Report of the Commission of Investigation into the Death of Gary Douch

Volume One

Executive Summary & Recommendations

Sole Member: Gráinne McMorrow S.C.

Executive Summary

In this Executive Summary any references to evidence heard, opinions expressed or conclusions reached by the Commission are given in summary form only, for the sake of brevity. Should any doubt, confusion or ambiguity arise in relation to such evidence, opinions or conclusions, the text of the Report in Parts One to Five is to be read as the definitive official version, to which the reader is referred in any event.

Gary Douch – Born 23/07/1985, Died 01/08/2006

RIP

▪ Introduction

Gary Douch, a young man from Dublin, tragically lost his life in the early hours of 1st August 2006 following a fatal assault which took place in Mountjoy Prison.

On 31st July 2006 Mr Douch, then a serving prisoner in Mountjoy Prison, had expressed concerns for his personal safety to a prison officer. As a result of this he was moved from a multiple-occupancy cell on "C" Wing of Mountjoy to a holding cell in the "B Base", an area of the prison which was used to house prisoners requiring protection from other prisoners.

During the night, Mr Douch was the victim of a brutal assault by Stephen Egan, one of the other prisoners in the holding cell. His unconscious body was discovered by prison officers when they unlocked the cell at approximately 6.50 a.m. the following morning. Medical staff at the prison and at the nearby Mater Hospital were unable to revive him.

Stephen Egan was subsequently arrested and charged with the murder of Gary Douch. Following a trial which took place in April 2009, Stephen Egan was convicted of manslaughter by reason of diminished responsibility and on 29th June 2009 he received a sentence of life imprisonment. An appeal against sentence was rejected by the Court of Criminal Appeal on 29th November 2010.

At the request of the Government an independent inquiry was carried out initially by Mr Michael Mellett (a former Senior Civil Servant) into the circumstances surrounding the death of Gary Douch. Arising from Mr Mellett's report, it was decided that a Commission of Investigation should be established to carry out further inquiries and make recommendations where appropriate. This was done by Order of the Government on 2nd May 2007. Gráinne McMorrow SC was appointed as Sole Member of the Commission on 8th June 2007.

Part One – The Irish Prison System and the Law

1.1 The Prison System in Ireland

The first part of the Commission's Final Report sets out the legal and organisational structure of the prison system in Ireland, as it was at the date of Gary Douch's death. Relevant changes that have taken place since that time are noted where appropriate. Sections are included on:

- administrative oversight of the prison system (including the Department of Justice and the Irish Prison Service)
- the internal organisation of prisons
- record-keeping within the prison system
- the care and treatment of mentally ill prisoners
- the transfer of prisoners to and from the Central Mental Hospital
- the transfer of prisoners between prisons

1.2 Obligations and Duties Owed to Prisoners by the State

In this section of the Report the Commission summarises the obligations owed by the State to prisoners under domestic, European and international law, based on sources which include the Irish Constitution, Acts of the *Oireachtas*, Statutory Instruments, the European Convention on Human Rights, the European Prison Rules and other international standards. These principles are also acknowledged in reports by the Inspector of Prisons and the, European Committee for the Prevention of Torture (CPT) and reference is made to such documents where appropriate.

The relevant duties and obligations of the State arising from these source documents are set out under the following headings:

- Accommodation
- Healthcare
- Safety of prisoners

Part Two – Investigation of Matters Prior to Death of Gary Douch

2.1 Background History of Gary Douch, 1997 – 2006

Gary Douch was born in 1985, the sixth of eight children.

He first came to the attention of the Juvenile Court in early 1997 for a minor larceny offence, and was remanded to St Michael's Assessment Unit. It was recommended that he be placed in one of the Eastern Health Board's Special Care Units, but there were no vacancies at that time. Gary Douch continued to come to the attention of the Gardaí for antisocial behaviour. In November 1998, aged 13, he was charged for the first time with offences under the Misuse of Drugs Acts. Further charges and convictions for drug-related offences, larceny, and assaults followed in the ensuing years.

On 15th July 2005 Gary Douch was sentenced to three years' imprisonment, backdated to 27th July 2004, for an offence of assault causing harm. He was committed to Mountjoy Prison on transfer from Midlands Prison on 24 July 2006, and was placed in a cell on "C" Wing.

2.2 Prison Management of Stephen Egan, 1998 – 2006

Stephen Egan was born in 1983.

In October 1998, aged 15 years, Stephen Egan appeared in the Dublin Metropolitan Children's Court and was remanded to St Michael's Unit, Finglas Children's Centre for assessment. He was remanded temporarily to Trinity House Reformatory School on 11th December 1998.

On 22nd December 1998, following a conviction on larceny charges, he was committed to Trinity House for 2 years.

Between June 2000 and July 2003 Stephen Egan spent most of his time in St Patrick's Institution, along with spells at Wheatfield Prison and Fort Mitchel Prison. He left St Patrick's Institution for the last time in July 2003.

Over the next 2½ years (between July 2003 and November 2005) Stephen Egan was moved from one prison to another on at least 17 occasions. This included spells at Mountjoy, Midlands, Cork, Limerick and Cloverhill prisons. During this period, he was reported on a number of occasions for incidents of abusive, aggressive, and / or violent behaviour towards prison staff and fellow prisoners.

On 2nd July 2005 he escaped from Cloverhill courthouse. He was recaptured ten days later.

On Sunday 27th November 2005 Stephen Egan seriously assaulted a prison officer during a transfer from Cork to Cloverhill Prison, by placing his rigid metal hand-cuffs over her head and around her throat. It required the intervention of several prison officers before Mr Egan's hold on the female prison officer could be released. Mr Egan continued to struggle violently for the remainder of the journey to Cloverhill Prison, resisting efforts to subdue him. An internal report on the incident commissioned by the IPS noted that the transport had been carried out in breach of prison policy concerning the escort of identified "disruptive prisoners". Under the terms of that policy Mr Egan should only have been moved in a separate, three-man escort.

On 2nd December 2005 Mr .Egan was committed to Cloverhill but then transferred to Mountjoy that same day, for "*security reasons*".

On 9th December 2005 he was placed in a special observation cell (also known as a "strip" cell) at his own request.

On 17th December 2005 he set fire to the cell, reporting visual and auditory hallucinations. He was moved to another special observation cell and was kept there until 25th January 2006, for what appeared to be regarded as "management" reasons rather than for any medical requirement.

On 25th January 2006 Stephen Egan was transferred to Cloverhill Prison, where he was placed on the "security" side of D2 wing – that is, the area of the prison reserved for troublesome or disruptive prisoners.

He was returned to Mountjoy Prison on 16th March 2006 in a swap with another prisoner for *"security reasons"*. The transfer was approved in principle by the IPS, but no Ministerial order authorising the transfer has been disclosed to the Commission.

On 15th April 2006 Mr Egan was moved to a single cell in the B-Base area of Mountjoy Prison.

He set fire to the cell on 20th May 2006.

On 27th May 2006 he was moved to a holding cell in the B-Base, which he flooded with water three days later.

On 4th June 2006 Mr Egan was transferred from Mountjoy Prison to Midlands Prison for 2½ weeks on punishment.

On 22nd June 2006 he was returned to Mountjoy Prison. He was placed in a special observation cell in B-Base and remained there until 5th July 2006.

On 5th July 2006 he was admitted to the Central Mental Hospital.

2.3 Medical Treatment of Stephen Egan, 2000 – 2006

Under its Terms of Reference the Commission was specifically tasked with examining, investigating and reporting on the chronology of Stephen Egan's medical treatment as part of an inquiry into matters of significant public concern. In the normal course of events a person's medical history is confidential and would not be placed in the public domain. The Commission has been troubled by the extent to which it has been necessary to include details of Stephen Egan's medical history in its final report. However without doing so the Commission would be unable to meet its obligations under its terms of reference. This decision was not taken lightly and was done with the full authority and consent of Mr Egan

and his legal representatives. As a further safeguard Stephen Egan's legal advisors were provided with a copy of the draft final report to enable them to make any submissions they felt necessary, prior to the Report being delivered to the Minister for Justice and Equality.

The earliest psychiatric report in Stephen Egan's prison medical file dates from November 2001.

He was next seen by the Psychiatric In-reach Service in July 2003, and again in September 2004.

On 3rd March 2005, whilst at Midlands Prison, Stephen Egan was visited by a member of the medical team at the request of a prison officer who said he was concerned about Egan's behaviour.

The documentation disclosed to the Commission does not indicate whether there was any further medical follow-up to this visit. It would appear that Mr Egan was not referred to the Psychiatric In-reach Service at this time.

Following the incident on 27th November 2005 when he assaulted a prison officer during a transport from Cork Prison to Cloverhill Prison, Stephen Egan was placed in a close supervision cell because of the risk he posed to others. Notwithstanding the unexpected, unprovoked and violent nature of Mr Egan's assault on the prison officer, and the fact that his bizarre behaviour continued to escalate even after his arrival at Cloverhill, there is no record of Stephen Egan being seen by a doctor from the time of his arrival at Cloverhill on 27th November until his transfer to Mountjoy Prison on 2nd December 2005. Nor was he referred to the Psychiatric In-reach Service during this period.

On 9th December 2005, one week after his arrival at Mountjoy Prison, Stephen Egan was placed in a special observation cell at his own request.

He was reviewed there by a member of the Psychiatric In-reach Service on 15th and 19th December 2005. The consultant psychiatrist who saw him on the 19th December reported that there was no further need to keep him in a special observation cell. Nonetheless, he remained there until his transfer to Cloverhill Prison on 25th January 2006.

Further psychiatric reviews took place at Cloverhill on 1st and 9th February 2006, following which Mr Egan was prescribed both anti-depressant and anti-psychotic medication.

A consultant psychiatrist's report dated 14th February 2006 recommended that Mr Egan remain on D2 wing at Cloverhill and that he be subject to *"on-going psychiatric review"*.

However, there is no record of Mr Egan being seen by the Psychiatric In-reach Service from 9th February 2006 until 26th June 2006 – some 4 months later – when he was seen in Mountjoy Prison following a request from a GP that he be reviewed.

The absence of any on-going review is particularly puzzling given that on 8th March 2006 Stephen Egan was moved to a special observation cell on the side of D2 wing reserved for "vulnerable" prisoners, where he remained until at least 10th March 2006, and possibly (according to the IPS computer records) until his transfer to Mountjoy on 16th March 2006.

The stated reason for placing him there was that he was a danger to himself and to others.

Notwithstanding his placement in a special observation cell and the recommendation for on-going psychiatric review, Stephen Egan was moved from Cloverhill to Mountjoy Prison on 16th March 2006 without any medical or psychiatric consultation.

On 26th June 2006 Stephen Egan was reviewed by a member of the Psychiatric In-reach Service at the request of a GP in Mountjoy. Following this review Mr Egan was recommenced on anti-psychotic medication and placed on a waiting list for the Central Mental Hospital.

Stephen Egan was admitted to the CMH on 5th July 2006. The Commission has been informed by the HSE that the average waiting period for admission to the CMH at that time was 26-27 days. In this instance, Mr Egan was admitted 9 days after his review, which indicates that his case was given a certain priority by the CMH.

2.4 Stephen Egan at the Central Mental Hospital, 5 – 14 July 2006

Stephen Egan was admitted to the Central Mental Hospital at 4.15 p.m. on 5th July 2006.

