



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

**Volume Two**

**Final Report**

**Sole Member: Gráinne McMorrow S.C.**



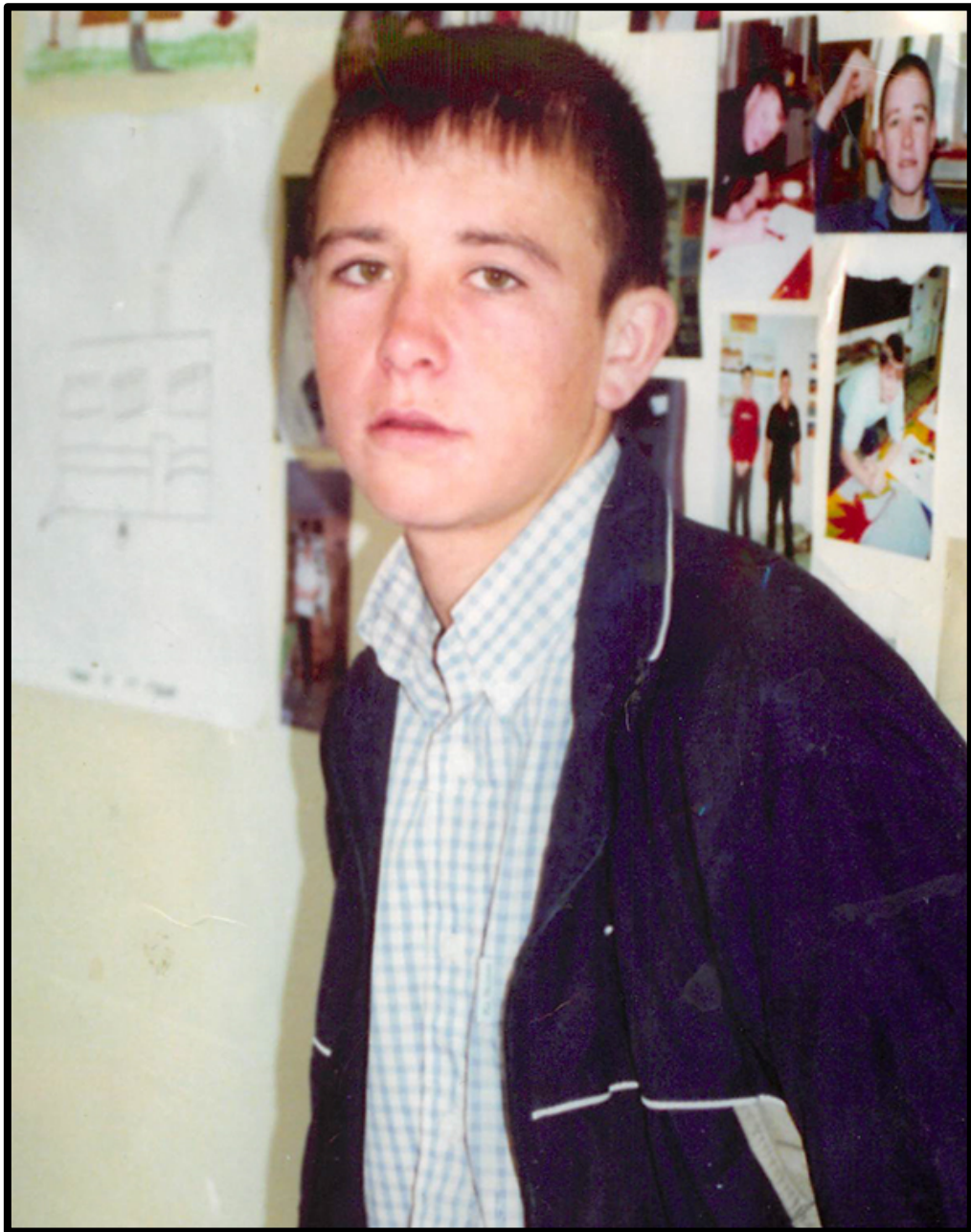
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# Introduction





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

*RIP*





## ▪ **Death of Gary Douch**

Gary Douch, a young man from Dublin, tragically lost his life in the early hours of 1<sup>st</sup> August 2006 following a fatal assault which took place in Mountjoy Prison. Mr Douch was just twenty-one years old when he died.

On 31<sup>st</sup> July 2006 Gary 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.

There were five other prisoners in the holding cell when Gary Douch arrived there. By 8.30 p.m. the cell contained as many as 14 prisoners. This number was reduced to seven (including Gary Douch) when the cell was locked for the night. All of these prisoners were categorised as “protection” prisoners.

During the night, Mr Douch was the victim of a brutal assault by 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. Gary Douch was pronounced dead at 7.35 a.m.

Gardaí investigating the incident arrested one of the prisoners, Stephen Egan, on 1<sup>st</sup> August 2006. Mr Egan was subsequently 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 29<sup>th</sup> October 2010. A further appeal on a point of law, though contemplated in 2011, was not ultimately pursued. The Commission’s Report could not have been completed until all criminal proceedings and appeals had been dealt with.

## ▪ **Report of Mr Michael Mellett**

On 1<sup>st</sup> August 2006, the then Tánaiste Mr Michael McDowell T.D. appointed Mr Michael Mellett, a former Senior Civil Servant in the Department of Justice to carry out an independent inquiry into the circumstances surrounding the death. Mr Mellett's terms of reference were as follows:

*“...to carry out an independent inquiry into the circumstances surrounding the tragic death of Mr Douch while in custody in Mountjoy Prison early this morning and in particular:*

- *to establish what action was taken by the IPS [Irish Prison Service], management and staff to safeguard Mr Douch*
- *to clarify whether Mr Douch had expressed special concerns about his safety*
- *to establish what procedures were followed and their adequacy*
- *to establish the procedures used to allocate prisoners to the cell in which Mr Douch died*
- *to establish the level of monitoring during the night of 31<sup>st</sup> July / 1<sup>st</sup> August 2006*
- *to make any observations and recommendations he sees fit”*

In the course of Mr Mellett's investigation, it became apparent that there were a number of significant issues arising from the death of Gary Douch, particularly with regard to the management and treatment of Stephen Egan (the prisoner accused of killing Mr Douch) in the weeks and months prior to the assault taking place.

Firstly, it emerged that Stephen Egan, the prisoner accused of killing Mr Douch, had a history of violent and disruptive behaviour within the prison system, including serious assaults on prisoners and staff.

Secondly, it became apparent that Mr Egan had a history of psychiatric problems, for which he had been treated in the Central Mental Hospital as recently as 5<sup>th</sup> – 14<sup>th</sup> July 2006, some 2 weeks prior to killing Mr Douch. Following his discharge from the Central Mental Hospital Stephen Egan was prescribed an anti-psychotic medication. Mr Mellett found evidence to suggest that he had not been taking this medication for some days prior to his assault on Gary Douch.

Further, it emerged that Stephen Egan had been transferred to Mountjoy Prison on Saturday 29<sup>th</sup> July 2006 from a single cell in a high security wing of Cloverhill Prison, at a time when Mountjoy Prison was operating well in excess of its capacity, and was consequently unable to house Stephen Egan with anything like the same level of physical security and psychiatric attention which was available in Cloverhill. Cloverhill prison was operating significantly below their prisoner capacity at the time.

Mr Mellett's Report was presented to the Tánaiste in March 2007. On the basis of legal advice from the Attorney General, it was decided that it should not be published because of a danger of prejudice to the criminal trial of Stephen Egan, the prisoner who had been charged with the murder of Gary Douch. Mr Egan was referred to throughout Mr Mellett's report as "Prisoner A".

On 23<sup>rd</sup> April 2007, the Tánaiste announced that a Commission of Investigation was to be set up to carry out more detailed and further inquiries into matters arising from the death of Gary Douch. Having thanked Mr Mellett for his report the Tánaiste went on to state:

*"There are serious implications for the future management of our prisons. It is now clear that a review going beyond the scope of the Mellett investigation's terms of reference is warranted. A detailed sworn inquiry is now essential. The issues are matters of public importance and the Government has agreed to my proposal that a statutory commission of investigation be established."*

## ▪ Establishment of the Commission

The Commission of Investigation into the death of Gary Douch in Mountjoy Prison (hereinafter referred to as "the Commission") was established by Order of the Government made under

section 3 of the Commissions of Investigation Act 2004 (hereinafter referred to as “the Act”) on 2<sup>nd</sup> May 2007.

I was appointed as Sole Member on 8<sup>th</sup> June 2007.

Notice of the Order of Government regarding my appointment, which also contained the terms of reference of the Commission, was published in the 27<sup>th</sup> July 2007 edition of *Iris Oifigiúil*. A copy of the Order of Government is contained in the Rules and Procedures of the Commission, which are appended to this Report.

## ▪ Terms of Reference

The Commission is required by its terms of reference to perform the following tasks:

*“To undertake a thorough investigation and make a report ... on the following specific matters: –*

*Following on from the report dated 2 March, 2007 of the Inquiry into the circumstances surrounding the death of Mr Gary Douch, a Prisoner in Mountjoy Prison by Mr Michael Mellett and without prejudice to any criminal or disciplinary proceedings, carry out any further investigations it considers necessary into the circumstances surrounding the death of Mr Gary Douch including in particular:*

- an examination of the chronology of treatment (including medical) and management (including transfers) of the individual identified in the [Mellett] report as ‘Prisoner A’ taking into account all available information and documentation in that regard and examining all persons whose testimony may throw light on the issues which arise*
- a review of policies, practices and procedures regarding the safety of prisoners in custody whether in prison, a place of detention, the Central Mental Hospital or other institution and in particular:*

- *a review of protocols for those prisoners with specific behavioural problems or vulnerabilities (psychiatric, violent or disruptive or those in need of additional protection)*
  - *a review of their application in this case*
  - *a review of any changes which have taken place since the 1<sup>st</sup> August 2006*
- *the making of recommendations on what cost effective policies and / or legislative measures could be adopted in the future for the management and treatment of such prisoners together with an estimate of the approximate implementation costs 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”*

## ■ Evidence Gathering - Discovery and Disclosure

The Commission made several requests – beginning from the earliest stage of its proceedings - for disclosure of all documentation with potential relevance to its Terms of Reference. It additionally took the step of issuing formal Directions for disclosure under section 16 of the Commissions of Investigation Act 2004, to all relevant agencies, intermittently between 2007 – 2013. However, despite this, many documents of importance only came to our attention either in an incomplete way or in a piecemeal fashion, out of sync or sequence, sometimes illegible or faint, lacking essential data or without a context that readily identified its significance. In fact many documents of importance were first disclosed to us only after the circulation of the Draft Report in April 2012.

While this is understandable taking account of the multi-agency involvement in the matters under scrutiny and the Commission's complex terms of reference, not having received all relevant materials at the appropriate time undoubtedly added to and prolonged the Commission's workload.

Discovery and disclosure are complex issues and are even more so when there is multi agency involvement, and it would be unfair not to acknowledge all the practical realities that flow from such requests, crossing as they do several professional disciplines and hierarchical boundaries. Often it is necessary to unearth archived documents sometimes from off-site locations. In addition given the fact that there are delegated responsibilities to different departments, agencies and sections for different classes and categories of files, it is no simple matter to track down every relevant document.

The Commission had its own difficulties in ascertaining specifically which documents and evidence existed, were discoverable, were directly relevant to its task and were needed to resolve key questions.

