 24 December 2019, IPS HQ were informed that Ms S had passed away on 20 December 2019.

Our investigation found that Ms S did not comply with the conditions of her RTR.

Recommendations

There are no recommendations in this report. In sanctioning Ms S's temporary release the necessary arrangements were made in advance for Ms S to engage with her community support worker with whom she failed to engage.

DÓCHAS CENTRE

The Dóchas Centre is a closed, medium security prison for females aged 18 years and over. It is the committal prison for females committed on remand or sentenced from all Courts outside the Munster area.

Ms S was the 2nd death of a Dóchas prisoner in 2019; and the 20th death in IPS custody that year which met the criteria for investigation by the OIP.

FINDINGS

Ms S was aged 38 years. She was committed to Mountjoy Women's Prison (the Dóchas Centre) on 8 July 2019. She had a remission date of 13 January 2020.

Ms S was approved RTR with effect from 7 October 2019 subject to thirteen conditions, as follows:

1. Must link in with and attend appointments arranged by Community Support Worker
2. Must link in with CAP
3. Must abide by daily curfew 10 PM to 7AM
4. Be of good behaviour
5. Do not convey messages in/out of Prison
6. Keep the peace
7. Report to [specified Garda Station] within 24 hours of release & daily thereafter to get TR form stamped
8. Return to Mountjoy Prison (Female) on date and time listed on TR form
9. Shall be of sober habits
10. Shall not enter a pub, club or other licensed premises or off-licence premises
11. Shall reside at [address specified]
12. Agree not to change address [specified] without new TR Form
13. Approved RTR to CSS¹

A condition of Ms S's RTR was that she would engage with Care After Prison, which is a peer led criminal justice charity supporting people affected by imprisonment. There was an appointment letter in Ms S's Release Park from Care After Prison advising Ms S that her first appointment was on the date of release (7 October 2019) at 12:00pm. The letter provided Ms S with the address of CAP together with the bus schedule from North Circular Road at the entrance to Mountjoy Women's Prison to the Community based project.

The award of Renewable Temporary Release (RTR) and breaching of same occurred on a few occasions during the month preceding the death of Ms S as the number of women in custody in the Dóchas Centre was very high at that time with a recreation room requiring to be converted into a multi-occupancy 'bedroom' with no privacy or lockers for personal belongings.

On 17 October 2019 Ms S was taken back into custody as she had new charges pending. As the number of women in the custody of the Dóchas Centre was very high – 146 with capacity for 105 - Ms S was approved a further period of RTR from 18 October 2019. Ms S was again taken back into custody on 25 October 2019 and released on RTR on 31 October 2019.

On 14 November 2019 Ms S did not sign on at Mountjoy Women's Prison as she was in the custody of An Garda Síochána. She attended the prison the following day, 15 November 2019 and was held in prison custody. On 18 November 2019 Ms S was again released on RTR as it was confirmed by An Garda Síochána that there were no new charges.

Ms S signed on at Mountjoy Women's Prison on 16 December 2019 and was due to sign on again on 23 December 2019. On the 24 December 2019 the Operations Directorate, IPS HQ were notified that Ms S had passed away on 20 December 2019.

Our investigation found that Ms S failed to engage with the community support project.

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

¹ Community Support Scheme