His treating psychiatrist formed the clinical impression that Stephen Egan was *"acutely psychotic"*.

Psychiatrists at the CMH reviewed Mr Egan on a daily basis throughout his stay at the hospital. He was co-operative in taking his anti-psychotic medication.

Stephen Egan was kept in seclusion for the duration of his stay at the CMH. This policy was adopted initially because of the acuteness of his mental state, but was continued primarily because of a perceived risk of serious violence outside of the context of mental illness, based on his prison disciplinary record.

Following a review conducted on the morning of 14th July 2006, Mr Egan's treating psychiatrist formed the opinion that he was *"fit to return to prison"*. Later that same day, Mr Egan was reviewed by the Clinical Director of the CMH, who decided that Stephen Egan no longer required inpatient treatment at the CMH.

Based on this decision the Clinical Director determined that Stephen Egan should be returned to Cloverhill Prison. Mr Egan was discharged from the Central Mental Hospital shortly thereafter.

The law applicable to the discharge of a patient in such circumstances is contained in Section 18 of the Criminal Law (Insanity) Act 2006. The section provides that a prisoner cannot be discharged from the CMH until a consultation has taken place with the Minister for Justice as to which prison the prisoner should be discharged. The discharge certificate signed by the Clinical Director in relation to Stephen Egan avers that a consultation did take place, but the Commission has been unable to satisfy itself with any other evidence as to the nature and extent of any such consultation.

2.5 Stephen Egan at Cloverhill Prison, 14 – 29 July 2006

Stephen Egan was discharged from the Central Mental Hospital on the evening of Friday 14th July 2006 and was brought directly to Cloverhill Prison.

Both the Clinical Director of the CMH and Stephen Egan's treating psychiatrist were adamant in their evidence to the Commission that the decision to discharge Stephen Egan had been influenced to some extent by their understanding that he would be going to Cloverhill Prison rather than to Mountjoy. However, administrative officials at the CMH were not informed of this preference, and initially contacted Mountjoy Prison with a view to his being returned there. The Commission is satisfied that if the management at Mountjoy had been willing to take Mr Egan at that time, he would have been returned there rather than to Cloverhill.

Following Mountjoy's refusal to take Mr Egan back, administrative officials at the CMH contacted Cloverhill Prison and informed staff that Mr Egan would be arriving there later that day. At some point after this a governor in Mountjoy Prison received a telephone call from the Governor of Cloverhill Prison asking him to take Stephen Egan back to Mountjoy. The request was refused. The Governor of Cloverhill then telephoned the Governor of Mountjoy and renewed his request. Again, it was refused.

According to the records disclosed to the Commission, Stephen Egan did not undergo the usual medical screening process upon his arrival at Cloverhill. A note in his prison medical file indicates that he was not seen by medical staff on the evening of his arrival at Cloverhill, as standard practice required. He was seen on the following day by one of the GPs serving Cloverhill Prison at that time.

Stephen Egan was placed on the "security" side of D2 wing at Cloverhill[1] on 14th July 2006 and he remained there until he was transferred to Mountjoy Prison on 29th July 2006.

The first psychiatric review of Stephen Egan following his return to prison from the Central Mental Hospital took place on 17th July 2006.

[1] For further information concerning D2 Wing at Cloverhill Prison see chapter 1.1 below.

He was seen again by a consultant psychiatrist on 20th July 2006.

There is no documented evidence that Mr Stephen Egan was seen by any member of the Psychiatry In-reach Service from 21st July 2006 until his departure from Cloverhill on 29th July 2006. A consultant psychiatrist was scheduled to visit the prison as part of the Psychiatric In-reach Service on 27th July 2006, but Mr Egan was not available for review on that date, as he had to appear in court.

On 26th July 2006 however – three days before his transfer from Cloverhill to Mountjoy Prison – Mr Egan was seen by an external senior clinical psychologist at the request of Mr Egan's solicitors. This senior consultant clinical psychologist had been asked to interview Mr Egan and to prepare a report in anticipation of a sentencing hearing on 27th July 2006. He had no prior knowledge of Mr Egan's history as a troublesome prisoner with a propensity for violence. Nor was he aware of Mr Egan's history of mental health problems, or of his recent sojourn in the Central Mental Hospital. Mr Egan was brought down to a regular visiting area for this interview.

In evidence to the Commission the psychologist stated that from a very early stage of his meeting with Stephen Egan, he became alarmed at Mr Egan's mental state and concerned for his own personal safety. He described Mr Egan on this occasion as being *"manic"*, *"completely deluded"* and *"very unwell"*. He completed a written report on the same day of his interview with Stephen Egan and sent it to Mr Egan's solicitor. There are no references to this report either in Stephen Egan's prison files or in the material disclosed to the Commission by the Central Mental Hospital. It seems that in July 2006 both the Psychiatric In-reach Service at Cloverhill and the prison management were not aware of the psychologist's interview with Mr Egan, nor of his concerns regarding Stephen Egan's mental health. They remained unaware of this information until the Commission brought it to their attention in 2010.

2.6 Transfer of Stephen Egan to Mountjoy Prison, 29 July 2006

Stephen Egan was moved from Cloverhill Prison to Mountjoy Prison on Saturday 29th July 2006. On the same day five other prisoners, including one referred to hereinafter as "Prisoner B", were moved from Mountjoy to Cloverhill.

The process which resulted ultimately in the transfer of Stephen Egan from Cloverhill to Mountjoy Prison was begun by a Chief Officer at Mountjoy. On 28th July 2006 he contacted his counterpart at Cloverhill with a view to arranging the transfer, not of Stephen Egan, but of Prisoner B. At that time there was a standing order in place that prisoner B was not to be accommodated in Mountjoy. In response to this request, the Chief Officer at Cloverhill suggested that Mountjoy would have to take back a prisoner – Stephen Egan – in return for moving prisoner B.

On 29th July 2006 the Chief Officer from Mountjoy contacted Cloverhill to ask if they could take more prisoners in order to reduce overcrowding at Mountjoy. Following negotiations between management at the two prisons, it was agreed that Cloverhill would take four prisoners in addition to prisoner B, with Stephen Egan being sent to Mountjoy.

A request for approval of the transfer of Stephen Egan was faxed to the relevant IPS official on Saturday 29th July 2006.

In evidence to the Commission the IPS official in question confirmed that he was not made aware of any specific reason why Stephen Egan in particular was being transferred, other than that it was part of a swap, and that it was in some way related to the transfer of five prisoners, including prisoner B, from Mountjoy to Cloverhill.

He was not aware that Stephen Egan had been recently discharged from the Central Mental Hospital.

From the information available to the Commission it is clear that no member of the medical or psychiatric personnel attached to Cloverhill or the CMH was consulted regarding Stephen Egan's transfer to Mountjoy.

2.7 Conclusions

Prison management of Stephen Egan, 1998 – 2006

- Stephen Egan was identified within the prison system as a troublesome and disruptive prisoner from 1998 onwards, and for at least two years prior to July 2006 Stephen Egan was well-known throughout the prison system as a management problem.

- Stephen Egan's transfer from Cork Prison to Cloverhill on 27th November 2005 was not managed in accordance with his known and recorded status as a disruptive and potentially violent prisoner. This failure of management resulted in a situation where a violent and potentially life-threatening assault on a prison officer took place.

- There was a systemic failure to carry out a proper review and assessment of the incident of the 27th November 2005. The failure to do so was a missed opportunity to establish whether Stephen Egan's behaviour and demeanour on 27th November 2005 had some underlying cause or was linked to any way to deterioration in his mental health.

- The frequency with which Stephen Egan was moved between prisons during 2005 – 2006 fostered a situation in which no one person or group of persons maintained an effective overall responsibility for his management.

Medical treatment of Stephen Egan, 2000 – 2006

- Record-keeping in relation to Stephen Egan's care and management within the prison system was inconsistent, incomplete, and unreliable to a degree which seriously compromised the ability of medical and psychiatric personnel to deliver care and treatment in an appropriate and timely manner.

- Stephen Egan should have been reviewed by a doctor and should also have been referred to the Psychiatric In-reach Service for review following the attempted hostage-taking incident while en route to Cloverhill Prison on 27th November 2005. This was not done.

- Stephen Egan's consistent refusal to take his anti-psychotic medication from 17 February to 3 March 2006 should have been brought to the attention of the Psychiatric In-reach Service in Cloverhill by the prison medical staff. On the evidence before the Commission, this was not done.

- Irrespective of whether Stephen Egan had been taking his medication during February / March 2006 or not, he should still have been the subject of on-going psychiatric review until such time as a member of the Psychiatric In-reach Service certified that further review was not necessary. This did not happen.

- Stephen Egan was moved out of D2 wing, Cloverhill on either 10th or 16th March 2006 and was transferred to Mountjoy Prison on 16th March. These movements took place without the knowledge of the Psychiatric In-reach Service, and were in contravention of the last psychiatric assessment, which was that he should remain on D2 pending further review.

- The evidence before the Commission indicates that Stephen Egan's psychiatric problems and his refusal to take medication while in Cloverhill in February / March 2006 were not brought to the attention of IPS medical personnel in Mountjoy or to the HSE Psychiatric In-Reach Services personnel who attend Mountjoy, following his transfer there on 16th March 2006.

- The transfer of Stephen Egan from D2 wing at Cloverhill to Mountjoy on 16th March 2006 without medical or psychiatric consultation represents a serious departure from good practice.

Stephen Egan at Central Mental Hospital, 5 – 14 July 2006

- The question of whether Stephen Egan was diagnosed correctly by his treating psychiatrists at the Central Mental Hospital in July 2006 cannot be answered by the Commission.

- The fact that no psychiatric review of Stephen Egan is recorded as having taken place between 9th February 2006 and 26th June 2006 makes it impossible to identify with certainty the extent to which Mr Egan exhibited psychotic symptoms during those periods.

- The suggestion that Stephen Egan's psychotic behaviour in or around June 2006 might have been drug-induced is not borne out by the evidence before the Commission.

- Given the complexity of Mr Egan's history and presentation, and the lack of information concerning his mental health state between February and June 2006, the Commission considers he should not have been discharged from the Central Mental Hospital back to the prison system on 14th July 2006, nine days after admission.

Stephen Egan at Cloverhill Prison, 14 – 19 July 2006

- The Central Mental Hospital did not inform Cloverhill or Mountjoy Prisons that Stephen Egan was being discharged solely on the basis that he was going to Cloverhill Prison or to D2 wing there.

- The Central Mental Hospital discharged Stephen Egan to Cloverhill knowing that once discharged back to prison, he could be transferred to another prison at any time for management reasons, without reference to the CMH or to the Psychiatric In-reach Service at Cloverhill.

- No meaningful consultation appears to have taken place with the Minister for Justice (or his representative) as required by section 18 of the Criminal Law (Insanity) Act 2006, in relation to Stephen Egan's proposed transfer to prison from the Central Mental Hospital on 14th July 2006.

- 6.30p.m. on a Friday evening was not an appropriate time to transfer Stephen Egan from the Central Mental Hospital to Cloverhill Prison.

- Notwithstanding his recent return from the Central Mental Hospital, Stephen Egan's management at Cloverhill Prison from 14th – 29th July 2006 was governed primarily by his reputation as a potential security problem, rather than as a vulnerable prisoner with a psychiatric illness.