The Commission does not consider that there was any deliberate withholding of the documents or evidence it required but rather that the process of identifying, accessing and assembling everything of relevance was incompletely understood by those from whom disclosure was sought, and most certainly the net was not, initially at least, cast widely enough to capture everything the Commission needed for its tasks.

Even with the diligence of those liaising with the Commission it required forensic examination across all records and archives to locate all relevant documents. The late discovery of additional and sometimes conflicting evidence involved the Commission in the frustrating process of issuing further directions, conducting further investigations and being obliged to revisit certain evidence which in some instances even required further hearings.

The Commission received its last evidential disclosure documents on the 24<sup>th</sup> January 2014 and held its last hearings on the 9<sup>th</sup> and 16<sup>th</sup> December 2013.

**Part One**  
**The Irish Prison System and the Law**





## **1.1 The Prison System in Ireland**

### **Legal and Organisational Structure**

By virtue of its terms of reference the Commission must take cognisance of the state of the prison system in Ireland as it was in August 2006 when Gary Douch was killed, and also consider how it now stands at the date of this Report. There follows a description in summary form of the elements of that system. Where there have been any significant changes between the two dates these are noted. Further detail can also be found in the various appendices, references and the bibliography of this Report.

#### **Department of Justice**

As of 1<sup>st</sup> August 2006 political responsibility for the prison system in Ireland vested in the Minister for Justice and Equality (hereinafter referred to as the Minister for Justice). That legal position and structure has been and remains the case to date since the foundation of the State.<sup>1</sup> Prior to 1999, the task of overseeing the prison system was, in effect, carried out by sections of the Department of Justice.

#### **Irish Prison Service**

In 1996 the Government gave its approval in principle to the establishment of an independent prisons agency. Following the report of an expert group on the matter (published in 1997) the Irish Prison Service (IPS) was established in 1999. A Director General and a Prisons Board comprising 12 members were appointed. The Director General was given responsibility under the Public Service Management Act 1997 for the day-to-day management of the prison service.

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<sup>1</sup> The General Prisons Board (Transfer of Functions) Order 1928 transferred all jurisdictions, powers, duties, and functions of the previous authority, the General Prisons Board, to the Minister for Justice.

The IPS is not a statutory body; rather, it operates as an executive agency within the Department of Justice and Equality.<sup>2</sup> It is headed by a Director General supported by seven Directors. Until recently, a non-executive Prisons Authority Interim Board provided advice and guidance in the management of the prison system. However, this Board has now been disbanded, as part of cost-saving measures taking place across the prison system. The Department of Justice retains a Prisons Policy section, which liaises with the IPS.

The budget for the IPS is not independent, but comes under the aegis of the Department of Justice.

The functions of the IPS are divided into a number of Directorates, each headed by a Director who reports to the Director General. The most significant Directorates from the point of view of the Commission are the Directorate of Operations, which oversees the day-to-day running of the prisons, and the Directorate of Healthcare, which oversees the healthcare regimes in the prison system.

The IPS describes its role as follows:

*“The Irish Prison Service is responsible for the receipt of all persons held on remand, persons held on immigration related matters and offenders sentenced to terms of imprisonment and for the safe care and secure custody of all those committed to it by the courts. The Service is responsible for ensuring that convicted persons properly serve sentences imposed on them and that decisions made relating to prisoners in its care do not result in any unnecessary danger / risk to the wider community. The Service is also responsible for engaging with convicted prisoners in a realistic and meaningful way in order to reduce their reoffending and enhance their reintegration back into society...”*<sup>3</sup>

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<sup>2</sup> Previously known as the Department of Justice, Equality and Law Reform, and referred to hereinafter as the Department of Justice.

<sup>3</sup> Irish Prison Service *Three Year Strategic Plan 2012-2015*.

## **The Prison Estate**

The following is a brief description of the prisons and institutions which are of particular importance in relation to the management of both Gary Douch and Stephen Egan within the prison system. The institutions concerned are: Mountjoy Prison, Cloverhill Prison, Midlands Prison, and Cork Prison. Similar descriptions of the other prisons in the State can be found in an appendix to this report.

### **Mountjoy Prison**

Mountjoy Prison is one of the oldest prisons in the State. Opened in March 1850, it was modelled on the design of Pentonville Prison in England, consisting of a two-storey building with a central hub and four wings radiating out in a fan shaped pattern. Although some stand-alone units have been added to the complex, the structure of the main prison has remained essentially the same for the 160 years of its existence.

Gary Douch was serving a sentence of three years imprisonment at Mountjoy Prison when he was killed. Stephen Egan spent a number of periods of detention in Mountjoy between 2003 and 2006, including the period immediately prior to his transfer to the Central Mental Hospital on 5<sup>th</sup> July 2006. He was transferred back to Mountjoy from Cloverhill on 29<sup>th</sup> July 2006, two days before Gary Douch was killed.

As at 1<sup>st</sup> August 2006 the stated bed capacity according to the IPS was 445. As at March 2011 the bed capacity was 630. However, in a report on Mountjoy Prison published on 24<sup>th</sup> March 2011, the Inspector of Prisons, Judge Michael Reilly was firmly of the view that the maximum number of prisoners who could be accommodated safely in Mountjoy at that time could not exceed 517. In reality, as the Inspector points out in his report, the number of prisoners housed in

Mountjoy continues to exceed this number by a considerable margin. On 8<sup>th</sup> March 2011, for example, there were 710 prisoners in the prison.<sup>4</sup>

### ***Reception & “B Base” area***

The Reception area, in which prisoners entering and leaving the prison are processed, is located in the basement of the main building. A short distance away is the area known as “B Base”, which contains the cell in which Gary Douch was attacked on 31<sup>st</sup> July 2006. This area was refurbished in the mid-1990s with the intention of using it as a dedicated committal and discharge facility. However, overcrowding problems within the prison rendered this unworkable, and the “B Base” came to be used as the primary placement area for “protection” prisoners – that is, prisoners who need to be separated from other prisoners for reasons of security or for their own safety. In recent years, cells on C2 Wing have also been used to house “protection” prisoners. The B Wing of the prison, including the B Basement, was closed for refurbishment in April 2012. It was reopened in December 2012. All cells in the Basement area are now single occupancy cells, with in-cell sanitation.

### ***Medical and Separation Units***

Amongst the stand-alone units constructed in the prison complex over the years are a Medical Unit (comprising three floors with accommodation for 60 prisoners, together with medical facilities) and a building known as the Separation Unit.

The Separation Unit when constructed consisted of 35 cells, together with a kitchen and other facilities. It was refurbished in 1997, but was taken out of use in September 2001. It was reopened in March 2010 and is now used to house “protection” prisoners. The unit has its own gym and exercise yard. In every respect it is a much more suitable environment for “protection” prisoners than either the “B Base” or C2 Wing, as the Commission itself witnessed during a visit to Mountjoy in April 2010.

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<sup>4</sup> Report on an Inspection of Mountjoy Prison by the Inspector of Prisons, 24 March 2011

### ***High Support Unit***

Perhaps the most significant development at Mountjoy Prison in recent years has been the opening of a 10-bed High Support Unit for vulnerable and mentally disordered prisoners. The unit, which opened in December 2010, has been generally acknowledged as a significant step forward in the care and treatment of such prisoners. In October 2011, the Psychiatric In-reach Service at Mountjoy Prison received the ‘Health in Prison – Best Practice Award’ from the World Health Organisation (WHO) in recognition of the success of the High Support Unit.

### **Cloverhill Prison**

Cloverhill Prison is situated in Clondalkin, Dublin 22 and is adjacent to Wheatfield Prison. It is the first purpose-built “remand” prison for adult male prisoners in the State, although it also houses some sentenced prisoners. The prison is classified as medium security.

Cloverhill was opened in 1999 with a bed capacity for 433 prisoners, accommodation consisting of 63 single occupancy cells, five double occupancy and 120 treble occupancy cells. All of the cells have in-cell sanitation.

The prison consists of five two-storey wings, located around a central hub, plus a number of stand-alone buildings to accommodate offices, stores, administration, and the like.

Stephen Egan was detained in Cloverhill on a number of occasions, including a two-week period following his discharge from the Central Mental Hospital on 14<sup>th</sup> July 2006. He was transferred from Cloverhill to Mountjoy Prison on 29<sup>th</sup> July 2006.

### ***D2 Wing***

D2 wing is a unique, high-security area of Cloverhill Prison. Following his discharge from the Central Mental Hospital on 14<sup>th</sup> July 2006, Stephen Egan was housed exclusively on D2 until his transfer to Mountjoy Prison on 29<sup>th</sup> July 2006.

D2 is on the second floor of the prison. The wing directly underneath, D1, is where the prison medical and psychiatric services are located. D2 consists of two sections divided by a central

area. The first section has been used for a number of years to house prisoners who are vulnerable with either mental or physical illnesses. Referred to as the “vulnerable” side, it contains a mix of ordinary cells (single and multiple-occupancy) and safety observation cells, formerly known as padded cells or “pads”.

In recent years the other side of D2, referred to as the “security” side, has been used to house prisoners who create significant management problems, either because they are a risk to others, or because they themselves require protection. The “security” side contains a mix of single cells, safety observation cells and “strip” cells – that is, cells which are not padded cells, but have been stripped of furniture and fittings. Since 2005, these cells are officially described as “close supervision cells”, but continue to be referred to informally by prison staff as strip cells or special observation cells.<sup>5</sup>

The central area between the two sides of D2 contains office space for the prison officers, as well as a consulting room for use by medical and / or psychiatric personnel when reviewing prisoners from the vulnerable side of D2. Medical visits to prisoners on the “security” side take place in their cells. There is no access between the two sides of D2 except through this central area, which is locked and manned by prison officers. Prison officers who are assigned to D2 look after both the “security” and “vulnerable” sides of the wing.

The “vulnerable” side of D2 cannot be described as a medical wing: the medical facilities there do not significantly exceed those in the rest of the prison. The principal distinction lies not in the

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<sup>5</sup> Following an IPS review carried out in 2005 of special cell” accommodation across the prison system, it was decided that all special cells would henceforth be standardised into two types: safety observation cells and close supervision cells. In a report on the use of special cells dated 26<sup>th</sup> August 2010 the Inspector of Prisons defined the two types as follows:

*“Safety observation cells were designed to accommodate prisoners who required frequent observation for medical reasons or because they were a danger to themselves. Such prisoners would in the past have been accommodated in ‘padded cells’ as they were then described.*

*Close supervision cells were designed to accommodate prisoners who were a danger to others in the prison or who were disruptive and in the opinion of management needed to be separated from other prisoners in order to maintain a safe and secure custodial environment.”*

facilities available, but in the level of medical and psychiatric attention that prisoners on the “vulnerable” side of D2 receive. [Consultant Psychiatrist A], one of the psychiatrists who regularly visits D2, told the Commission:

*“It is not a hospital wing, but it is a high vulnerability [wing]. So the doctor and the nursing staff [attend] – there is a high level of clinical input into D2”.*

In 2006, the “vulnerable” side of D2 received this high level of clinical input as a matter of course. The same could not be said of the “security” side of D2. The Commission has spoken with a community psychiatric nurse (CPN) who was part of the Psychiatric In-reach team for Cloverhill in 2006. He told the Commission that, whereas prisoners on the “vulnerable” side of D2 would be seen on a regular basis, prisoners on the “security” side would be reviewed “*as necessary*”:

*“A: If there are people with mental health issues on the security side you would see them as well. If there is anybody that is expressing low mood or having thoughts of self-harm or if they are feeling sad or irritable or anxious...”*

*Q: The mere fact that someone’s in the security side of D2 doesn’t indicate that they have no mental health problem?*

*A: No, they could have mental health issues from time to time and you would review them as necessary”.*

## **Midlands Prison**

Midlands is a closed, medium security prison for males aged 17 and over. It caters for sentenced prisoners, and since 1<sup>st</sup> December 2006, operates as the committal prison for counties Carlow, Kildare, Kilkenny, Laois, Offaly, and Westmeath. It is located on the Dublin Road, Portlaoise, adjacent to Portlaoise Prison.