- Stephen Egan's psychiatric aftercare at Cloverhill Prison following his discharge from the Central Mental Hospital was not of the intensity that might have been expected given his history and the course of his illness while an inpatient.

- A failure of management and security resulted in a visitor to Cloverhill Prison on 26th July 2006, a Consultant Clinical Psychologist being exposed to a serious risk of injury or harm from Stephen Egan.

Transfer of Stephen Egan to Mountjoy Prison, 29 July 2006

- It was not necessary for Stephen Egan to be transferred from Cloverhill to Mountjoy Prison on 29th July 2006.

- It was not in the best interests of Stephen Egan to be transferred from Cloverhill to Mountjoy Prison on 29th July 2006.

- The transfer of Stephen Egan on 29th July 2006 may have been intended as a "swap" with Prisoner B, but that alone was not sufficient to justify the transfer.

- The transfer of Stephen Egan on 29th July 2006 does not appear to have been directly related to the transfer of four other prisoners from Mountjoy to Cloverhill on the same day. Even had it been, Cloverhill Prison had the capacity to accept those additional prisoners without having to transfer Stephen Egan.

- There were fundamental systemic failures in Stephen Egan's transfer from Cloverhill Prison to Mountjoy on the 29th July 2006.

- The Governors of both Mountjoy Prison and Cloverhill Prison at the time of Stephen Egan's transfer on 29th July 2006 failed to ensure delivery of acceptable standards of prisoner management, health, and safety.

- The decision to transfer Stephen Egan to Mountjoy on 29th July 2006 was arrived at without any regard to his on-going need for psychiatric care and treatment as set out in the Discharge Summary from the Central Mental Hospital.

- The fact that Stephen Egan's transfer to Mountjoy took place on a weekend increased the risk that he would not receive appropriate medical and psychiatric attention.

- Mountjoy Prison management should not have agreed to accept Stephen Egan on 29th July 2006.

- There was inadequate oversight by the Irish Prison Service of the transfers which took place on 29th July 2006.

- Cloverhill's apparent determination to transfer Stephen Egan, although they had no pressing operational reason to do so, was, in fact if not in intent, "sweetened" by an arrangement where they offered to relieve Mountjoy of five prisoners that day.

- The management at Cloverhill Prison exhibited what this Commission regards as a reckless disregard for the health and safety of Stephen Egan in transferring him to Mountjoy Prison without any consultation with his Doctors or with the Psychiatric In-Reach Service. This was not helped by the transfer taking place on a Saturday/weekend when the staff complement might reasonably have been expected to be reduced.

- In selecting Stephen Egan for transfer, Cloverhill also exhibited a reckless disregard for the health and safety of staff and prisoners at Mountjoy Prison, which they knew was under severe pressure from overcrowding. He was wholly unsuitable for transfer, given that he was a prisoner with known violent history, still under psychiatric care and on anti-psychotic medication, recently discharged from the Central Mental Hospital. The transfer also involved moving Stephen Egan from the safety of a high observation single cell on Cloverhill's D2 wing to Mountjoy, when they knew, or could reasonably be expected to have known that he would not be accommodated in anything approximating the facilities available in D2.

Part Three – Investigation of Circumstances Surrounding the Death of Gary Douch

3.1 Stephen Egan at Mountjoy Prison, 29 – 31st July 2006

Stephen Egan arrived at the gates of Mountjoy Prison at approximately 2.40 p.m. on Saturday 29th July 2006. He was escorted to the reception area where he was interviewed by a medical orderly. Despite requests no written record of this interview has been produced to the Commission. Mr Egan was not seen by a doctor during the three days prior to his assault on Gary Douch. The doctors on duty at Mountjoy during that period were not made aware of his presence in the prison. Nor did Mr Egan receive his anti-psychotic medication during that period.

On his arrival at Mountjoy it was found that Stephen Egan could not be placed in a cell on any of the main wings of Mountjoy Prison, because of threats made against him by other prisoners. Instead, he was placed in Holding Cell 2 in the "B Base" area of Mountjoy until such time as he could be moved safely into the main part of the prison. At first he was alone in Holding Cell 2 in "B Base", but was later joined by one other prisoner overnight and then over the next two days by 13 other prisoners, some of whom were subsequently moved elsewhere. By the afternoon of Monday 31st July Stephen Egan was one of six prisoners being kept in Holding Cell 2. At 6.45 p.m. that evening Gary Douch became the seventh prisoner to be placed in the cell.

3.2 Death of Gary Douch, 1 August 2006

On Monday, 31st July 2006, Gary Douch was sharing cell 17 on C1 Wing, Mountjoy Prison with three other prisoners. He told his fellow prisoners that he wanted to be moved from C Wing, as he was afraid he was going to be attacked. At 5.20 p.m. he spoke to a prison officer and asked to be put on "protection". He repeated his assertion that he was going to be attacked, but did not identify who he felt threatened by. Following consultation with the

Chief Officer on duty, Gary Douch was escorted to the "B Base", where he was placed in Holding Cell 2.

As the evening progressed, a number of men who had arrived at Mountjoy on committal that day were placed in the cell, along with another prisoner who returned from the Mater Hospital following treatment for a knife attack which had taken place in the prison yard earlier in the day.

By 8.30 p.m., Holding Cell 2 contained 14 prisoners.

The night guards came on duty and assumed control of "B Base" at 8 p.m. At approximately 9 p.m., seven prisoners were taken out of Holding Cell 2 and brought to the reception area, where they spent the night. The remainder, including Gary Douch and Stephen were given bedding and then locked into Holding Cell 2.

There were two prison officers on duty in the "B Base" area for the night of 31st July / 1st August. Cells in the Base were to be checked at regular intervals of 30 minutes (or 15 / 20 minutes for cells containing protection prisoners). These checks were carried out by looking into each cell through a viewing hatch in the cell door. At the far end of the Base area there was an electronic clock which the officers punched at the end of each round to indicate that they had checked all the cells in the area.

According to both officers on duty that night, the atmosphere in Holding Cell 2 appeared to be good throughout the night. The Commission was told that tea and cereal were given to the occupants at around 9.45 p.m. At around 1.45 a.m. the prisoners requested milk. Just after 4 a.m. a prisoner – possibly Gary Douch – asked for the toilet light to be turned on.

At 6.30 a.m. on the morning of 1st August 2006, the master lock was removed from the cells, allowing the prison officers in the "B Base" to unlock the individual cells. Holding Cell 2 was opened at around 6.50 a.m. and the prisoners were told to come out. Stephen Egan emerged first. The other prisoners, with the exception of Gary Douch, then came out. They informed the prison officers quietly that Gary Douch was still in the cell. The prison officers entered the cell and found Mr Douch under a pile of duvets with a sheet over his face. The Nurse Officer on duty was sent for immediately. He commenced CPR and continued using CPR and a defibrillator for 20 minutes, at which point Dublin Fire Brigade personnel arrived.

Gary Douch was placed in an ambulance for immediate transport to the Mater Hospital Accident and Emergency Department, a mere two hundred yards from the entrance to the prison. Further efforts were made in the hospital to revive Gary Douch but to no avail. He was pronounced dead by a doctor at 7.35 a.m.

A post mortem examination on the body of Gary Douch was carried out by Professor Marie Cassidy on 1st August 2006, with further examinations on 2nd and 9th August 2006. In her subsequent report (dated 12th January 2007) Professor Cassidy identified the cause of death as follows:

> *"**Post mortem examination** showed that this man had been violently assaulted and then his face smeared with faeces.*
>
> *He had died from blunt force trauma to his head and neck. There were also injuries to the front and back of the trunk and arms".*

There was no evidence of a sexual assault.

3.3 Conclusions

Stephen Egan at Mountjoy Prison, 29 – 31st July 2006

- Stephen Egan was not given a proper medical assessment on arrival at Mountjoy Prison on 29th July 2006. There were evident deficits in management, decision-making, record-keeping and communication in this regard.

- Governor Barclay was dealing with severe overcrowding in Mountjoy on the 29th July 2006 and Cloverhill's willingness to take 5 prisoners from Mountjoy notwithstanding their insistence that Mountjoy take Stephen Egan, was a deal no one could reasonably refuse in the circumstances, even if we accept that Governor Salley would personally not have agreed to this, had he been on duty himself on the 29th July.

- Deputy Governor Barclay did not know that Governors Lonergan and Salley had refused to take Stephen Egan when he was discharged from the CMH on 14th July 2006 on two occasions when requested to do so by Cloverhill.

- There is a conflict of evidence between Governor Salley and Governor Barclay arising from oral and documentary testimony. Their divergent recollection perspectives and understanding of the facts surrounding Stephen Egan's transfer from Cloverhill to Mountjoy prison on the 29th July and his presence there between the 31st-July and the 1st August, are matters which the Commission investigated but was ultimately unable to resolve definitively.

- The decision to keep Stephen Egan in a holding cell in B Base from 29-31st July 2006 was made on the basis of incomplete information. This fact was not known to the persons responsible for his management at that time.

- Leaving aside the issue of what Governor Salley was told or knew or ought to have known concerning Stephen Egan's presence was in Mountjoy on 31st July

2006, it is certainly the case that both he and Deputy Governor Barclay were not in possession of a number of crucial pieces of information concerning Stephen Egan at that time, including;

- that he had been transferred to Mountjoy without the knowledge or consent of the Psychiatric In-reach Service at Cloverhill;

- that he was not seen by a doctor or by any member of the Psychiatric In-Reach Service in Mountjoy over the period 29-31st July 2006; and

- that he was not receiving his prescribed anti-psychotic medication.

Death of Gary Douch, 1 August 2006

- Overcrowding in Mountjoy Prison completely undermined the ability of the prison to respond in a meaningful and safe way to Gary Douch's request for protection.

- The conditions in which the 7 Protection prisoners were kept in Holding Cell 2 on the 31st July/1st August 2006 were appalling and unacceptable.

- The conditions in which the prisoners in Holding Cell 1 and particularly in the Reception area on the 31st July/1st Aug 2006 were appalling and unacceptable.

- Keeping seven prisoners overnight in Holding Cell 2 of the "B Base" was a violation of each of those prisoners' human rights.

- Keeping seven vulnerable "protection" prisoners overnight in Holding Cell 2 of the "B Base" created an unquantifiable and unacceptable safety and security risk for prisoners and staff.

- Given his psychiatric history and his established reputation for violent behaviour towards prisoners and staff, Stephen Egan should never have been accommodated in a holding cell overnight with six other prisoners.

- The regime that operated at Mountjoy at the time of Gary Douch's death was inept, dysfunctional, and showed a reckless disregard for the safety needs of both prisoners and staff.

- The supervision of "B Base" by officers does not appear to have been as vigilant as it should have been given the circumstances

- No spot checks or inspections were carried out by the ACO in the Base on the 31st July/1st August 2006.

- Un-metabolised alcohol was found in Gary Douch's blood following the autopsy, evidence that he had consumed a considerable amount of alcohol in the cell within the hour preceding his death.

- The investigation carried out in the immediate aftermath of the death of Gary Douch did not include drug and alcohol screening of the others present in the Holding Cell 2 "B Base".

- Prison officers at Mountjoy at the time of Gary Douch's death received inadequate support and supervision, and were not provided with necessary training in risk assessment.

- A culture of non-compliance with regulations, protocols, guidance, and orders was tolerated at Mountjoy Prison.

- From the evidence provided to the Commission it emerged that some of Stephen Egan's speech patterns in the cell prior to the assault are similar in theme and content to patterns recorded by (i) staff at the Central Mental Hospital during 5-

14th July 2006, (ii) a Consultant Clinical Psychologist during his interview with Stephen Egan at Cloverhill prison on 27th July 2006 and (iii) staff at the CMH again between Aug-Oct 2006. In particular, Mr Egan displayed the same delusional pre-occupations with "the Beast" and "rapes" as well as other symptoms of psychosis in Holding Cell 2 on the 31st July/1st August that he had displayed previously when unwell.

Part Four – Management of Stephen Egan after the Death of Gary Douch

4.1 Management of Stephen Egan, 1 August 2006 to date

When the assault on Gary Douch was discovered on the morning of 1 August 2006, Stephen Egan was transferred immediately to a strip cell on C2 landing at Mountjoy. At 9 a.m. he was moved to a special observation room in Mountjoy Medical Unit. On the following day Stephen Egan was transferred to Cloverhill Prison, where he was placed in a special observation cell. On 3rd August 2006 he was transferred to the Central Mental Hospital for treatment.

Stephen Egan was recommenced on Olanzapine (an anti-psychotic medication) and was reviewed on a daily basis. A second antipsychotic medication, Amisulpride, was added to his medications on 6th August 2006. In terms of risk, Mr Egan was assessed as presenting *"…an extreme risk of violence towards staff and patients"*. He was kept in seclusion for the duration of his stay at the CMH – as he had been during his earlier stay from 5th – 14th July 2006.

During the month of August 2006 Stephen Egan continued to report psychotic symptoms, but was compliant with medication. No further incidents were reported. There was no marked change in his presentation during the month of September 2006. At a multi-disciplinary case conference held on 4th October, he was noted as having been fully compliant with his medication to date. His appetite and sleep pattern over the period of admission were noted as having remained stable.

Reviews carried out by psychiatrists at the CMH on 3rd and 4th October 2006 reported Stephen Egan's mood as euthymic and his affect as calm and relaxed. Also on 4th October the Clinical Director of the CMH conducted a detailed interview with Mr Egan, at the end of which he concluded that Mr Egan *"has not had any sustained periods of abnormal mental state"* and was no longer in need of treatment at the CMH. On 5th October 2006 the Clinical Director wrote to the Director General of the Irish Prison Service informing him of a decision to direct Stephen Egan's transfer back to prison. The letter contained advice concerning the future placement of Stephen Egan within the prison system.

Stephen Egan was transferred to Midlands Prison on 6th October 2006. A discharge summary, together with a prescription sheet from the Central Mental Hospital, was faxed to the prison on the same day. Also sent was a report containing the results of a risk assessment instrument known as Historical-Clinical-Risk Management– 20 [HCR– 20], which confirmed that Stephen Egan remained a high risk in terms of possible violent behaviour.

Under the heading, 'Final Diagnosis', the discharge summary recorded a diagnosis of *"dissocial personality"*. A formal diagnosis of psychosis was not made. Mr Egan was discharged with prescriptions for two anti-psychotic medications. Follow-up by the Psychiatric In-reach Services was recommended.

On arrival at Midlands Prison, Stephen Egan was placed in a single cell on a section of the C1 landing devoted to troublesome or disruptive prisoners, an area known as the Special Protection Area. In effect, Mr Egan has been there ever since.

A note from Stephen Egan's prison medical file records that he was reviewed at Midlands by a member of the Psychiatric In-reach Service on 10th October 2006. The Commission has seen no record of any further follow-up by the Psychiatric In reach Services between 25th October and 9th January 2007, when concerns expressed by prison officers about Mr Egan's behaviour prompted another review by a consultant psychiatrist. Drug Administration records at the prison are incomplete, but it would appear that Mr Egan had ceased taking his anti-psychotic medication in or around the middle of October 2007. Efforts were made to persuade him to recommence taking his medication, but in the absence of complete medical records, it is not possible to establish the extent to which this was successful. The prescribed amount of medication was increased, and he was placed on a waiting list for a return to the Central Mental Hospital.

In mid-February 2007, one month after he had been placed on a waiting list for the Central Mental Hospital, Stephen Egan was still in isolation at Midlands Prison. The Governor of Midlands and the resident GP expressed concern regarding an apparent deterioration in his mental health. On 19th February the Governor spoke to the IPS Director of Health Care to enlist his help in securing a place at the CMH.

A Drug Administration Record on Stephen Egan's medical file indicates that from 22nd February onwards, Mr Egan was taking his medication. He may have been doing so prior to

that date, but in the absence of any record on the file, this cannot be confirmed. He was reviewed by the Psychiatric In-reach Service again on 28th February 2007 and found to be *"much calmer in his demeanour"*.

Stephen Egan remained in Midlands Prison, and was not transferred to the CMH. He was reviewed by the Psychiatric In-reach Service on 15th May and again on 17th September 2007. He was noted to have improved, but was kept on a daily dose of anti-psychotic medication. This remains the case at the time of writing.

4.2 Conclusions

- There was an appropriate level of consultation between the CMH and the Irish Prison Service prior to Stephan Egan's discharge on 6th October 2006.

- Stephen Egan's psychiatric aftercare at Midlands Prison following his discharge from the CMH in October 2006 was not of the intensity that might have been expected given his history and the course of his illness while an inpatient.

- Stephen Egan's drug administration record since his discharge from CMH on 6th October 2006 was not properly maintained.

Part Five – Review of Policy Issues

5.1 Prisoner Safety – Policies, Practices And Procedures

This part of the Commission's report contains a review of policy issues pertaining to the circumstances surrounding the death of Gary Douch. These policy issues can be grouped under the following headings:

1. Overcrowding in prisons and related institutions
2. Prisoners on protection
3. The management of violent and disruptive prisoners
4. The transfer of prisoners between prisons
5. Systems for dealing with the death of a prisoner

5.2 Overcrowding

Overcrowding is undoubtedly one of the key contributing factors in the death of Gary Douch. Without it, he and Stephen Egan would not have ended up sharing a cell in Mountjoy with five other prisoners on the night of 31st July – a cell with no beds and little ventilation, which was never designed to accommodate prisoners for anything more than a few hours, and certainly was not designed to accommodate that number of prisoners on an overnight basis.

Significant problems with overcrowding are not new to the Irish prison system. This section of the Commission's report provides an historical overview of such problems, with reference *inter alia* to reports by the Whitaker Committee of Inquiry into the Penal System, the European Committee for the Prevention of Torture (CPT) and the Inspector of Prisons.

Consideration is given to the effects of overcrowding, with particular reference to the situation in Mountjoy Prison, both as it was before the death of Gary Douch and as it has been since.

5.3 Prisoners On Protection

On 31st July 2006 Gary Douch asked to be moved from his cell on C1 landing to another part of Mountjoy Prison, apparently for fear of being attacked where he was. Tragically, it was this request for a safer prison environment which led to his placement in a holding cell in the "B Base", where he would lose his life at the hands of another prisoner, Stephen Egan.

Stephen Egan himself had been placed in that holding cell three days previously. This too was done for reasons of protection, in circumstances where threats from other prisoners had made it impossible to accommodate Egan on any of the main prison wings.

The problem of how to prevent violent incidents between prisoners is one which every prison system has to address. In the case of Ireland, the past two decades have seen a considerable rise in the number of prisoners requesting protection from other prisoners, and this has placed further strain on an already overcrowded and under-resourced system.

This section of the Commission's report examines this issue, with particular reference to the management of protection prisoners at Mountjoy Prison, both before and after the death of Gary Douch.

5.4 Management of Violent / Disruptive Prisoners

Almost from the time he first entered into the prison system, Stephen Egan was regarded as a difficult and potentially disruptive prisoner. Between January 2001 and July 2006 he was the subject of more than 90 written disciplinary reports (referred to within the prison system as P.19 reports). Approximately half of these reports related to incidents of violent, abusive, or threatening behaviour towards prisoners or staff. By August 2004 his behaviour was of sufficient concern to the prison authorities that he was brought to the attention of the

Disruptive Prisoners and Security Group, a system-wide body which met regularly to discuss the management of particularly disruptive prisoners.

It is clear that any assessment of how Stephen Egan was managed in prison must have regard to the general policies adopted by the Irish prison service in dealing with disruptive prisoners. This section of the Commission's report examines prison policy in this regard, beginning with the establishment of an expert review group by the Government in 1999.

5.5 Transfer of Prisoners Between Prisons

Arising from its investigations into the circumstances of Stephen Egan's transfer to Mountjoy Prison on 29 July 2006, the Commission considers it necessary to address a number of issues of policy and procedure concerning inter-prison transfers. These issues, which are considered in this section of the Commission's report, can be summarised as follows:

- The exchange of prisoners between prisons on a "swap" basis
- The role of the medical and psychiatric services in prisoner transfers
- Communication of essential information between prisons involved in transfers
- The role of the Irish Prison Service in overseeing and approving prisoner transfers
- The circumstances in which a transferred prisoner can and should be returned to the transferring prison (known as the "spring return" policy)
- Difficulties associated with transfers taking place on a weekend

5.6 Death of a Prisoner – Procedures And Protocols

In its Interim Report, delivered to the Minister for Justice, Equality and Law Reform on 20th December 2007, the Commission made a number of recommendations concerning the treatment of bereaved families in the event of the sudden and unexpected death of a prisoner.

The Commission's recommendations, which are set out again in this section of the Commission's report, are founded on the fundamental principles of compassion and respect for human dignity. In the case of Gary Douch, many of the victim's family first learned of his death through the media, rather than from officials of the State. The Commission's recommendations are intended to ensure firstly, that this does not happen again, and secondly, that the family of any prisoner who dies in prison is treated from the outset with the appropriate level of support and respect.

5.7 International Perspectives

The systemic problems which contributed to the tragic death of Gary Douch – which include poor record-keeping, inadequate risk assessment, failures of communication, inadequate medical screening, and breaches of continuity of care – are not unique to this State. For that reason the Commission has given some consideration to the experience of other countries regarding similar deficiencies. In particular, the Commission has had regard to the following cases, inquiries, and reports and research from the United Kingdom and elsewhere:

- An inquiry into the death of Christopher Edwards, a prisoner in Chelmsford Prison who was killed by another prisoner, Richard Linford
- The 2009 report of Lord Bradley on people with mental health problems or learning difficulties in the prison system
- An inquiry into the death of Zahid Mubarek, a teenager who was murdered by a fellow inmate at Feltham Young Offenders Institute
- The 2007 report of the World Health Organisation, *Health in Prisons* – and in particular the following sections:
    - 'Standards in prison health: the prisoner as a patient' (Andrew Coyle)
    - 'Primary health care in prisons' (Andrew Fraser)
    - 'Mental health in prisons' (Eric Blaauw and Hjalmar J.C. van Marle)

- Screening instruments

This section of the Commission's Report refers to other relevant issues arising from additional international sources and research.

5.8 Conclusions

Overcrowding

- The chronic overcrowding experienced in Mountjoy Prison on the weekend of 29th – 31st July 2006, while not the only factor, was critical in creating the circumstances which resulted in the death of Gary Douch.