The prison was opened on a phased basis from November 2000 onwards. As at July 2010, the bed capacity of the prison was listed by the IPS as 566. In October 2012 a new block became

operational. As of May 2013, the Inspector of Prisons put the maximum capacity of the prison at 777.<sup>6</sup>

C1 landing in Midlands is used to contain disruptive or troublesome prisoners, some of whom have been transferred there from other prisons. The landing is also used to contain prisoners who are placed there “on punishment” – that is, in response to specific disciplinary infractions.

Stephen Egan has been housed on C1 landing at Midlands since October 2006. He had previously been detained in Midlands for most of 2004, and for shorter periods in 2005.

## **Cork Prison**

The building which houses Cork Prison was originally a British Army barracks, constructed in 1806. In 1983, it was re-opened as a committal prison, taking prisoners from courts in counties Cork, Kerry, and Waterford. As at July 2010 the bed capacity of the prison according to the IPS was 272.

In 1990 a stand-alone cell block known as “D” unit was opened. This unit, which is separate from the other sections of the prison, is used to accommodate disruptive prisoners, most of whom have been transferred there from other prisons. There are eight ordinary cells and two special observation cells in the unit, all single-occupancy.

Stephen Egan has occasionally been housed in “D” unit for periods of punishment following incidents of aggressive behaviour towards prisoners and / or prison staff.

In an Assessment of the Irish Prison System dated May 2013, the Inspector of Prisons stated:

*“The prison is not fit for purpose. It is dangerously overcrowded.”*

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<sup>6</sup> *An Assessment of the Irish Prison System* (Inspector of Prisons, May 2013).



*The Irish Prison Service in its Three Year Strategic Plan 2012-2015 committed itself to replacing outdated accommodation and facilities. The Minister accepted this plan and secured the necessary funding.*

*A new prison will be built in the car park adjacent to the old Prison. I have been informed that this Prison will have capacity for a maximum of 300 prisoners. It will have all necessary services. It is expected that the new prison will be commissioned in March / April 2016.”*

## **Internal Organisation of Prisons**

### **Prison Staff (Non-Medical)**

For the period with which this report is concerned, the hierarchy of management within a prison was as follows:

#### ***Prison Governor***

The Governor is responsible for the management of the institution to which he or she is appointed, and for the welfare of the offenders within the institution. The Governor is also responsible for the conduct and discipline of offenders. There are three levels of Governors – 1, 2 and 3. In 2006 it was usual for some of the larger prisons (including Mountjoy and Cloverhill) to have a Governor 1 and a Governor 2.

#### ***Deputy and Assistant Governors***

The Deputy Governor reports directly to the Governor. Assistant Governors report to the Deputy Governor. Both Deputy and Assistant Governors can act for the Governor in his or her absence. They assist the Governor in the creation and implementation of the overall policy for the prison. The roles vary from institution to institution depending on the nature and regimes in the institutions involved.

### *Chief Officer*

The Chief Officer is the most senior officer “on the floor” of the prison and plays a key role in its day to day operation. He directs both staff and prisoners throughout the working day.

### *Assistant Chief Officers*

The Assistant Chief Officer (ACO) is the basic supervisor in the prison system. He/she ensures that the orders of the Governor are complied with throughout the institution. Being the immediate supervisor of the basic grade officers, the ACO is directly responsible for the duty performance, conduct, and discipline of the officers in his or her charge. By means of such supervision, the ACO is also responsible for the smooth operation of the area of the institution within his or her charge and for the security and control of any prisoners in that area.

## **Prison Staff (Medical)**

The Irish Prison Service is responsible for the provision of primary healthcare services in the Irish prison estate. Secondary psychiatric services are provided by the Health Service Executive (HSE) as and when requested.

General issues of relevance to medical staff could be raised with operational prison management through informal channels or via committees such as the Healthcare Committee at Mountjoy Prison, which was set up around 2002 to provide a forum for discussion of such matters. The committee was attended by representatives of the Governor, the medical staff, the IPS Healthcare Directorate and the National Forensic Mental Health Service. Minutes of the meetings were recorded by the Governor’s secretary.

Amongst the matters the Commission was not made aware of, for example, was the existence of the Healthcare Committee at Mountjoy, until June 2012, following receipt of a particular submission. A recent further search of the IPS archives found minutes of some meetings in 2003, 2005 and 2006, but the records were not complete.

### ***Prison Doctors***

Attached to each prison are one or more General Practitioners, whose remit is the general health care of the prison population. The GPs work within the prison system but are not part of the organisational hierarchy of prison staff.

### ***Chief Nurse Officer***

The Chief Nurse Officer has responsibility for the delivery of patient care and for the supervision of staff involved in the provision of medical services in his/her prison.

### ***Nurse Officers / Medical Orderlies***

The Nurse Officer is responsible for providing prisoners under his/her care with a level of nursing care equivalent to that available in the general community. He/she is responsible for maintaining a safe clinical environment. He/she is responsible for the maintenance of an Inmate Medical Record on each prisoner.

Prior to the introduction of qualified Nurse Officers into the prison system, medical staff consisted of prison officers who were designated as Medical Orderlies. They did not as a rule have nursing qualifications. The replacement of Medical Orderlies with Nurse Officers has been taking place on a phased basis over the last number of years, and is now virtually complete.

## **Record-Keeping in the Prison System**

### ***Prisoner Information***

In 2006, information and records concerning a given prisoner were kept in an individual paper file. This file accompanied the prisoner to whatever prison he was accommodated in.

In addition to the paper file, certain information concerning prisoners (including information on sentence, disciplinary records and their movements within the prison estate, and) was kept on a computerised system known as PRIS (Prisoner Records Information System).

PRIS has been in operation in all prisons across the State since 2001. It had, according to those who used it, many design flaws, and there was a dearth of adequate training to extract and input data. In 2010, the IPS began the process of redesigning and redeveloping the system. According to the IPS Annual Report for 2010,

“The new system will improve on the older system in many critical areas and provide a comprehensive means of recording and sharing information about the prisoner population. In addition, it will significantly reduce the cost of maintaining this system in the future”.<sup>7</sup>

This new Prisoner Information Management System (PIMS) was implemented in March 2012.

### ***Medical Records***

Since the early 1990s, a prisoner’s personal medical information has been kept in an individual file, separate from their prison file. These medical files are kept in the medical area of the prison where they reside. They are confidential files, accessible only to medical personnel and to the prisoner themselves. Non-medical prison staff, up to and including Governor Level, cannot access these files.

The requirement of confidentiality in relation to prisoners’ medical files is based on the principle of equivalence of care – in other words, that prisoners should have the same level of privacy in relation to their medical history as they might expect outside of the prison system. There is also the vitally important issue of trust between prisoners and the medical personnel attending upon them, as former IPS Director of Healthcare Dr Enda Dooley explained to the Commission in evidence:

*“When I came into the role [in 1990], there wasn't such a thing as a medical file. There were big Dickensian ledgers which you may have seen in some prisons. Everyone had a common entry in the books. There was no privacy to the record. It wasn't an individual*

*record... So one of the first things I did was to seek to have printed and developed a medical file which people would recognise...it was promoted that people would have an individual record of their healthcare interventions, which would be private. It would not be shared and, hopefully, the prisoner would have some element of confidence that they were being dealt with as they would be dealt with in the community because one of the big problems is prisoners do not trust the system. You don't expect them to. But they feel, 'Oh, the Governor is reading my file at night or the Chief and it is very difficult to convince them that this stays confidential'".*

Prior to the introduction of computerised systems, a prisoner's medical file consisted of an orange folder, inside which all relevant medical documents were supposed to be kept – prescriptions, drug administration records, committal screening documents, hospital records and records kept by relevant medical personnel. Notes from GPs or nursing staff were handwritten on white sheets called Medical Continuation Sheets. Notes by visiting psychiatrists or psychiatric nurses were kept on Psychiatric Continuation Sheets (coloured blue).

Beginning in July 2005, a computerised Prison Medical Records System (PMRS) was rolled out on a gradual basis across the prison system. This system gradually became the primary vehicle for recording prisoners' medical information. In May 2010, PMRS was replaced with a new Prisoner Healthcare Management System (PHMS). As with the paper medical files and PMRS which preceded it, PHMS can only be accessed by medical personnel.

The Commission has been told by senior officials in the Health Directorate of the IPS that PHMS will eventually do away with the necessity to keep paper medical files. A system for scanning medical documents was piloted in Mountjoy Prison, and was rolled out across the prison system during 2011. At the time of writing, existing paper medical files are kept in storage, but are no longer in daily use, and no paper files are created for new prisoners entering the system.

## **Mentally Ill Prisoners in the Irish Prison System**

One of the matters which the Commission is tasked to investigate concerns the care and treatment afforded Stephen Egan in relation to his mental health, both when in prison and in the Central Mental Hospital. There follows a brief account of the principal institutions involved in the provision of mental health care to prisoners. Reference is made also to developments in forensic mental health policy from 2006 onwards.

### **National Forensic Mental Health Service**

The provision of mental health services to prisoners in the State is not a function of the Department of Justice, but is the responsibility of the Department of Health. The National Forensic Mental Health Service operates as an agency of the Health Service Executive, under the jurisdiction of the Minister for Health. It is based at the Central Mental Hospital (CMH), Dundrum.

The Central Mental Hospital was first opened as an asylum in 1850, following the passing of the Central Criminal Lunatics Asylum Act, 1845. The essential structure of the CMH while having had some alterations and extensions added in 2005 and 2007, has not changed significantly since that time. Plans to build a new forensic hospital at an alternative location are on-going.<sup>8</sup>

In 2006, the CMH was the only forensic psychiatric hospital in the State. This remains the case today. The hospital provides accommodation and treatment in a range of high, medium, and low-security settings. At the time of writing, 93 beds are available within the hospital complex. This includes acute admission beds, step-down beds and hostel beds. In July 2012 the HSE appointed a team to design a new facility to replace the CMH. A press release from the Department of Health stated:

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<sup>8</sup> *'Health spending priorities revealed'*, The Irish Times, 9 December 2011.

*“The design team will commence work immediately on the design of the new facilities which include a new modern, state of the art National Forensic Hospital, a Forensic Child and Adolescent Mental Health Unit, a Forensic Mental Health Intellectual Disability Unit and an Intensive Care Rehabilitation Unit (ICRU) to be located at Portrane, as well as three regional ICRU’s that will be located at HSE South, HSE West and Dublin Mid Leinster regions. It is expected that construction will commence in 2014 and take 2 years to complete.”*

Although prisoners can be transferred to the Central Mental Hospital for treatment and kept there for long periods if necessary, the CMH is not a prison. It is not under the control of the Irish Prison Service, and CMH staff are answerable ultimately to the Minister for Health, not the Minister for Justice

In addition to the in-patient services available at the CMH, the National Forensic Mental Health Service also provides in-reach services to most prisons in the State. For the most part, these services consist of regular visits by consultant psychiatrists and community mental health nurses.