- Since the death of Gary Douch in August 2006, the problem of overcrowding in Irish prisons has not abated, but has in fact grown to an unprecedented extent.

- In the immediate short term, some measure of overcrowding is unavoidable in the Irish prison system. However, it can only be countenanced in circumstances where clear and cogent measures are being taken to reduce and eliminate such overcrowding within a definite timeframe.

- Statistics on prison capacity should be presented in a manner that accurately reflects the capacity of a prison to house prisoners in accommodation which meets acceptable standards.

Prisoners on Protection

- The safe management of prisoners on "protection" is compromised to an unacceptable degree by overcrowding within the Irish prison system.

- The current overcrowding crisis in Irish prisons is exacerbated by the growing numbers of prisoners seeking protection.

- The introduction of a formal system for assessing, categorising, and managing risk throughout the Irish prison system is urgently required.

- The human rights of prisoners on "protection" must be respected.

Management of Violent / Disruptive prisoners

- The IPS must take active responsibility for the management of disruptive prisoners across the prison system.

- The management of disruptive prisoners should place particular emphasis on identifying the causes of disruptive behaviour in each individual case and on devising plans to address these.

- Disruptive prisoners cannot be managed effectively without proper record-keeping, supervision, continuity of care, personalised management plans, risk assessment, and regular review, as well as communication of essential information to those who have responsibility for their safety, security and health.

- There is widespread confusion and uncertainty within the prisons with regard to what constitutes appropriate and necessary information sharing.

- There is an incomplete understanding of the parameters of confidentiality amongst prison staff which needs to be addressed with training and guidance to eliminate the risks of compromise to best practice and safe management of prisoners.

- The use of psychotropics, sedatives and related medication in the treatment of disruptive prisoners, and the reasons for such use, must be properly recorded and reviewed.

- The systematic assessment, recording, and communication of risk is essential to the proper management of disruptive and violent prisoners.

Transfer of Prisoners between Prisons

- The Irish Prison Service must take a central role in overseeing the transfer of prisoners between prisons.

- All sides involved in an inter-prison transfer have a responsibility to ensure that they are as fully informed as possible concerning the prisoner or prisoners involved.

- The protocols outlined in the IPS Health Care Standards in relation to prisoner transfers must be followed.

Recommendations

▪ Overview

The Commission considered the evidence and submissions of over 228 people and organisations in the course of its work.

The Commission scrutinised the way in which our prison management system operates as well as its interaction with other stakeholder agencies, particularly psychiatric services.

The Commission acknowledges that it would be unfair to regard this tragedy as having been caused by any one person or service.

It was, however, an avoidable systems failure compounded by the fact that non-compliance with or disregard for some of our existing rules, regulations, orders and policies was discovered to be the norm rather than the exception.

The Minister for Justice ultimately carries the legal responsibility for prisoner transfers under the legislation and this function is delegated to the IPS who in turn rely on the information provided to them by the Governors via their senior officers. There was no effective mechanism or practice in place at the time to test the accuracy and adequacy of the information provided. This information was therefore subject to little scrutiny and taken on trust, serving largely as a rubber-stamping exercise. The IPS bear responsibility for ensuring that such decisions are made on the basis of full information in order that they carry out the Minister's legal function properly. The Commission is concerned that this did not happen here.

In the discharge of their functions, Governor Lonergan of Mountjoy Prison and Governor Somers of Cloverhill Prison must bear considerable responsibility for what tragically transpired. Both Governors were in charge, (albeit in Governor Somers case, he was only in Cloverhill 4 months) at the relevant time, and were therefore responsible for the systems in place in each of their prisons, which failed to identify and appropriately manage Stephen Egan's risk to others. The management in place at that time in Cloverhill and Mountjoy Prisons, despite knowledge of and familiarity with Stephen Egan – with the apparent exception of Governor Salley, failed to recognise and evaluate the risk he presented, exacerbated as it was by his serious mental illness, at a time when he was still under the care

of the Forensic Mental Health Service. As a consequence, grievous errors of judgment were made in transferring him from Cloverhill Prison to Mountjoy Prison when they did, without consultation with his psychiatrists.

The ensuing mistakes and errors of judgement in Mountjoy that followed his transfer resulted in a failure to protect the life of Gary Douch when he had sought protection from other dangers.

The Commission recognises also that the Prison system is frequently overwhelmed and under-resourced, as are many of our essential services and that our Government struggles to meet the competing needs for resources.

However, given that the Commission found in the main, good policies, rules and regulations and laws in place, what emerges is the question – why are they not followed, complied with, or implemented? Are they misunderstood? Or are there deficits in training and knowledge that leave staff confused about their duties?

The Commission has had to conclude from the evidence it heard that there were considerable deficits in knowledge, training, management, supervision, and oversight.

While several staff at all levels and in all services were found to have made periodic representations to management regarding risk, prisoner stratification, resources, policies and practices, the Commission heard that there were also those whose entrenched attitudes undermined safe practice, and resisted change.

Taking everything the Commission heard into account it is impossible not to conclude that flawed management, poor decision-making, lack of accountability and a culture of inattentiveness prevailed throughout the system. The IPS and the Governors in general should have been more vigilant in their oversight, more cognisant of risk management and more insistent on compliance to ensure safety and good practice.

This is not to take from the efforts of those Governors, officers and staff who consistently tried to improve conditions, maintain good standards and secure better resources.

The Commission met Governors, officers and IPS staff of the highest calibre and dedication who were committed to bringing the highest professional standards to the prison service.

The scale of change in recent years and the enormity of the task of modernizing our prisons cannot be superficially commented upon.

It has also been a time of great change in the development of the Forensic Mental Health Service, committed as it is to an enhanced delivery of psychiatric care and treatment to prisoners in its on-going development of In-Reach services. The Commission acknowledges the expertise and dedication of Professor Kennedy, Clinical Director of the Central Mental Hospital and the commitment and work of Dr Mohan and Dr Conor O'Neill of the Forensic Mental Health Service and their colleagues who have been to the forefront of implementing better models of care to mentally ill offenders.

Mr Douch's mother, Margaret Rafter and his family are, at a minimum, entitled to reassurance that his unacceptable, tragic death prompted key changes in the way prisons are managed. They hope that the legacy of his tragic death is that these changes will make a difference and help to save some other family the grief and distress they have suffered.

The focus of this work is to put the system that prevailed in August 2006 under the microscope, to learn lessons from it and to try to find ways of preventing it happening again.

The Commission recommends that a new and better way of working be adopted, with newly designed protocols which include practical and unambiguous standardised guidance for the management and transfer of prisoners, with particular reference to mentally disordered offenders. The design and implementation of these protocols will require the best endeavours of everyone in the Prison Service, the Forensic Mental Health Service and all others who provide professional services to prisoners.

▪ Outline

The Commission is required by paragraph 3 of its Terms of Reference to make recommendations as to what cost-effective policies and / or legislative measures could be adopted to improve the management of prisoners with specific behavioural problems or vulnerabilities – in particular:

- prisoners with psychiatric problems
- violent or disruptive prisoners
- prisoners in need of additional protection

In making such recommendations the Commission is required to do so with a view to:

- promoting the safety and health of prisoners
- providing a secure and safe environment for prisoners and persons dealing with prisoners
- safeguarding the public interest

The Commission has also necessarily included in its Final Report recommendations arising from specific aspects of its investigation into the care and management of Gary Douch and Stephen Egan.

The recommendations of the Commission have been grouped under five main headings which derive from the Commission's Terms of Reference. The following subheadings include relevant and sometimes overlapping themes.

1. The death of persons in custody
2. Mental health care and treatment of prisoners
    - Infrastructure and Resources
    - Protocols and Policy

3. Management of risk in the prison system

    - Accommodation
    - Communication
    - Violent / disruptive prisoners
    - Prisoners on protection
    - Risk management

4. Transfer of prisoners between prisons

5. Changes in Irish prison law

The Commission recognises that many essential improvements have been put in place since the death of Gary Douch and acknowledges the considerable work done in that regard by the various stakeholders who are tasked with delivering prison management, healthcare and the numerous other services within the Irish Prison System.

The Commission supports the approach and initiatives undertaken by the Cross Sectoral Team, a collaboration between the Departments of Justice and Health working together to implement the recommendations of the policy document *A Vision for Change* (Department of Health and Children, 2006).

The Commission is also optimistic that the Irish Prison Service Three Year Strategic Plan 2012-2015, published in April 2012, will substantially improve the prison service.

The Commission believes that all 'alternatives to custody' options need to be considered, to reduce the prison population to safe levels. The implementation of alternative sentencing options could deliver measureable benefits all round including significant cost benefits.

In formulating its recommendations the Commission has adopted the "S.M.A.R.T.E.R". criteria used in project management and has endeavoured to ensure, as far as possible, that each recommendation is Specific, Measurable, Attainable, Relevant, Time-bound, and

amenable to Evaluation and Re-evaluation. These criteria are further explained in the Appendices to this report.

In respect of each recommendation an indication is given as to whether achieving its designated outcome (i) will involve a "Cost Burden" in the sense that budgetary provision will need to be made or (ii) will be "Cost Neutral" in the sense that it can reasonably be expected to be delivered within existing budgetary constraints.

The Commission considers that the primary legislative changes recommended in Part 5 should be put on the statute book subject to the timetable of the *Oireachtas*.

Consideration should be given to the use of secondary legislation by way of statutory instrument to enable any of the overall changes envisaged by the recommendations to be given greater force and certainty in Irish law.

However the Commission considers that the emphasis should be on immediate and expeditious delivery of the objectives targeted by the recommendations so that all; both prisoners and those who take care of them can obtain the maximum benefit from the deliberations of the Commission.

Central to the Commissions' recommendations are that consideration be given to the preparation of new Protocols in respect of management and movement of prisoners, with particular focus on certain categories of prisoners. This process could usefully include collating the policies, rules, regulations, laws and orders we already have. From these sources, practical guidance, standardised forms and checklists could be drawn up which can be more easily followed and monitored by the people who have to carry out the day to day running of the prisons. The Commission believes that this will provide better tools for everybody working in the Prison system. A "fit for purpose" I.T. system is a vital part of this. Essentially what is needed are different and better working practices. The Commission acknowledges that many issues it looked at, would benefit from further specific research beyond the scope of this work.

Not every eventuality or tragedy can be anticipated but not every change for better has to be crisis-driven.

While the main stakeholders are identified, the Commission considers that a joint collaborative approach by all stakeholders is to be preferred in order to ensure the most effective delivery of the improvements identified by the recommendations.

The value of a thorough multi-disciplinary assessment and screening process carried out when a prisoner first arrives in prison cannot be overestimated. This attention to detail from the outset, capturing all information possible, will inform better decision making regarding the risks and vulnerabilities and management of prisoners.

For each recommendation and for ease of reference, a tag is given to signify the Minister and the Department responsible, the stakeholders and the cost factor involved.

In addition, an identifier for responsibility for facilitating future evaluation and re-evaluation has been added.

1 Death of Persons in Custody

1.1 A protocol to be followed in the event of the sudden and unexpected death of a prisoner and incorporating best practice guidance should be drawn up within three months of the date of publication of this report.

1.2 The Protocol should require that at a minimum two prison officers, (or delegated persons such as a member of the Gardaí and a Prison Chaplain if there is a perceived risk to prison officers attending the home of the next of kin) of whom one must be at senior management level, should travel to the home of the next of kin to inform them immediately of the death or risk of death and accompany that person or persons to the hospital or prison as the case may be.