The most significant in-reach service is that provided in Cloverhill, the principal remand prison in the State. Towards the end of 2006, a new Prison In-reach & Court Liaison Service (PICLS) was established at Cloverhill. The new Service, comprised of personnel from the Central Mental Hospital, reached its full staff complement in mid-2007. Since that time, the Service has maintained a permanent presence in Cloverhill, dedicated to screening, assessing and delivering psychiatric care to remand prisoners. In 2010, approximately 20% of prisoners committed to Cloverhill Prison were seen by the Psychiatric Service according to the HSE.

The Service also provides assistance to the courts, voluntarily and on request, on such issues as an accused’s fitness to be tried, or the diagnosis and treatment options associated with custodial or non-custodial disposals.

Establishment of the PICLS resulted in a permanent psychiatric presence in Cloverhill Prison. Prior to this, psychiatric in-reach to Cloverhill consisted of visits from a consultant psychiatrist on Mondays, Wednesdays and Thursdays, supported by visits from a community psychiatric nurse on Tuesdays, Wednesdays and Fridays. The regime in Mountjoy also involved visits from a community psychiatric nurse, together with a weekly visit from a consultant psychiatrist.

Minutes from Healthcare Committee meetings at Mountjoy in 2005 and 2006 indicate an ongoing problem whereby a lack of available prison staff to escort prisoners to and from psychiatric consultations meant that the consultant psychiatrist felt that he was not getting to see as many prisoners as he should be. There were repeated representations also regarding inadequate facilities and resources. In February 2006, the problem was serious enough for [Consultant Psychiatrist A] to threaten a withdrawal of psychiatric services from Mountjoy unless immediate improvement took place.

### **Government Policy as Outlined in *A Vision for Change***

In 2006 the Department of Health and Children published the report of an Expert Group on Mental Health Policy which had been convened in August 2003. The report was entitled *A Vision for Change*, and in the words of the then Minister of State at the Department:

*“...sets out a comprehensive policy framework for our mental health services for the next 7 – 10 years”.*<sup>9</sup>

In relation to Forensic Mental Health Services (FMHS), the report made the following recommendations:

- Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery oriented and based on evolved and integrated care plans.
- FMHS should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.
- Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region.

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<sup>9</sup> A Vision for Change (2006), p.6.



- The CMH should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and the capacity of the CMH should be maximised.
- Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between FMHS and other specialist community mental health services.
- A dedicated residential 10-bed facility with a fully resourced child and adolescent mental health team should be provided with a national remit. An additional community-based, child and adolescent forensic mental health team should also be provided.
- A 10-bed residential unit, with a fully resourced multidisciplinary mental health team should be provided for care of intellectually disabled persons who become severely disturbed in the context of the criminal justice system.
- Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Síochána.
- A senior Garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.

## **The Mental Health Commission**

In 2004 the Mental Health Commission established a Forensic Mental Health Services Committee to conduct its own review of existing models and best practice for forensic mental health services in the State. In February 2006 the Mental Health Commission published a discussion paper entitled *Forensic Mental Health Services for Adults in Ireland*. In addition to reaffirming the right of prisoners to equivalence of care in terms of mental health services (as set out by the United Nations High Commissioner for Human Rights in *Principles Regarding the*

*Protection of Persons with Mental Illness and the Improvement of Mental Health Care*)<sup>10</sup> the discussion paper recommended the establishment of low and medium security forensic mental health services in regional centres, with high security care confined to one national centre, such as the Central Mental Hospital.

In February 2011 the Mental Health Commission published an updated position paper which contained eleven recommendations in relation to the provision of forensic mental health services in the State. These recommendations are as follows:

- A comprehensive needs assessment must be undertaken as an initial and immediate action to inform the future development of forensic mental health services in Ireland. Specific areas to be addressed as part of this assessment of need include a review of the unmet mental health needs of the generic population and specifically of the prison population.
- There is general agreement, based on the size of our population that high and medium secure care can be provided centrally in one location in the Dublin area. All other forensic mental health services including low secure units should be provided on a regionalised basis. The needs of service users are not well served by the provision of forensic mental health services from one central complex. Regionalised services are a very necessary development in moving towards a modern and comprehensive service.
- Clear protocols between forensic and general mental health teams, including seamless referral and treatment pathways are essential in ensuring optimal care for service users. Models of care which promote collaboration and the removal of barriers to a continuum of mental health care such as joint responsibility for low secure regional units, co-case management, formalised liaison schemes, should be developed through the use of service level agreements and individual service user care and treatment contracts.

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<sup>10</sup> Publ. 1991 by the Office of the High Commissioner for Human Rights. See in particular Principles 1.1, 7.1 and 7.2.

- To support the robust governance of forensic mental health services the HSE should establish a national oversight group to oversee the utilisation of high and medium secure inpatient forensic beds. This group also should have a policy development function within the forensic mental health services including the monitoring of relevant legislation. The membership of the national group should include management and clinical representation from the four regional areas, and service user and carer representation. This group should also prepare a template for local protocols and referral procedures.
- Greater priority should be given to the reform of the legal framework governing mental disorder as this provides the basis for many essential aspects of forensic service provision.
- Mental health professionals, Gardaí, lawyers, and the courts in all regions should have a comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings. Services should be based on a nationally established policy of diversion towards treatment and recovery options, in keeping with the principles of “A Vision for Change” (DOHC 2006) and the proposal by the National Crime Council to introduce Community Courts in Ireland.
- The enactment of a new mental capacity law in line with the recommendations of the Law Reform Commission (2005) is an urgent priority and an essential protection for the human rights of people availing of forensic mental health services.
- It is also important that in any new legislation in the mental health sphere, Ireland should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients between England, Wales, Scotland, Northern Ireland, and the Republic of Ireland. This will reduce the current level of frustration and confusion for practitioners and families who become involved in inter-country transfers and make best use of referral to specialist services.

- Mental health services to each prison population should be provided by the forensic mental health service for the region the prison is situated in as a secondary in-reach service.
- Mental health services in prisons should be guided by the Recommendations on European Prison Rules (Council of Europe, Committee of Ministers to member states on the European Prison Rules).
- The establishment of Appropriate Person, Police, and Court Diversion Schemes must be a priority.

## **Legal Framework for the Transfer of Prisoners from Prison to the Central Mental Hospital**

Prior to June 2006, the transfer of a prisoner from a prison to the Central Mental Hospital was an administrative act of the Minister for Justice which in relation to sentenced prisoners could be done either under section 2 of the Criminal Lunatics (Ireland) Act 1838 (as amended by section 8 of the Criminal Justice Act 1960) or section 8 of the Central Criminal Lunatic Asylum (Ireland) Act 1845. Remand prisoners could be transferred to the CMH under section 13 of the Lunatic Asylums (Ireland) Act 1875.

Under both s.2 of the 1838 Act (as amended) and s.13 of the 1875 Act, two medical practitioners were required to certify that the prisoner was of unsound mind before the Minister could direct his or her transfer to an asylum or mental hospital. By contrast, s.8 of the 1845 Act, which was passed in order to regulate transfers to the Central Lunatic Asylum when it opened, simply required:

*“... That whenever and as soon as the said Central Asylum shall be erected, and fit for the Reception of Criminal Lunatics, it shall be lawful for the Lord Lieutenant or other Chief Governor or Governors of Ireland to order and direct that all Criminal Lunatics then in Custody in any Lunatic Asylum or Gaol, or who shall thereafter be in Custody, shall be removed without Delay to such Central Asylum, and shall be kept therein so long as such Criminal Lunatics respectively shall be detained in Custody”.*

All of the above sections were repealed by the Criminal Law (Insanity) Act 2006 (hereinafter referred to as “the 2006 Act”), which came into force on 1<sup>st</sup> June 2006 – two months prior to the death of Gary Douch on 1<sup>st</sup> August 2006. A copy of the 2006 Act can be found in an appendix to this report.

Following on from the policy recommendations put forward by the Expert Group on Mental Health Policy and by the Mental Health Commission, section 3 of the Criminal Law (Insanity) Act 2006 gave power to the Minister for Health and Children to establish “designated centres” for the reception, detention and, where appropriate, care or treatment of persons or classes of persons committed or transferred thereto under the provisions of the Act.

Notwithstanding the creation of this new power, at the time of writing the Central Mental Hospital remains the only “designated centre” under the Act. The expansion of low and medium-security services to regional facilities outside of the CMH which was envisaged in *A Vision for Change* has not taken place.

It is important to bear in mind that, although it is a “designated centre” under the 2006 Act, the CMH is not and is not intended to be a “prison” in legal terms within the Irish prison system. At all times the CMH has been and remains under the ultimate control of the Minister for Health.

The 2006 Act also provided for the independent review of the detention of such prisoners by a new Mental Health (Criminal Law) Review Board (MHCLRB). The MHCLRB was not established until 27<sup>th</sup> September 2006, by order of the Minister for Justice. Further consideration of the powers and functions of the MHCLRB can be found in chapter 4.1 of this report, which deals with the treatment of Stephen Egan at the CMH following the death of Gary Douch, from August until October 2006.

Section 15 of the 2006 Act provides a legal and practical mechanism for the physical transfer and legal “detention” of prisoners suffering from a mental disorder to the CMH in certain circumstances (“s.15 transferees”). In legal terms s.15 transferees remain in legal custody and “detained” as described in the 2006 Act notwithstanding that they are not physically in a prison.

Section 15 of the 2006 Act provides:

*“15. — (1) Where—*

*(a) a relevant officer certifies in writing that a prisoner is suffering from a mental disorder for which he or she cannot be afforded appropriate care or treatment within the prison in which the prisoner is detained*

*(b) the prisoner voluntarily consents to be transferred from the prison to a designated centre for the purpose of receiving care or treatment for the mental disorder*

*then the Governor of the prison may direct in writing the transfer of the prisoner to any designated centre for that purpose.*

*(2) Where two or more relevant officers certify in writing that a prisoner is suffering from a mental disorder for which he or she cannot be afforded appropriate care or treatment within the prison in which the prisoner is detained, then the Governor of the prison may direct in writing the transfer of the prisoner to any designated centre for the purpose of the prisoner receiving care or treatment for the mental disorder notwithstanding that the prisoner is unwilling or unable to voluntarily consent to the transfer”.*

For the purposes of s.15, the phrase “mental disorder” is defined in the 2006 Act as follows:

*“‘mental disorder’ includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication”.<sup>11</sup>*

The Commission notes that section 3 of the Mental Health Act 2001, which deals with the care and treatment of mentally ill persons outside of the prison system, contains a much more detailed definition of “mental disorder”, as follows:

*“3.—(1) In this Act ‘mental disorder’ means mental illness, severe dementia or significant intellectual disability where—*

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<sup>11</sup> Criminal Law (Insanity) Act 2006, s.1

*(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*

*(ii) 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”.*

The section goes on to provide definitions of “mental illness”, “severe dementia” and “significant intellectual disability”.<sup>12</sup>

The definition of “mental disorder” provided by 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 to a designated centre, only the 2006 Act definition applies. It is questionable whether this distinction is justifiable.

## **Legal Framework for the Discharge of Prisoners from the Central Mental Hospital Back to Prison**

Under the legislation in force prior to the Criminal Law (Insanity) Act 2006, once it was certified by two medical practitioners that a prisoner transferred to the CMH was now of sound mind, the prisoner had to be discharged back to the prison from whence he/she came, unless they were no longer under any sentence of imprisonment, in which case they were to be released.

From 1<sup>st</sup> June 2006 the position was altered by section 18 of the 2006 Act, which states:

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<sup>12</sup> Mental Health Act 2001, s.3(2)

*“Where the clinical director of a designated centre forms the opinion in relation to a prisoner detained in the centre pursuant to section 15 that he or she is no longer in need of in-patient care or treatment he or she shall, after consultation with the Minister, direct in writing-*

*(a) the transfer of the prisoner back to the prison from which he or she was transferred to the centre, or*

*(b) the transfer of the prisoner to such other prison as the Minister considers appropriate in all the circumstances of the case”.*

Referring to this section during the final stages of the *Dáil* Debate on the bill which would become the 2006 Act, the then Minister for Justice Michael McDowell indicated that the proposed section served two purposes. In the first place, it was to give the Clinical Director of the CMH or similar institution the power to discharge patients who no longer required in-patient treatment. The Minister told the *Dáil*:

*“The matter was drawn to the Department’s attention by Dr Harry Kennedy, the clinical director of the Central Mental Hospital. The lacuna in the Bill in this regard is at odds with the procedure in place whereby two doctors in the Central Mental Hospital can decertify a ministerial order patient, which has the effect of returning the prisoner to the prison from which he or she was originally transferred. Clearly, it is important for the treating consultant psychiatrist to be able to discharge a patient when he or she no longer needs care or treatment”.*

The second purpose of the proposed section was to ensure that the discharge of patients from designated centres such as the CMH back to the prison system would not take place without the Minister for Justice being consulted as to the appropriate prison to which the prisoner should be returned. The Minister told the *Dáil*:

*“This will ensure the prison from which the prisoner was originally transferred is the most suitable location at the time of transfer for him or her to be sent. In other words, if the prisoner came from Mountjoy Prison, the Minister might say he should be sent to Loughan House as it is more suitable or vice versa”.*



Accordingly, the new procedure under section 18 of the 2006 Act fixes the Clinical Director of the CMH with two obligations:

- an obligation *to form an opinion* that the prisoner concerned no longer needs to be kept at the CMH for treatment
- an obligation *to consult with the Minister for Justice* prior to discharging that prisoner back into the prison system

It is important to note that the Clinical Director does not have to form an opinion that the prisoner no longer requires *any* psychiatric treatment; it is sufficient to form the view that their on-going psychiatric needs can be cared for outside of the specific environment provided by the Central Mental Hospital.

It follows therefore that in any case where the prisoner is not fully recovered from any mental disorder (including that which required him to be admitted to the CMH) the process of consultation between the Clinical Director and the Minister for Justice should specifically address the on-going care requirements of the prisoner concerned, and whether they can be provided at the prison to which the prisoner is to be returned.

The Commission will return to this issue at a later stage of this report when it examines the psychiatric treatment of Stephen Egan, including the circumstances of his discharge from the Central Mental Hospital on 14 July 2006.

The fact that prisoners can be returned from the CMH to prison whilst still suffering from a mental disorder may be contrasted with the situation applicable to non-prisoners who are detained involuntarily at the CMH. In the latter case, s.28 of the Mental Health Act 2001 requires the treating psychiatrist to discharge a patient once he or she “...*becomes of opinion that the patient is no longer suffering from a mental disorder*”, subject only to the need to ensure (a) that the patient is not inappropriately discharged, and (b) that the patient is detained only for so long as is reasonably necessary for his or her proper care and treatment.

As a matter of practice, the differences between the regimes applicable to prisoners and non-prisoners may not be significant. This is because the definition of “mental disorder” which

applies to non-prisoners under the 2001 Act is restricted to conditions which result in either (a) a serious likelihood of the person causing “*immediate and serious harm*” to themselves or others, or (b) circumstances where admission to the CMH is necessary in order to treat the person. As category (b) in effect corresponds with s.18 of the 2006 Act, the only practical difference between the discharge regimes for prisoners and non-prisoners is that under the 2001 Act, the CMH cannot discharge a patient who, *by reason of their mental disorder*, would be likely to cause immediate and serious harm to themselves or others.

Nevertheless, the Commission considers that for the purposes of clarity and to honour the principle of equivalence of care, the admission and discharge regimes for prisoners and non-prisoners should be based on an identical definition of “mental disorder”. As between the definitions used in the 2001 and 2006 Acts, the more detailed version contained in the 2001 Act is clearly preferable.

## **The Concept and Principle of Equivalence of Care**

Recognising the principle of equivalence of care to which patients are entitled legally and constitutionally, both in our laws and our Government policies, the Commission felt compelled to carry out its work using equivalence of care as a primary benchmark, and it has at all times been determined not to facilitate any dilution of this important principle for those citizens who are prisoners.

The Commission felt that it would be greatly assisted in having “a best practice” expert to assist its review. It was felt that this could be particularly useful in deciding what appropriate recommendations to make to the Minister to ensure the implementation of equivalence and best practice. That expert is Dr Paul Lelliott, a consultant psychiatrist from the U.K. Dr Lelliott is the Director of the Centre for Quality Improvement at the Royal College of Psychiatrists. In that capacity he has established and leads national quality improvement programmes that encompass every mental healthcare specialty in the U.K. He is also chairman of the Healthcare Quality Improvement Partnership, an organisation established in 2008 by the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices (formerly the Long-term Conditions Alliance) to promote quality in healthcare in the U.K.

A prisoner with mental health problems is entitled to the best available psychiatric care and treatment, at a minimum equivalent to that available to the general public. This principle is particularly important in light of the fact that detained prisoners are not at liberty to secure such care and treatment for themselves.

It is worth clarifying that such care and treatment should not fall under a different category of psychiatry than that available to the general population. “Forensic psychiatry” is not an excepted discipline to that of general psychiatry; it is rather a kind of informal “specialism” which has evolved from general psychiatry which is sometimes defined as dealing with patients and problems at the interface of law and psychiatry. It is a specialism which addresses the clinical needs of patients whose characteristics exhibit a propensity for criminal behaviour and the necessity of having to provide psychiatric care in prisons or secure hospital settings. The same principles of diagnosis and care and treatment however apply and there is no such thing as a forensic patient.

## 1.2 The Obligations and Duties Owed to Prisoners by the State

The Commission felt it would be useful at the outset to outline the duties and obligations the State owes to prisoners.

### Sources

In a report dated 29 July 2010, the Inspector of Prisons Judge Michael Reilly examined the duties and obligations which the State owes to those prisoners in its care. The sources of those obligations were summarised by the Inspector as follows:

*“As a country our obligations towards our prisoners can be found in our Constitution, our laws, our jurisprudence, our prison rules and in the standards that I published. Our international obligations can be found in the many international instruments to which we are a party, the jurisprudence of the European Court of Human Rights (ECtHR), the European and International rules that refer to prisoners and the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment”.*

Though the Inspector of Prisons published his standards in 2010, they are based on national and international standards which were in place prior to the death of Gary Douch in 2006.<sup>13</sup>

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<sup>13</sup> See, for example, the European Prison Rules 1987, rules 14–19. Further information as to the relevant, internationally acceptable standards can be found in the pre–2006 reports of the European Committee for the Prevention of Torture (CPT).

## The Constitution

Article 40.3.1 of the Constitution provides:

*“The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen”.*

Article 40.3.2 goes on to provide that:

*“The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen”.*

Of course lawful imprisonment, by its nature, necessarily interferes with the ability of prisoners to enjoy or exercise certain of their constitutional rights, such as the rights to personal liberty, privacy, and freedom of association. However this is not to suggest that all constitutional rights of prisoners are limited or suspended. As Budd J. stated in *Brennan – v – The Governor of Portlaoise Prison* [1998] IEHC 140:

*“A convicted person who is held in a prison pursuant to a lawful warrant is in the situation that many of his normal constitutional rights are abrogated or suspended. He must accept prison discipline and accommodate himself to the reasonable organisation of prison life as laid down in the prison regulations...”*

*The Executive has a duty to carry out the order of a Court concerning each prisoner in its care. A prisoner retains certain constitutional rights and in some cases these may require to be vindicated”.*

Budd J. quoted with approval the following passage from Barrington J. in *The State (Susan Richardson) – v – Governor of Mountjoy Prison* [1980] ILRM 82:

*“It appears to me that the purpose of the Prison Rules is to reconcile the need for security and good order in the prison with the prisoners’ subsisting constitutional rights. Clearly, the prison authorities must be allowed a wide area of discretion in the*

*administration of the prisons in the interests of security and good order. Clearly also the Rules, being made by an executive authority established under the Constitution, must be presumed to have respected the prisoners' subsisting constitutional rights. For the same reason they should be interpreted in a manner consistent with these rights..."*

In particular, the State retains an obligation under the Constitution to vindicate prisoners' rights to life and health, and to protect them from inhuman or degrading treatment.

In the jurisprudence of the Irish courts, discussion of prisoners' rights has usually taken place in the context of *habeas corpus* applications under Article 40.4.2 of the Constitution, which provides:

*"Upon complaint being made by or on behalf of any person to the High Court or any judge thereof alleging that such person is being unlawfully detained, the High Court and any and every judge thereof to whom such complaint is made shall forthwith enquire into the said complaint and may order the person in whose custody such person is detained to produce the body of such person before the High Court on a named day and to certify in writing the grounds of his detention, and the High Court shall, upon the body of such person being produced before that Court and after giving the person in whose custody he is detained an opportunity of justifying the detention, order the release of such person from such detention unless satisfied that he is being detained in accordance with the law".*

As only one form of relief is available under an Article 40.4.2 application – the immediate release of the applicant from custody – the decisions made by the court in such cases are confined to the question of whether the conditions in which a prisoner is being detained violate his constitutional rights to the extent that release from detention is the only appropriate remedy.

Thus for instance in the recent case of *Kinsella – v – Governor of Mountjoy Prison* [2011] IEHC 235, Hogan J. found that the detention of Mr Kinsella in a padded cell in the basement of Mountjoy Prison for 11 days "...objectively amounts to a breach of the State's obligation under Article 40.3.2 of the Constitution to protect the person of Mr Kinsella", but decided that this breach was not, at that time, "so serious that it immediately vitiates the lawfulness of his detention". On that basis, Mr Kinsella's application under Article 40.4.2 failed.

However, as is clear from the *Kinsella* case and others, the fact that a *habeas corpus* action does not succeed by no means exonerates the State from its obligations under the Constitution to maintain a prison system which protects prisoners' rights to life, bodily integrity, mental health, and freedom from inhumane and degrading treatment. It simply means that the specific procedure established by Article 40.4.2 is not the appropriate vehicle for ensuring that the State honours its obligations. As Barrington J. stated in *The State (Susan Richardson) – v – Governor of Mountjoy Prison* [1980] ILRM 82:

*“A prisoner lawfully convicted and sentenced has lost his right to personal liberty for the period of his sentence. Therefore, habeas corpus is not an appropriate procedure in which to investigate his complaints.*

*Exceptionally, however, the conditions under which a prisoner is detained may be such as to make his detention unlawful, notwithstanding the existence of a valid warrant. In such case, habeas corpus will lie.*

*Lesser legitimate complaints of prisoners fall to be investigated in other forms of legal proceedings”.*

## Primary Legislation and Prison Rules

In terms of domestic legislation the prison system is supported by the Prisons Acts, 1826 – 2007 and by the various Rules made thereunder. As of 1<sup>st</sup> August 2006 the applicable Rules were (with certain amendments)<sup>14</sup> contained in the Rules for the Government of Prisons 1947 (S.R. &O. No. 320 of 1947). As one might expect, many of these Rules were outdated long before July 2006 and were being ignored or contravened as a matter of course. For example, in *Brennan – v – The Governor of Portlaoise Prison* [1998] IEHC 140 the applicant contended that his physical and mental health were being put at risk by the conditions under which he was being kept and by the manner in which certain of the 1947 Prison Rules relating to medical care were being flouted by the prison authorities. Budd J. stated in his judgment:

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<sup>14</sup> For amendments to the Rules prior to 2007 see S.I. 127/1955, S.I. 30/1976, S.I. 135/1983 and S.I. 90/1987.