1.3 The Protocol should require that a suitably qualified person, preferably a social worker be appointed to act in a supportive role to advise and assist the family to cope with the sudden death, and to act as a liaison between the bereaved family and the authorities.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Health Justice	IPS Prison Medical Service Forensic Mental Health Service Regimes Directorate	Director of Healthcare, IPS Prison Chaplains Regimes Directorate	Neutral

2 Mental Health Care & Treatment in Irish Prisons

Infrastructure and Resources

2.1 The Central Mental Hospital should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and its capacity should be maximised, as recommended in the policy document *A Vision for Change* (Department of Health and Children, 2006).

2.2 Immediate consideration should be given to opening up additional "designated centres" under the Criminal Law (Insanity) Act 2006 to ensure more effective and efficient delivery of forensic mental health services across the Irish Prison System.

The Central Mental Hospital is currently the only "designated centre" for the reception, detention, care, and treatment of persons committed or transferred thereto under the provisions of the 2006 Act.

2.3 Consideration should be given to locating appropriately resourced "designated centres" within the grounds of prisons. This would allow mentally disordered offenders for whom a high level of security is required to be treated promptly in a proper clinical hospital setting with full 24/7 medical staff and integral "step-down" facilities in situ.

The Commission believes that this might also aid the development of multi-disciplinary team working.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Health Justice	IPS Prison Medical Service Forensic Mental Health Service	Director of Healthcare, IPS	Burden

2.4 Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region, as recommended in the policy document *A Vision for Change* (Department of Health and Children, 2006).

2.5 Urgent consideration should be given to introducing a mandated "Step-down" programme as part of the on-going care plan for all prisoners who have or are receiving psychiatric care and treatment as an in-patient or care and treatment as an out-patient. Its duration should be tailored to the particular patient's clinical needs, but should not be for a period of less than one month. This should include special directions regarding accommodation provision, a plan for multi-disciplinary involvement and heightened supervision and monitoring to prevent or detect relapse and thereby afford the possibility of immediate response and intervention. Such a procedure should be incorporated in any Care and Treatment Protocol and its efficacy evaluated and revised periodically.

2.6 The Forensic Mental Health Service should be expanded and reconfigured so as to provide enhanced court diversion services and supporting legislation should be devised to allow this to take place, as recommended in the policy document *A Vision for Change* (Department of Health and Children, 2006).

2.7 Consideration needs to be given as to whether the provision of a separate specialist facility that can offer care and treatment to mentally disordered offenders who also have personality disorders would be worthwhile.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Health Justice	IPS Prison Medical Service Forensic Mental Health Service	Director of Healthcare, IPS Forensic Mental Health Service Inspectorate of Mental Health Services	Burden

2.8 The services of the Health Information and Quality Authority (HIQA) should be extended to all prison healthcare facilities.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Health Justice	IPS Prison Medical Service Forensic Mental Health Service	Director of Healthcare, IPS Regimes Directorate	Neutral

2.9 Consideration should be given to expanding psychology services to prisons. Doing so would enhance risk assessment and screening, provide support, care and treatment to prisoners, and would contribute to the development of multi-disciplinary healthcare models. Psychology services have an important role to play in devising the protocols recommended by the Commission in the areas of risk assessment and screening, in designing and delivering behaviour modification programmes for prisoners, and in assisting the development and implementation of integrated sentencing management and enhanced regimes and in making significant contributions to staff training programmes.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Health Justice	IPS Psychology Service Prison Medical Service Forensic Mental Health Service Regimes Directorate	Director of Healthcare, IPS Prison Chaplains Regimes Directorate	Burden

2.11 In order to support the delivery of prison mental health services, awareness training on mental health and learning disabilities should be made available for all prison officers. The training programme must be developed in conjunction with service users and where appropriate, training should be undertaken jointly with other services to encourage shared understanding and partnership working.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS Prison Officers Association The Governors of all prisons IPS Training and Development Centre Prison Medical Service Psychology Service Forensic Mental Health Service	Director of Healthcare, IPS Prison Officers Association Psychology Service	Neutral

Protocols and Policy

2.12 As a matter of urgency all stakeholders involved in the health care of prisoners should collaborate with a view to developing a Protocol for the Care and Treatment of Prisoners with Mental Disorders, to be completed within twelve months of the date of publication of this report and implemented as soon as practicable thereafter.

2.13 The Protocol when drawn up must have regard to the following rights and principles:

a The right of every prisoner to equivalence of care and treatment as compared with persons outside of the prison system

b The right of every prisoner to receive mental health care and treatment from the non-forensic mental health services unless there are cogent legal or public policy reasons why this should not be done

c The principle that forensic mental health services should be person-centred, recovery oriented and based on evolved and integrated care plans arising from a multi-disciplinary approach to health care and treatment.

d The principle that prisoners should be referred to secondary mental health services only in circumstances where the primary health care available in the prison is not sufficient to ensure their proper care and treatment in an appropriate and safe environment.

e Recognition that appropriate provision should be made for the care and treatment of "dual diagnosis" prisoners, that is, prisoners with drug / alcohol problems as well as mental health problems. Such provision should reflect the need for mental health services and substance abuse services to work closely together in seeking to address the needs of such prisoners.

f Recognition that separate provision for those prisoners diagnosed with both personality disorders and mental illness may be warranted and should be considered.

g Recognition of the importance of ensuring continuity of care, particularly for prisoners returning to the prison system having received in-patient care at the Central Mental Hospital.

h Recognition of the fact that health services require support from the rest of the prison system to ensure that the prison environment supports the health, emotional wellbeing and mental health of prisoners as far as possible.

i Recognition of the importance of encouraging prisoner participation in activities which promote their rehabilitation, self-improvement, behaviour modification and life skills including literacy and education, self-care, anger management, cognitive therapy as well as opportunities for reading, painting, music, exercise, and the opportunity of receiving counselling and support from others.

j Recognition of the importance of reconciling the Care and Treatment protocol for the prisoner with his/her integrated sentence management plan.

2.14 The Protocol should take into consideration the recommendations made in relation to forensic mental health services in the reports entitled *A Vision for Change* (Department of Health and Children, 2006) and *Forensic Mental Health Services for Adults in Ireland* (Mental Health Commission, 2011). The Commission adopts and endorses these recommendations, which can be found in full in section 1.1 of this Report.

2.15 The Protocol should adopt and incorporate the relevant parts of the Health Care Standards published by the Irish Prison Service in 2009, particularly Standard 3 (which relates to the provision of mental health services in the prison system) and Standard 4 (which relates to the transfer, release and through-care of prisoners).

2.16 The Protocol should adopt and implement the specific recommendations of the Commission numbered 2.17 – 2.34 below.

2.17 When prisoners are undergoing a mental health assessment, this should include a full and detailed assessment of the risk which the prisoner may pose to themselves, other prisoners, prison staff, and to persons visiting the prison.

2.18 No prisoner who is receiving mental health care and treatment or who is under on-going review by the Psychiatric In-Reach Service may be moved within a prison or transferred to another prison without the consent in writing of a member of the Psychiatric In-reach Service.

2.19 Before agreeing to any proposed transfer of a prisoner to another prison, the Governors of the transferring and receiving prisons must ascertain if the prisoner requires on-going mental health care and treatment, and whether such care and treatment can be provided at the receiving prison.

2.20 When a prisoner is transferred to the Central Mental Hospital or another designated centre pursuant to s.15 of the Criminal Law (Insanity) Act 2006, the Governor of the transferring prison and the Clinical Director of the designated centre should

communicate in writing with the Mental Health (Criminal Law) Review Board to confirm the details of the transfer so that the Board can expeditiously discharge its function pursuant to section 17 of the 2006 Act.

2.21 Where the Clinical Director of the Central Mental Hospital or another designated centre forms the opinion that a prisoner no longer requires in-patient treatment at a designated centre but will require on-going out-patient treatment and review, that prisoner should not be returned to the prison system unless and until he or she can be returned to a prison where the required out-patient care and treatment can be provided.

2.22 When the Clinical Director of the Central Mental Hospital or another designated centre consults with the Minister for Justice (or his delegated representative) prior to ordering the transfer of a prisoner back to the prison system under s.18 of the Criminal Law (Insanity) Act 2006, the Clinical Director must inform the Minister in writing of any on-going requirements for care and treatment of that prisoner, and must advise the Minister as to what prison, prisons or area of a prison can provide such care and treatment.

2.23 Where, following consultation between the Clinical Director of a designated centre and the Minister for Justice, a decision is made to return a prisoner receiving in-patient treatment at the designated centre to a specified prison, the Minister (or his representative) must certify in writing that the Minister is satisfied that all on-going requirements for care and treatment of that prisoner can be met at the specified prison.

2.24 Transfers of a prisoner from the Central Mental Hospital or another designated centre to a prison should not take place late in the evening, at weekends or when medical staff are not available to receive the prisoner on his or her arrival.

2.25 A prisoner who is returned to the prison system from the Central Mental Hospital or another designated centre must be met and reviewed by a prison doctor and referred to the a member of the Psychiatric In-reach Service within two hours of his or her arrival at the prison.

2.26 A prisoner who is returned to the prison system from the Central Mental Hospital or another designated centre must be accompanied by a Discharge Summary from the designated centre, outlining any on-going requirements for care, treatment, medication, and review. A copy of the Discharge Summary should also be sent to the Director of Prison Health Care for the Irish Prison Service.

2.27 A prisoner who is returned to the prison system from the Central Mental Hospital or another designated centre should be accommodated in a single cell and kept under close observation unless and until he or she is reviewed by a psychiatrist who confirms in writing that the prisoner can share a cell with other prisoners and that all arrangements have been put in place for his or her on-going mental health care and treatment.

2.28 Access by visitors to prisoners who have recently been discharged from the Central Mental Hospital or another designated centre should be regulated by guidelines which protect the health and safety of both the prisoner and the visitor.

2.29 Records of all medication prescribed and administered to prisoners as a result of any psychiatric treatment or review must be strictly maintained. Administration records for such medication should be signed by two medical dispensing staff in order to enhance the clinical monitoring of compliance with prescribed medication. Refusal to take medication or suspicion about non-compliance or suspicions regarding other substance use/abuse must be documented and reported to the prison GP who should then refer the matter to the HSE Psychiatric In-Reach Service. Administration records for such medication should be checked regularly by the prison medical doctor and by the Psychiatric In-Reach Service.

2.30 A prisoner in receipt of mental health care and treatment on an out-patient basis should continue to be kept under regular review by the Psychiatric In-reach Service and by the prison medical staff until a member of the Psychiatric In-reach Service certifies in writing that such review is no longer necessary.

2.31 Information concerning a prisoner's health care and treatment must be recorded clearly, reliably and with sufficient detail to ensure that any decision made concerning

that prisoner's care and treatment is made with access to all the information relevant to that decision. The information recorded should include not only the substance of any medical intervention or review, but should also clearly identify the person or persons responsible for each intervention or review.

2.32 When a prisoner has been diagnosed with a condition requiring care and treatment at the Central Mental Hospital or another designated centre, then as a matter of urgency arrangements should be made for a bed to be provided at the CMH or a suitable designated centre within 72 hours, so that any decision to transfer him/her under s.15 of the 2006 Act can be put into effect at once.

2.33 With due respect for the confidentiality of prisoners' medical files, the Governor of a prison should be kept informed by prison medical staff and by the Psychiatric In-reach Service of any risk posed by a prisoner who is undergoing mental health care and treatment, to themselves, to other prisoners, prison staff and visitors to the prison.

2.34 A protocol should be devised by the Irish Prison Service in conjunction with the National Forensic Mental Health Service setting out the circumstances in which information about a prisoner's mental health care and treatment should be disclosed by prison medical staff and / or members of the Psychiatric In-reach Service to operational staff in a prison and / or the senior management of the Irish Prison Service.

2.35 The Director of Prison Healthcare for the Irish Prison Service should be given the power to review prisoners' individual medical files or, where appropriate, to appoint an independent medical expert to review such files. If necessary, legislation should be devised to give effect to this power.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Health Justice	Forensic Mental Health Service Prison Medical Service The Prison Psychology Services IPS	Clinical Director, CMH Director of Healthcare, IPS Mental Health Commission Regimes Directorate	Neutral

3 Management of Risk in the Prison System

Accommodation

3.1 The elimination of enforced cell-sharing should remain the objective of the Prison Service, and the achievement of this goal should be regarded as a high priority.

3.2 If the resources currently available to the Prison Service are insufficient to produce a significant decrease in enforced cell-sharing, central government should allocate further funds to the Prison Service to enable more prisoners to be accommodated in cells on their own.

3.3 The Prison Service should review whether the resources currently available to it might be better deployed towards achieving this goal, without compromising standards in other areas, and should set a date for realising this objective.

3.4 All cells used to accommodate prisoners should meet the requirements of the Inspector of Prisons as set out in his report, *Standards for the Inspection of Prisons in Ireland* (July 2009).

3.5 All "special cells" (i.e. safety observation and close supervision cells) used to accommodate prisoners should meet the requirements of the Inspector of Prisons as set out in his *Report of an Investigation on the Use of 'Special Cells' in Irish Prisons* (August 2010).

3.6 All decisions about who a prisoner should share a cell with should be made, if possible, by a senior officer. If that cannot be done, the decision should be reviewed by a senior officer within 24 hours. The suitability of prisoners to continue to share with each other should be reviewed at regular intervals, by the Assistant Chief Officer responsible for that section of the prison.

3.7 The Prison Service should publish guidelines to assist officers in allocating cells to those prisoners who have to share a cell, with particular emphasis on the assessment of risk and the need to identify and protect vulnerable prisoners.

3.8 Wings holding sentenced and remand prisoners together should be kept to a minimum, and should only be used when there is no operational alternative.

3.9 All cells used for accommodation must allow adequate viewing and audibility from the point of view of the supervising officers.

3.10 All cells used for accommodation must have an alarm facility which is easily accessible to the prisoners, and which is capable of providing an immediate response from the prison officers on duty. This alarm system should be checked regularly to ensure that it is in full working order.

3.11 Enhanced regimes should be developed as soon as possible – preferably within the 12 months of this Report – and rolled out in every prison, linked to a prisoner's integrated sentence management. An area of each prison should be identified and designated for the implementation of an enhanced regime where incentivised freedoms and responsibilities can be afforded to those prisoners deemed suitable. The admission criteria for this regime must be predetermined and follow a suitability (multi-disciplinary) assessment. Many prisoners are subjected to far greater restrictions within prisons currently on a "one size fits all" antiquated security model that inhibits rehabilitation and carries far greater cost implications. This would create an effective mechanism for rewarding co-operation and good behaviour and formalise a system for effective rehabilitation. It should include setting targets and personal goals for individual prisoners with resulting rewards for achievement. The present system of giving all prisoners the same privileges regardless of their behavioural patterns and subjecting all prisoners to the same restrictions regardless of their offences and conduct is inefficient, inhumane, and costly. The focus should be on rehabilitation, progression, and normalisation. The evidence emerging from the evaluation of these regimes elsewhere is that they contribute enormously to the morale and efficiency of prisons for everybody, staff, and prisoners alike, and deliver better outcomes for prisoners and significantly reduce reoffending.

Those prisoners who carry greater risk for whatever reason could also then be managed more effectively with more specialised supervision and input into their sentence management.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS The Governors of all prisons Prison Medical Service Forensic Mental Health Service Psychology Services Regimes Directorate	Director of Operations, IPS Director of Healthcare, IPS Inspector of Prisons Regimes Directorate	Burden

Communication

3.12 Within 12 months from the date of publication of this Report the Irish Prison Service should publish a model procedure dealing with how establishments should bring Prison Service Orders and other instructions, whether national or local, which affect the management of prisoners, to the attention of staff. The model procedure should be regarded as having been adopted by any establishment which does not produce one of its own.

3.13 Governors should ensure that any relevant comments or recommendations in external reports about their establishments which have implications for the safety of prisoners be brought to the attention of the workforce.

3.14 Every establishment should appoint an officer not below the grade of governor to be responsible for overseeing the flow of information relevant to the management of risk. Such an officer should ensure that systems are in place for the transfer of information within an establishment and that the systems are being followed. They should take action when they find that they are not, and should review the arrangements periodically to ensure best practice is being maintained.

3.15 Where a prisoner is to be transferred from one prison to another, the senior officers who sanction the transfer in both prisons have a duty to apprise themselves of any available risk assessment information concerning that prisoner before the transfer is approved. This duty applies also to the relevant IPS official who deals with the transfer request.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS The Governors of all prisons	Director of Operations, IPS Director of Healthcare, IPS	Neutral

Violent / Disruptive Prisoners

3.16 The IPS must take active responsibility for the identification and management of violent and disruptive prisoners across the prison system. Their method for doing so could be assisted by, or delegated to, or even overseen by a Violent and Disruptive Prisoners Strategy Group to be set up and jointly managed by the IPS Director of Operations in conjunction with the IPS Director of Prison Health Care, in order to achieve more effective management of this prisoner group.

3.17 The Strategy Group should meet regularly, preferably monthly but at a minimum, a quarterly basis, and ensure input from all relevant prison staff and service providers, including:

a The Governors of every prison in the State

b The Prison Officers Association

c Prison Medical Service

d The National Forensic Mental Health Service

e The Prison Psychology Services

f The Prison Chaplains

g Probation and Welfare Service

h An Garda Síochána – when appropriate

3.18 The Strategy Group should focus in particular on the following matters:

a designing a criteria-based screening and assessment model for identifying prisoners in the violent and disruptive risk category

b identifying risk groups

c identifying common causes / triggers causes of disruptive behaviour in individual cases and on devising plans to address these

d effective monitoring and oversight of any use of psychotropic drugs, sedatives and related medications in the treatment of disruptive prisoners (including devising a protocol and documentation/forms the reasons for such use)

e the systematic assessment, recording and communication of risk which is essential to the proper management of disruptive and violent prisoners

f effective and proper record-keeping and communication of necessary information between relevant personnel

3.19 The minutes of all Strategy Group meetings should be recorded.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS The Governors of all prisons The Prison Officers' Association Prison Medical Service The Prison Psychology Services The Prison Chaplains Probation and Welfare Service An Garda Síochána – when appropriate Forensic Mental Health Service	Director of Operations, IPS Director of Healthcare, IPS Regimes Directorate	Neutral

Prisoners on Protection

3.20 Within six months of the date of publication of this Report the Irish Prison Service should draw up a Protocol for the Management of Prisoners on Protection. This should be done in conjunction with the development and implementation of a formal system for identifying, assessing, categorising, communicating, and managing risk throughout the Irish prison system.

3.21 The Protocol should emphasise that the safety of protection prisoners is and should be the paramount concern of those responsible for their management. Within the constraints imposed by this duty, the management of protection prisoners should be carried out with a view to minimising any additional loss of liberty or loss of access to resources, educational, recreational, medical, or otherwise.

3.22 The Protocol should provide standard procedures (including document templates) for the assessment, conferring, monitoring, review, and removal of protection status for prisoners throughout the prison system.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS The Prison Psychology Services Prison Medical Service Forensic Mental Health Service Regimes Directorate	Director of Operations, IPS Director of Healthcare, IPS Prison Chaplains Regimes Directorate	Neutral

Risk Management

3.23 Within 12 months of the date of publication of this Report the Irish Prison Service should develop and implement a Protocol on the Management of Risk in the prison system. The Protocol, which should be developed with input from the National Forensic Mental Health Service and An Garda Síochána, will set out a formal system

for identifying, assessing, categorising, communicating, and managing risk throughout the Irish prison system.

3.24 The Protocol should address the sharing of intelligence information the Gardaí may have about prisoners which could affect their management in prison, via the establishment of Garda liaison officers for the relevant establishments where the prisoners are being held.

3.25 The Protocol should address the recording, evaluation and disclosure of information received by the Prison Service from visitors to the prison – whether friends, family members, members of the public and legal or medical professionals – which could affect the risk management of a prisoner or prisoners.

3.26 The Commission further recommends that any visitor to a prisoner should be informed, not merely of their right but their obligation to make a confidential disclosure to the Governor and the IPS if they had any concerns about the health and safety of the prisoner and to feed back information on a strictly confidential basis about any concerns they had for their own safety or the safety of other prisoners to the Governor of the prison concerned.

3.27 The computerised records system for the Irish Prison Service should include a facility for an "alert" to appear if information is discovered or held on prisoners which could affect their management but which is too sensitive for wider dissemination. An officer at the grade of Chief Officer or above should be able to ask the Governor of the prison for that information. The Governor should be able to refuse the request, or grant it on condition that the senior officer does not disclose the information to anyone or on certain terms and conditions which might include that the senior officer can tell their wing staff about it on grounds of necessity to protect the prisoner himself, staff, and other prisoners.

3.28 Any incident involving any inappropriate behaviour against a staff member should be thoroughly debriefed and reviewed with that staff member and his line manager or the Governor so as to assess and address the effect of the incident on that staff member and the possible implications for other staff members. The primary objective must be

to meaningfully support that officer, and gain insight into ways of avoiding similar future incidents. Consideration should also be given to official commendation of staff member for any outstanding behaviour.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS Forensic Mental Health Service The Prison Psychology Services An Garda Síochána Prison Medical Service	Director of Operations, IPS Director of Healthcare, IPS	Neutral

4 Transfer of Prisoners between Prisons

4.1 Within six months of the date of publication of this Report a Protocol on Transfers of Prisoners should be drawn up by the Irish Prison Service to standardise and clarify the factors which must be considered when any transfer of a prisoner is being proposed.

4.2 Matters to be addressed by the Protocol should include the following:

a the capacity of a receiving prison to accommodate a given prisoner

b the timing of transfers

c the need to consider the health care requirements of the prisoner to be transferred

d the best interests of the prisoner

4.3 The Prison Rules 2007 should be amended to include the rules on transfers as set out in the proposed Protocol on Transfers of Prisoners.

4.4 The Commission recommends that The IPS and the proposed Disruptive Prisoners Strategy Group should reflect seriously upon and devise a strict detailed protocol regarding the use of a "carousel policy" in the short-term management of disruptive prisoners. The Commission is not generally in favour of its use as a mechanism for short-term management of prisoners. If such a policy is utilised, the IPS and the relevant prison Governors should strive to avoid a lack of coherent oversight regarding the long-term management of (including record keeping for) any prisoners involved.