*“It is conceded by the Respondent that many of these Rules are obsolete and are not observed. Doctor Enda Dooley, the Director of the Prison Medical Services, made it clear that there is now no full time doctor in any of the prisons. Accordingly, the 1947 Rules, which were drafted on the basis of a Medical Officer being resident at the prison and having a supervisory role with regard to hygiene and the kitchens, are obsolete. Specifically, Rule 16, which requires every prisoner to be examined by the Medical Officer before being removed to any other prison and before being discharged from prison, is now impractical and not observed. Both Doctor Dooley and Doctor Anthony Reeves, the leading medical officer at Portlaoise Prison, were candid and clear witnesses. Doctor Anthony Reeves made it clear that he and his colleagues do not regard the 1947 Rules as good guidelines for medical practice. His contract with the Department of Justice is at complete and utter variance with the 1947 Rules and the Rules do not relate to modern medical practice. He said that the Rules were antiquated, out of date and inappropriate to present practice... I mention this at the outset as the obsolescence of the Rules and the ignoring of the Rules by the authorities (often because they are outmoded and impractical) are common case. Times change and so has medical practice but apparently the Rules have not kept pace despite the strictures of the Courts in a number of cases”.*

The 1947 Rules were eventually replaced on 1<sup>st</sup> October 2007 by the Prison Rules 2007 (S.I. 252/2007).

Again, it must be emphasised that in interpreting and carrying out the requirements of the Prison Acts and the Prison Rules, regard must be had to the duties and obligations imposed on the State by virtue of the personal rights protected in the Constitution, the European Convention on Human Rights and other international standards.

In relation to the management of prisoners in general, it should be noted that the formal categorisation of prisoners is not permitted by the current legislative regime. Section 11(4) of the Criminal Law Act 1997 provides:



*“So far as any enactment provides that any person sentenced to imprisonment or committed to prison is or may be directed to be treated as an offender of a particular division, or to be placed in a separate division, it shall cease to have effect”*

## **Transfer of Prisoners between Prisons**

The legal power to transfer prisoners between prisons under Irish law is vested in the Minister of Justice and is contained in section 17 of the Criminal Justice Administration Act 1914 which provides:

- (1) The [Lord-Lieutenant] may from time to time by any general or special rule under the Prisons (Ireland) Acts 1826 to 1907, appropriate either wholly or partially, particular prisons within his jurisdiction to particular classes of prisoners.
- (2) A prisoner sentenced to imprisonment or committed to prison on remand, or pending trial, or otherwise maybe lawfully confined in any prison to which the Prisons (Ireland) Acts 1826 to 1907 apply.
- (3) Prisoners shall be committed to such prisons as the [Lord Lieutenant] may from time to time direct, and may on the like direction be removed therefrom during the term of their imprisonment to any other prison.

## **European Convention on Human Rights (ECHR)**

The ECHR has been incorporated into Irish law by virtue of the European Convention on Human Rights Act 2003. It is the only significant human rights treaty to have been given the force of domestic legislation by the State. The particular importance of this in the context of prison conditions has been described by the Inspector of Prisons in his *Standards for the Inspection of Prisons in Ireland*, where he states:

*“Although the ECHR does not contain any specific provisions relating to prisoners’ rights it does protect some of their fundamental rights as human beings such as the right*

*to life as guaranteed by Article 2, the prohibition on inhuman and degrading treatment as guaranteed by Article 3, the right to a fair trial/access to the courts as guaranteed by Article 6 and the right to privacy as guaranteed by Article 8. The jurisprudence of the European Court of Human Rights (ECt.HR), which determines whether a violation of an Article in the Convention has occurred, has been of particular importance in the advancement of the rights of prisoners. The jurisprudence is continually evolving, determining new obligations and acceptable minimum standards regarding the treatment of persons deprived of their liberty”.*<sup>15</sup>

The Inspector goes on to point out:

*“Section 3 of the European Convention on Human Rights Act 2003 places an obligation on all organs of this State to perform their functions in compatibility with the Convention and Section 4 of the Act requires Irish Courts to interpret the law in a manner that is compatible with the provisions of the Convention. Individuals can, therefore, petition Irish Courts in the case of a breach of a Convention Article. This procedure has the potential to be the most useful and important instrument in the advancement of prisoners’ rights, in an Irish context”.*<sup>16</sup>

In terms of protecting prisoners’ rights, it is also worth noting Article 14 of the ECHR, which states that *“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground...”*

## **European Committee for the Prevention of Torture (CPT)**

The CPT was set up under the Council of Europe’s European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which came into force in 1989. It builds on Article 3 of the European Convention on Human Rights which provides that *“No one shall be subjected to torture or to inhuman or degrading treatment or punishment”*. The CPT is

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<sup>15</sup> Standards for the Inspection of Prisons in Ireland (July 2009), p.9

<sup>16</sup> Ibid. p.11.

not an investigative body, but provides a non-judicial preventive mechanism to protect persons deprived of their liberty against torture and other forms of ill-treatment.

The work of the CPT was intended by the Council of Europe to complement the judicial work of the European Court of Human Rights. The CPT provides a specialist system of oversight of places of detention and over the years has developed a set of standards based on international human rights instruments, and the “soft-law” standards formulated by the Council of Europe. While these are not directly enforceable in courts, the European Court of Human Rights has considered them in a number of cases before it, and in particular used the information provided in country reports by the CPT in a number of cases regarding application of Article 3 of the ECHR to prison conditions (including overcrowding). Standards developed by the CPT, as well as its work in monitoring conditions of detention in States-parties to the Convention significantly impact, therefore, on the Court’s judgments.<sup>17</sup>

## European Prison Rules

In 1973, in an effort to enshrine common principles held amongst member States regarding penal policy, the Committee of Ministers at the Council of Europe adopted a set of Standard Minimum Rules for the Treatment of Prisoners<sup>18</sup>, otherwise known as the European Prison Rules. These rules were amended in 1987 to reflect “*significant social trends and changes in regard to prison treatment and management*”.<sup>19</sup> Two decades later, on 11<sup>th</sup> January 2006, a substantially revised and updated version of the European Prison Rules was adopted by the Committee of Ministers.<sup>20</sup>

The preamble to the 2006 Rules notes that the revised Rules were developed having regard to the European Convention of Human Rights, the case law of the European Court of Human Rights, the work of the CPT and the United Nations Standard Minimum Rules for the Treatment of

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<sup>17</sup> Irish Penal Reform Trust, *Human Rights in Prison* (August 2009), p.4

<sup>18</sup> Council of Europe Resolution 73(5).

<sup>19</sup> Council of Europe Recommendation No. R (87) 3.

<sup>20</sup> Council of Europe Recommendation Rec(2006) 2.

Prisoners, as well as to previous recommendations by the Council of Europe concerning specific aspects of penal policy and practice such as education,<sup>21</sup> healthcare<sup>22</sup> and prison overcrowding.<sup>23</sup>

The 2006 Rules begin with a number of “Basic Principles”, the first four of which in particular are important for the Commission’s work and bear repeating:

*“1. All persons deprived of their liberty shall be treated with respect for their human rights.*

*2. Persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody.*

*3. Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which they are imposed.*

*4. Prison conditions that infringe prisoners’ human rights are not justified by lack of resources”.*

The Rules go on to cover all aspects of a prison regime, including admission, accommodation, hygiene, recreation, education, movement of prisoners and release from detention.

## **Other International Standards**

In addition to the European standards referred to above, Irish penal policy should have regard to a variety of international conventions, not least the UN Covenant of Civil and Political Rights (ICCPR) and the UN Convention against Torture and Inhuman or Degrading Treatment (CAT).

In addition, the United Nations has developed and promoted standards for the protection of human rights in criminal justice systems, beginning with the Standard Minimum Rules for the Treatment of Prisoners, adopted in 1955.

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<sup>21</sup> Council of Europe Recommendation No. R (89) 12.

<sup>22</sup> Council of Europe Recommendation No. R (98) 7.

<sup>23</sup> Council of Europe Recommendation No. R (99) 22.

Regard must also be had to standards and policies adopted in relation to healthcare, such as the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted by the UN General Assembly in 1991), or the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN General Assembly resolution 37/194).

## Duties and Obligations

The Commission is required by its Terms of Reference to investigate the circumstances of Gary Douch's death, to examine the treatment and management of Stephen Egan and to review policies, practices, and procedures regarding the safety of prisoners in custody.

Completion of these tasks necessarily involves a consideration of the State's obligations with regard to:

- the provision of appropriate **accommodation** for both Stephen Egan and Gary Douch
- the provision of an appropriate **healthcare regime** for Stephen Egan
- the taking of measures to ensure, insofar as possible, the **safety of prisoners** in custody

There follows a brief summary of the State's duties and obligations under each of these headings, in light of the domestic and international standards referred to earlier. In compiling this summary the Commission has relied extensively on the excellent work of the Inspector of Prisons, Judge Michael Reilly – in particular his *Standards for the Inspection of Prisons in Ireland* (July 2009) and *The Irish Prison Population – an examination of duties and obligations owed to prisoners* (July 2010). As noted previously, the Inspector's standards are based on national and international standards and principles which were in place prior to the death of Gary Douch in 2006, and which continue to apply today. References to these sources can be found in the abovementioned publications of the Inspector.

## Accommodation

The size of a cell must be suitable for its purpose. The suitability of the cell size is dependent on the number of hours spent in the cell, the number of prisoners accommodated in the cell and the availability of in cell-sanitation facilities that ensure privacy.<sup>24</sup>

Cells should not be used to accommodate more prisoners than the intended design capacity, unless justified in exceptional circumstances. Cells shall be suitable for accommodating prisoners in respect of size, lighting, heating, ventilation, and fittings. Each prisoner shall be provided with a bed and appropriate bedding.<sup>25</sup>

Where possible, prisoners should have individual cells to sleep in. Prisoners who are required to share cells shall be carefully selected and assessed as suitable for sharing accommodation. Where possible, prisoners on remand shall be accommodated in single cells and be separated from sentenced prisoners.<sup>26</sup>

Adequate and appropriate observation facilities shall be provided for all cells in closed prisons.<sup>27</sup>

In terms of the suitability of accommodation, Rule 3 of the 1947 Prison Rules provided:

*“A cell shall not be used for the separate confinement of a prisoner unless it is certified by the Minister to be of such a size, and to be lighted, warmed, ventilated, and fitted up in such a manner as may be requisite for health, and furnished with the means of enabling the prisoner to communicate at any time with an officer of the prison”.*

The 1947 Rules envisaged single-cell occupancy as the norm unless medical reasons or “*other special circumstances*” required otherwise.

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<sup>24</sup> Standards for the Inspection of Prisons in Ireland (July 2009), no.18.

<sup>25</sup> *Standards* no.19, 24, 41.

<sup>26</sup> *Standards* no.20 –22.