4.5 The IPS and the prisons involved should monitor the frequency of transfers in order to ensure that there is at least one agency or person with an effective overall responsibility for the prisoner's management.

4.6 The IPS and the prison staff should pursue careful enforcement and compliance with any official policy for transporting prisoners, with particular reference to the number of staff to escort each prisoner

4.7 Transfers of prisoners based on a "swap" alone should not be considered – regard should be had to all factors outlined in other recommendations.

4.8 The Minister for Justice and the IPS should retain overall control of all transfers of prisoners in the Irish Prison system and the Prison Rules should be amended to codify this.

4.9 No transfer should ever take place without:

a the written consent and approval of the IPS

b the acknowledgment of that consent by the Governors of the transferring and receiving prisons

4.10 All sides involved in an inter-prison transfer must take steps to ensure that they are as fully informed as possible, through the full and transparent sharing of all relevant information concerning any prisoners (incoming or outgoing) who are involved.

4.11 When considering the transfer of a prisoner, regard should be had to (in addition to other relevant factors) the necessity for such transfer to take place.

4.12 The reason or reasons for the transfer of any prisoner should be properly articulated and recorded on the single computer system recommended by the Commission.

4.13 The IPS must take a primary or supervisory role in the transfer of prisoners between prisons.

Ministers Responsible	Stakeholders	Facilitators for Evaluation/Re-evaluation	Cost
Justice	IPS Prison Medical Service Forensic Mental Health Service	Director of Operations, IPS Inspector of Prisons	Neutral

5 Changes in Irish Prison Law

The Commission recommends consideration be given to the following:

1. **Definition of "Mental Disorder"**

The Criminal Law (Insanity) Act 2006 (as amended by the Criminal Law (Insanity) Act 2010) incorporates specific elements of the Mental Health Act 2001, which deals with the care and treatment of mentally ill persons outside of the prison system.

In the 2001 Act the concept of "mental disorder" is defined in section 3 as follows:

> *"**3.**—(1) In this Act 'mental disorder' means mental illness, severe dementia or significant intellectual disability where—*
>
> > *(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or*
> >
> > *(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission*
>
> *the reception, detention, and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent."*
>
> *(2) In subsection (1) –*
>
> *"mental illness" means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons*

> *"severe dementia" means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression*
>
> *"significant intellectual disability" means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person."*

This definition from the 2001 Act is adopted explicitly by the 2006 Act in relation to certain matters, such as the power of the court to order in-patient care and treatment at a designated centre for a person who has been convicted or found not guilty by reason of insanity.

However, in relation to the transfer of prisoners from a prison to a "designated centre" such as the Central Mental Hospital for treatment, the 2006 Act employs a different and less comprehensive definition of "mental disorder" than that contained in the 2001Act. Section 1 of the 2006 Act provides:

> *"**1.** – In this Act, save where the context otherwise requires –*
>
> *…*
>
> *"mental disorder" includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication..."*

Where an ordinary citizen requires in-patient treatment at the Central Mental Hospital, the definition of "mental disorder" as set out in the 2001 Act is applied. It seems right that once a citizen comes under the care of the State through the criminal justice system, the same definition should be applied in considering whether that person requires in-patient treatment for a mental disorder. This is particularly so given the fact that remand prisoners are innocent until proven guilty. And since no justification can be made for treating remand and convicted prisoners differently from the point of view of requiring in-patient care and treatment the Commission considers that the 2006 Act should be amended to ensure consistency in treatment throughout the prison system. This will also ensure due regard for the principle of

equivalence of care which is a benchmark of international standards for the treatment of prisoners.

The Commission therefore recommends that consideration be given to amending the 2006 Act so as to ensure that the definition of "mental disorder" contained in the 2001 Act is employed throughout the 2006 Act.

2. Mental Health (Criminal Law) Review Board

Section 17 of the 2006 Act gives the Mental Health (Criminal Law) Review Board powers to review the detention of a prisoner in a designated centre such as the Central Mental Hospital.

Under subsection (3)(b) of section 17, if the Board is satisfied that the prisoner no longer suffers from a mental disorder for which he or she cannot be afforded appropriate treatment within the prison from which they were transferred to the centre, then the Board may, after consultation with the Minister for Justice, order the prisoner to be transferred back to that prison or to such other prison as the Minister considers appropriate in the circumstances.

The Commission notes that section 13 of the 2006 Act, which deals with the review by the Board of accused persons either deemed unfit to be tried or found not guilty by reason of insanity, gives the Board power to make orders for discharge which can be made *"... subject to conditions for out-patient treatment or supervision or both."*

The Commission recommends that consideration be given to amending s.17 of the 2006 Act to allow the Mental Health (Criminal Law) Review Board to impose conditions for out-patient treatment, supervision or both when ordering the transfer of a prisoner detained under s.15 of the 2006 Act back to prison.

3. Transfer of Prisoners Back to Prison

Section 18 of the 2006 Act empowers the Clinical Director of a designated centre, following consultation with the Minister for Justice, to direct that a prisoner who is no longer in need of in-patient care or treatment be transferred back to the prison from which he or she came, or to such other prison as the Minister for Justice considers appropriate.

As with the powers of the Mental Health (Criminal Law) Review Board under section 17 considered above, it seems sensible that section 18 be amended to give the Clinical Director express powers to make such transfer orders subject to conditions for out-patient treatment or supervision or both. The Commission recommends that consideration be given to amending s.18 of the 2006 Act in such terms.

4. Equivalence of Care and Treatment

Section 4 of the Mental Health Act 2001 imposes express statutory duties on those persons who make decisions about care and treatment of persons under the 2001 Act. Subsection (1) provides:

> "*In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made."*

Subsection (3) provides:

> *"In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy."*

It seems only right that similar duties should apply to those who make decisions about the care and treatment of prisoners under the Criminal Law (Insanity) Act 2006.

The Commission recommends that consideration be given to amending the 2006 Act by the insertion of provisions analogous to sections 4(1) and 4(3) of the Mental Health Act 2001.

5. Hospital Orders

Consideration should be given to the introduction of Hospital Orders into the Criminal Law (Insanity) Act 2006.

Hospital Orders are an important feature in the 1983 Mental Health Act UK (section 37) and are universally regarded as a useful and humane option for the Courts in dealing with mentally disordered offenders.

They allow a Court to make a hospital or guardianship order as an alternative to a penal disposal for mentally disordered offenders who are found (by two medically registered practitioners) to be suffering from a mental disorder at the time of sentencing such as to necessitate their detention in hospital or reception into guardianship. No causal relationship has to be established between the offender's mental disorder and his criminal activities.

Information regarding this legislative measure will be included in the Appendices to this Report.

6. Community Treatment Orders

Community Treatment Orders have become well established features of various common law jurisdictions including those in North America and Australia. Its introduction into England and Wales was a central element of the government's reform of the Mental Health Act 1983 which resulted in the enactment of the 2007 ACT. Community Treatment Orders are also a feature of Scottish Law although it has to be said that there is no single form of Community Treatment Order and its introduction has been controversial.

What is common to all Community Treatment Orders is the desire to provide a regime for patients who are assessed as being able to function in the community so long as they accept medication but who may disengage from treatment and relapse to the extent that they require in– patient treatment. These patients often become "revolving door" patients to both hospitals and prisons. The Order allows for Treatment in the community previously unavailable out of a hospital setting.

The Commission recommends that research into the efficacy of Community Treatment Orders in the UK and elsewhere should be carried out with a view to considering whether their introduction into our legislation would be beneficial.

Their introduction though peripheral to this inquiry could provide both a safety net and a means of pre-empting deterioration in the mental health of certain patients in the community,

including for the small number of those patients whose mental disorder may have been associated with aggression or violence or other offending.

Information regarding this legislative measure is included in the Appendices to this Report.

7. Investigation of Deaths in Custody

When a death occurs in our prisons three separate investigations can take place, a Garda investigation, the Coroner's investigation, and an internal investigation by the prison authorities. A fourth investigation conducted by a Commission of Investigation may also occur.

The European Court of Human Rights' position is that the procedural obligation may be satisfied by a combination of processes. The requirements do not need to be satisfied through a single process.

The Inspector of Prisons Judge Michael Reilly is satisfied that provided the investigation process taken as a whole fulfil the Jordan requirements (Jordan v The United Kingdom) Judgment 4th May 2001 the procedural aspect of Article 2 should not be violated.

The Inspector of Prisons in his Report, *Guidance on best practice relating to the Investigation of Deaths in Prison Custody*, 21st December 2010,[2] recommended that the establishment of a system similar to the Garda Ombudsman Commission which undertakes independent investigation of all deaths in Garda custody could be considered.

On 19th April 2012 the Minister for Justice announced that, following consultation with the Inspector of Prisons, it had been decided that the death of any prisoner in the custody of the IPS should be the subject of an independent investigation by the Inspector of Prisons.

In an Assessment of the Irish Prison System (dated May 2013) the Inspector wrote:

> *"I accept that I do not have statutory backing for such investigations. Apart from the provisions of the Prisons Act 2007 and the Irish Prison Rules I do not have powers to enable me to compel witnesses to co-operate or to demand*

[2] *Guidance on best practice relating to the Investigation of Deaths in Prison Custody*, 21st December 2010

> *disclosure of documents. The Minister is aware of this and is committed to strengthening my powers in this regard in upcoming primary legislation."*

This Commission supports the introduction of new legislation governing the investigation of Deaths in Custody which codifies this process of investigation and introduces the independent element necessary under Article 2.

However the Commission recommends further consideration and reflection be given to the question whether by simply adding the burden of investigating deaths in custody to the already onerous responsibilities and workload of the Inspector of Prisons, the State is fully meeting its obligations under the European Convention of Human Rights in respect of the Investigation of Deaths in Custody.

8. Confidentiality of prisoner correspondence

Rule 44(1) of the Prison Rules 2007 states that a prisoner is entitled to send and receive letters from any one or more of the following persons or bodies:

- Their legal advisor
- A member of the Prison Visiting Committee
- The Minister
- The Chief Justice, the Presidents of the High Court, Circuit Court and District Court, and the presiding judge of the Special Criminal Court
- The European Court of Human Rights
- The European Committee for the Prevention of Torture (CPT)
- The Parole Board
- The Inspector of Prisons
- The Irish Human Rights Commission

- The International Committee of the Red Cross.

The Rule goes on to state:

> *"(3) A letter from a prisoner intended for a person or body referred to in this Rule shall be sent to that person or body without delay and shall not be opened before it is so sent.*
>
> *(4) A letter sent to a prisoner by a person or body referred to in this Rule shall be given to the prisoner without delay and shall not be examined to any greater extent than is necessary to determine that it is such a letter. If any such letter is to be examined, it shall only be opened in the presence of the prisoner to whom it is addressed."*

The Commission recommends that the list of persons or bodies cited in Rule 44(1) be amended to include (i) Commissions of Investigation and (ii) Tribunals of Inquiry.

9. Establishment of the Office of Prison Ombudsman

The establishment of an Office of Prison Ombudsman should be considered with a statutory remit to investigate prisoner complaints.

10. Language

When updating or incorporating any new provisions into our Mental Health legislation, consideration should be given to using modern contemporary language, one understood by both lawyers and psychiatrists.