<sup>27</sup> *Standards* no.29.

The current Prison Rules (introduced in October 2007) retain the concept of certification of cells as being fit for use. Rule 18 states:

*“18. (1) The Minister shall, in relation to a prison or part of a prison, certify that all such cells or rooms therein as are intended for use in the accommodation of prisoners are, in respect of their size, and the lighting, heating, ventilation and fittings available in the cells or rooms in that prison or that part, suitable for the purposes of such accommodation.*

*(2) (a) The Minister may specify the maximum number of persons who may, in normal circumstances, be accommodated in cells or rooms belonging to such class as may be so specified.*

*(b) The Minister shall when specifying a maximum number under subparagraph (a) have regard to the size of, and the availability of lighting, heating, ventilation and fittings in cells or rooms belonging to the class concerned.*

*(3) The Minister shall, in relation to a prison or part of a prison, designate particular cells or rooms, to be used only for the purposes of the special observation of prisoners in accordance with the provisions of Rule 64 (Use of special observation cell), and such cells or rooms must comply with the design requirements approved by the Minister for such special observation cells.*

*(4) Each cell or room used to accommodate prisoners shall be fitted with a mechanism by which a prisoner locked inside may attract the attention of a prison officer and each such mechanism shall be capable of being operated by such a prisoner at all times”.*

However, Rule 19 allows for prisoners to be temporarily accommodated in non-certified cells “if the Governor considers on reasonable grounds that exceptional circumstances exist that would warrant the prisoner concerned to be so accommodated”. Subsection (2) of Rule 19 provides:

*“The Governor shall notify the Minister if circumstances require the accommodation of a prisoner under paragraph (1) of this Rule for a period of more than 24 hours”.*

## Healthcare

### *Standards of Care*

Primary healthcare services shall be provided in each prison to a standard equivalent to that available to the community in general. This is reflected in Rule 33(1) of the 2007 Prison Rules, which states:

*“Each prisoner shall be entitled, while in prison, to the provision of healthcare of a diagnostic, preventative, curative and rehabilitative nature (in these Rules referred to as ‘primary healthcare’) that is, at least, of the same or a similar standard as that available to persons outside of prison who are holders of a medical card”.*

The provision of healthcare to prisoners shall be private and confidential. Every prisoner shall have access to appropriately qualified medical personnel in the prison at all times.<sup>28</sup>

Prisoners with mental health difficulties shall be entitled to care appropriate to their circumstances, commensurate to the type of care available for people with similar mental health difficulties in the community. Prisoners who require the services of a psychiatrist shall have access to such services. Prisoners who require psychiatric in-patient care should be transferred to a suitable hospital facility of an appropriate security level without undue delay. A multi-disciplinary service shall be available to prisoners with mental health difficulties and where appropriate such services shall be integrated with services in the community.<sup>29</sup>

### *Medical Records*

Rule 107(1) of the 2007 Prison Rules provides:

*“A prison doctor shall create and maintain such individual medical records in respect of prisoners as the Director of Prison Healthcare Services shall direct”.*

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<sup>28</sup> Standards no.54, 55, 57.

<sup>29</sup> Standards no.78–82.



Medical records shall be created and accurately maintained on all prisoners and such records shall be treated as confidential. When a prisoner is being transferred to another prison his / her medical records must be transferred with him / her.<sup>30</sup>

### ***Medical Examination***

Every prisoner shall undergo a medical examination (in private) either by a nurse reporting to a doctor or by a doctor on committal. During this initial examination, the doctor/nurse shall pay particular attention to the detection of injuries, mental illnesses, of withdrawal symptoms resulting from the use of drugs, medication or alcohol, of contagious and chronic conditions, and assess the prisoner's suicide / self- harm risk.<sup>31</sup> Following the examination, the doctor / nurse shall advise as to the appropriate accommodation for that prisoner.

The requirement for a medical examination of newly admitted prisoners has been in place since the 1947 Prison Rules, which provided:

*“9. Every prisoner shall, as soon as possible after his admission, be separately examined by the medical officer, who shall record the state of health of the prisoner, and such other particulars as may be directed”.*

The 1947 Rules also required a medical examination to be carried out by the medical officer on any prisoner who was to be transferred to another prison or discharged into the community. Rule 16 states that *“No prisoner shall be removed to any other prison unless the medical officer certifies that he is fit for removal”*.

Rule 11(1) of the 2007 Prison Rules provides that a medical examination by a doctor should take place for each prisoner on the day of their admission. This is qualified by sub rule (2) which provides:

*“Save in the most exceptional circumstances, a prisoner admitted to prison on the day of his or her committal, at a time when a doctor is not available, shall, immediately*

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<sup>30</sup> Standards no.56, 75.

<sup>31</sup> Standards no.58, 59, 61, 62.

*following his or her committal, be given a preliminary medical screening by a nurse officer, or any other person, duly authorised in that behalf, and shall then be examined by the prison doctor on the first scheduled visit of the prison doctor to the prison following his or her committal”.*

### ***Monitoring Prison Regimes***

If a healthcare professional considers that an aspect of the prison regime or environment is posing a serious risk to a prisoner’s physical or mental health this shall be reported to the Governor.<sup>32</sup>

This duty was reflected in Rule 175(6) of the 1947 Prison Rules, which provided:

*“Whenever the medical officer is of opinion that the life of any prisoner will be endangered by his continuance in prison, or that any sick prisoner will not survive his sentence or is totally and permanently unfit for prison discipline, he shall state the opinion, and the grounds thereof, in writing, to the Governor, who shall duly forward the same to the Minister”.*

More generally, Rule 184 of the 1947 rules stated that:

*“The medical officer shall have the general care of the health of the prisoners, and shall report to the Minister, and make known to the Governor, any circumstances connected with the prison or the treatment of the prisoners which at any time appears to him to require consideration on medical grounds”.*

In the 2007 Prison Rules, the duties of healthcare professionals working in the prison system are set out at Rule 100(1), and include the following:

*“(h) where he or she becomes aware of an aspect of the prison environment or regime that he or she considers to be particularly detrimental to the physical or mental health of*

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<sup>32</sup> Standards no.73.

*any prisoner or other person, draw it to the attention of the Governor as soon as may be after his or her becoming so aware”.*<sup>33</sup>

### ***Use of Special Cells***

When a prisoner is detained in any type of special cell he/she shall be regularly monitored by a prison officer. A detailed record must be maintained of, *inter alia*, the monitoring of such prisoners, their expressed requirements, actions taken in response to such requests and details of visits by officers or others to such prisoners. A prisoner detained in a special cell shall also be visited daily and as frequently as is necessary by a doctor who shall, *inter alia*, monitor his/ her physical and mental health.<sup>34</sup>

Prisoners detained in special cells shall be visited by the Governor, or such person lawfully delegated in accordance with Rule 76 of the Irish Prison Rules 2007, at least once a day.<sup>35</sup>

## **Safety of Prisoners**

### ***Risk Assessment***

Upon admission, each prisoner shall be assessed to determine whether he/she pose a safety risk to other prisoners or staff, or whether they pose a threat to themselves. If a prisoner is assessed as being at risk, such risk shall be managed for the duration of such prisoner’s sentence. Regular reviews shall be undertaken by prison management regarding the level of security required for each prisoner throughout that prisoner’s time in custody.<sup>36</sup>

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<sup>33</sup> See also Rule 104, 2007 Prison Rules.

<sup>34</sup> *Standards* no.71, 187.

<sup>35</sup> *Standards* no.189.

<sup>36</sup> *Standards* no.63, 64, 177.

### ***Prisoners on “Protection”***

Regular reviews of the placement of prisoners on protection are to take place and prisoners shall only be subject to protection status for as long as either they pose a threat to another prisoner or whilst their life or safety is under threat. Prison management are to have due regard to issues affecting prisoners placed on protection in light of the remarks made by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment which include, *inter alia*, the right to exercise in the open air, to medical and welfare treatment, access to educational and vocational training, appropriate hygiene facilities and contact by telephone and visits with the outside world.<sup>37</sup>

### ***Vulnerable Prisoners***

Prisoners assessed as vulnerable shall be accommodated in such area(s) of the prison as is most convenient and appropriate for the monitoring and treatment of such prisoners by the medical personnel and other relevant agencies. The risk associated with vulnerable prisoners, which may be an on-going risk, must be continually kept under review, and managed for the duration of the prisoner's sentence.<sup>38</sup>

### ***Maintenance of Order***

Prison staff shall maintain good order and safe security in prisons at all times while also interacting positively with prisoners. Prison staff shall promote a safe environment for prisoners.<sup>39</sup>

All incidents of bullying/violence/threatening behaviour between prisoners, and any breach of discipline shall be reported to an officer of a higher rank and shall be duly recorded and properly investigated.<sup>40</sup>

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<sup>37</sup> *Standards* no.178, 179

<sup>38</sup> *Standards* no.180, 181

<sup>39</sup> *Standards* no.132, 133

<sup>40</sup> *Standards* no.138

**Part Two**  
**Investigation of Matters Prior to the**  
**Death of Gary Douch**



## 2.1 Prison History of Gary Douch, 1998–2006

Gary Douch (“Gary”) was born in 1985, the sixth of eight children. His father has a history of schizophrenia and alcohol problems. From an early age Gary exhibited mild learning difficulties at school, together with patterns of hyperactive and disruptive behaviour. 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 continued to come to the attention of the Gardaí for antisocial behaviour. In September 1998 it was reported by Probation and Welfare Officer that he was beyond parental control and was at risk of being drawn into criminal activities. 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 15<sup>th</sup> July 2005 Gary Douch was sentenced to three years’ imprisonment, backdated to 27<sup>th</sup> 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.

DATE	TRANSFER TO	REASON
11/11/2004	Cloverhill	On remand following court appearance.
16/12/2004	St. Patrick’s Institution	Sentenced to 12 months, backdated from 18/11/2004.
31/12/2004	Mountjoy	Fighting with prisoners in St. Patrick’s, 30/12/2004.
20/06/2006	Midlands	On punishment following assault on prison officer in Mountjoy.
13/07/2006	Mountjoy	Return following punishment transfer.

## 2.2 Management of Stephen Egan, 1998–2006

### 1998 – 2000

Information made available to the Commission indicates that as a juvenile, Stephen Egan was placed into detention in the State's reformatory system. The emphasis in juvenile reform institutions is on education with a view to diverting children and young people away from paths of criminal behaviour. It is regrettably the case, however, that many individuals who enter this system eventually end up in the adult prison system. In this regard, Mr Egan's history is similar to many others.

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 refused to be seen by a psychiatrist, but he was reviewed by a psychologist, who recommended a placement at a special residential school.

During his time at St Michael's, multiple instances were recorded of Stephen Egan exhibiting aggressive, disruptive, and violent behaviour towards staff and other boys. On 7<sup>th</sup> December 1998 he absconded and was returned by Gardaí on the following day. A report from St Michael's dated 8<sup>th</sup> December stated:

*"In the interest of general safety, Stephen was segregated from the group because of his continued and escalating influence for disruption among the other boys and his threatening attitude toward staff and another boy. He did not accept that his behaviour was unacceptable".*

Stephen Egan was remanded temporarily to Trinity House Reformatory School on 11<sup>th</sup> December 1998. On 22<sup>nd</sup> December 1998, following a conviction on larceny charges, he was committed to Trinity House for 2 years.

For most of the time he was at Trinity House, Stephen Egan's behaviour seems to have improved significantly. A report dated 20<sup>th</sup> March 2000 (prepared in anticipation of a court hearing) described his progress as follows:



*“Since being committed to Trinity House School, Stephen has achieved a great deal. He has successfully completed his Junior Certificate. He has worked on a number of issues with both staff at Trinity House School and a counsellor...he has successfully made and maintained relationships with both the tuition and care staff and also his peers”.*

On 26<sup>th</sup> January 2000 he was commenced on a temporary release programme. He was returned to Trinity House by his parents on 3<sup>rd</sup> March 2000 having been arrested as a passenger in a stolen car. Subsequently his behaviour at Trinity House underwent a notable deterioration, as the report of 20<sup>th</sup> March 2000 records:

*“Since his return Stephen’s behaviour has been disruptive and totally unacceptable. He recently set fire to his room whilst locked in at bed time... The reason Stephen gave for his behaviour is that he wanted to be charged and remanded to St Patrick’s Institution”.*

Following a court appearance on 20<sup>th</sup> March 2000, Stephen Egan was discharged from Trinity House to the care of his mother.

## **2000 – 2003**

On 22<sup>nd</sup> June 2000 Stephen Egan appeared in Dublin District Court in relation to a series of alleged car thefts carried out in March and April 2000. He was remanded by the court to St Patrick’s Institution. He was 16 years old.

On 8<sup>th</sup> August 2000 Stephen Egan was transferred to Wheatfield prison. The then Governor of Wheatfield, John O’Sullivan, told the Commission that he has a clear memory of meeting Stephen Egan on at least two occasions during this period:

*“He was a big fellow; he had come from St Patrick’s Institution. In that prison he was regarded as being a disruptive individual... When I have a difficult person in my establishment that I am responsible for, I have a policy of meeting with them... I wanted to see how he could settle in. And he was okay; he wasn’t difficult at that time, not at all”.*

Stephen Egan's prison records indicate that he was transferred back to St Patrick's in January 2001.

In April 2001 he was transferred to Wheatfield prison, where he remained for approximately four months before returning to St Patrick's. In November 2001, at his own request, he was moved to Fort Mitchel prison. He returned to St Patrick's in August 2002, again at his own request. In May 2003 he was transferred to Wheatfield, ostensibly to relieve overcrowding in St Patrick's. He returned to St Patrick's Institution for the last time on 11<sup>th</sup> July 2003.

## July 2003 – November 2005

Over a period of 2½ years between 19<sup>th</sup> July 2003 and 27<sup>th</sup> 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. The principal movements are summarised in the table below:

DATE	TRANSFER TO	REASON
19/07/2003	Mountjoy	
26/09/2003	Wheatfield	Fight with another prisoner.
13/10/2003	Mountjoy	
20/01/2004	Midlands	Fight with another prisoner, 12/01/2004.
14/06/2004	Limerick	Temporary transfer following "difficulties" with other prisoners
26/06/2004	Midlands	Return following temporary transfer to Limerick.
22/11/2004	Cork	On punishment following assault on prisoner.
02/01/2005	Midlands	Return following punishment transfer.
23/01/2005	Mountjoy	Fight with other prisoners, 21/01/2005.
02/07/2005	Cloverhill	On remand following court appearance.
28/07/2005	Mountjoy	Sentenced to seven days for contempt of court (excrement thrown in courtroom).
03/08/2005	Cloverhill	Sentence for contempt of court completed.
06/09/2005	Mountjoy	
15/09/2005	Cloverhill	On remand following court appearance.
17/09/2005	Mountjoy	
07/10/2005	Cork	On punishment following assault on prison governor, 06/10/2005.
27/11/2005	Cloverhill	For court appearance. Remained there following assault on prison officer during transport from Cork Prison.

Stephen Egan was transferred to Mountjoy Prison for the first time on 19<sup>th</sup> July 2003. He stayed there for two months. On 26<sup>th</sup> September 2003 he was involved in a fight with another prisoner. He was placed on protection, and appears to have been transferred to Wheatfield prison on either that day or the following day. On 28<sup>th</sup> September 2003 he was placed on protection at Wheatfield following another fight. He was returned to Mountjoy on 13<sup>th</sup> October 2003, where he remained for a further 3 months. On 12<sup>th</sup> January 2004 he was reported again for fighting with another prisoner.

On 20<sup>th</sup> January 2004 Mr Egan was transferred for the first time to the Midlands Prison.

Midlands was a relatively new facility, having been opened in August 2000. From the time it opened until April 2008 the prison was managed by Governor John O’Sullivan. Governor O’Sullivan had encountered Stephen Egan previously at Wheatfield, shortly before taking up his post as Governor of Midlands Prison.

Stephen Egan remained in Midlands for a period of six months until 14<sup>th</sup> June 2004 when he was transferred to Limerick in a swap with another prisoner. According to Governor O’Sullivan, this was done because Mr Egan “*got into difficulties with other prisoners*”. Stephen Egan’s prison file shows that he was reported on two occasions during this period in Midlands for assaults on prisoners and on another two occasions for abusive behaviour towards staff. In evidence to the Commission Governor O’Sullivan explained that Stephen Egan’s transfer to Limerick was intended as a short-term measure:

*“I just gave him a break out of the prison to allow me to make alternative moves with other prisoners”.*

Having spent 12 days in Limerick, Mr Egan returned to Midlands on 26<sup>th</sup> June 2004 and remained there for the next five months, notwithstanding a number of further incidents of abusive and / or aggressive behaviour, which were reported as follows:

- 20 July 2004      Activated a break-glass alarm, threatened and abused staff
- 31 July 2004      Threw urine at staff, spat at Governor
- 1 Aug 2004        Threw milk carton at staff
- 6 Aug 2004        Struck an officer
- 31 Aug 2004      Verbally abused an officer
- 1 Sept 2004        Flooded his cell, verbally abused an officer
- 29 Oct 2004        Obstructed staff who were attempting to end a fight
- 20 Nov 2004        Fought with another prisoner
- 22 Nov 2004        Assaulted another prisoner

Documentation disclosed to the Commission by the Irish Prison Service (IPS) indicates that Stephen Egan was discussed at a meeting of the Disruptive Prisoners and Security Group on 11<sup>th</sup> August 2004. At that time this Group (consisting of the IPS Director of Operations together with the Governors of Mountjoy, Wheatfield, Cloverhill, Cork, Limerick, Portlaoise, and Midlands Prisons) met regularly to discuss the management of particular disruptive prisoners.<sup>41</sup> It was decided by the Disruptive Prisoners and Security Group on this occasion that Mr Egan should remain in Midlands for another two months.

Following an incident on 22<sup>nd</sup> November 2004 in which he entered another prisoner's cell and struck him a number of times to the head and face, Stephen Egan was transferred to Cork Prison for five weeks on punishment. He returned to Midlands on 2<sup>nd</sup> January 2005.

On 21<sup>st</sup> January 2005 Stephen Egan was involved in a fracas between prisoners in a yard at Midlands. He was placed in a "strip" cell – that is, a cell from which all furniture and fittings have been removed – for two days, and then transferred to Mountjoy Prison.

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<sup>41</sup> For further information concerning this Group and its functions, see chapter 5.4 below.

This latter transfer to Mountjoy marked an apparent change in policy concerning Stephen Egan's management. During the previous year he had been kept for the most part in one institution (Midlands Prison), notwithstanding an on-going pattern of disruptive and occasionally violent behaviour. However, during 2005 and 2006 he was moved on an increasingly frequent basis between Mountjoy, Cloverhill, Cork, and Midlands Prisons.

In his evidence to the Commission, Governor O'Sullivan stated:

*"...we had now reached a stage where Stephen had been burning his bridges, if I may use the phrase, and he was being moved around between a number of prisons for a period of time. The efforts that I and others were [making] was to allow him to settle and establish himself so that he could get a footing... But he wouldn't last very long in any environment. He wanted to move on and he caused disruption".*

The policy of keeping difficult prisoners on the move is referred to within the prison system as a "carousel" policy. In the IPS Operations Directorate Report into the death of Gary Douch, IPS Director of Operations William Connolly explained the rationale behind the policy as follows:

*"The practice of moving troublesome prisoners between closed prisons on a regular basis is also one which has been in operation for many years. It assists the orderly management of prisons by preventing such prisoners from getting too settled in a prison where they can then instigate trouble and plan disturbances or even escape attempts".*

Governor O'Sullivan told the Commission that he had noticed changes in Stephen Egan's demeanour and behaviour, beginning towards the end of 2004:

*"...from the latter end of 2004, after he had returned after several visits to other prisons, I could see a huge change in him. Going into 2005 he wasn't with me that often but he came for short periods on punishment, and I could see his whole demeanour changing. He was getting to be a bigger man, he was getting more aggressive and he was certainly getting more difficult to manage".*

On 2<sup>nd</sup> July 2005 Stephen Egan escaped from Cloverhill courthouse. He was recaptured ten days later. On 28<sup>th</sup> July 2005 he was sentenced to seven days imprisonment in Mountjoy for contempt

of court, following an incident in which he threw excrement in Cloverhill courthouse. Between then and October 2005 he was transferred several times between Mountjoy and Cloverhill Prisons.

On 5<sup>th</sup> September 2005 he was reported for an assault on another prisoner in Cloverhill Prison. He was transferred to Mountjoy Prison on 17<sup>th</sup> September 2005 and placed in a cell on C2 wing. On 29<sup>th</sup> September 2005 he was transferred to Cloverhill for a court appearance, returning to Mountjoy on the following day.

On his return to Mountjoy on 30<sup>th</sup> September 2005 Mr Egan was placed in a holding cell in the Reception area. He remained there overnight, along with several other prisoners, before being returned to his cell on C2 wing. The Commission has received evidence from a prisoner who states that he shared a holding cell with Stephen Egan for at least one night around this time. This prisoner told the Commission:

*“I went from the main prison in Mountjoy to the Medical Unit to do the drug course, which was a two weeks detox and a six weeks course. After the completion of that you go from the Medical Unit to the Training Unit. I completed the two weeks detox, I did the six weeks course... and although under oath I tell you, I hadn’t touched any drugs, the first morning in the Training Unit, after eight weeks I tested positive for a tiny amount of cannabis... So I was removed automatically there and then...”*

*...The night I shared a cell with Stephen Egan was the night I came back from the Training Unit.”*

The cell placement records available for this prisoner are incomplete, but do indicate that on 23<sup>rd</sup> September 2005 he was allocated a cell in the Training Unit, from which he was “de-allocated” on 30<sup>th</sup> September 2005. The next chronological entry on PIMS (the IPS computer records system) indicates that this prisoner was placed in a cell on C2 landing on 3<sup>rd</sup> October 2005. There is no record of where he was from the time he left the Training Unit on 30<sup>th</sup> September until his placement in C2 on 3 October. In light of his evidence to the Commission that he was removed from the Training Unit as a result of a positive drugs test, it seems likely that he was placed in a holding cell – either in the Reception area or in the B Base - pending his relocation to a cell in the main prison. The Commission therefore considers it likely that he did indeed share a

holding cell with Stephen Egan on the night of 30<sup>th</sup> September 2005. In a meeting with the Commission, this prisoner gave the following account of his encounter with Mr Egan:

*“I was placed that first night in the cell... with about 5, 6 people, Stephen Egan being one of them. So I would have been in the exact same circumstances Gary would have found himself in that night. I can remember the horror of having to spend a night in the cell with Stephen Egan and the fear we all felt. We spent the whole night on tenterhooks watching every word, having to placate him, having to agree with him. I remember the air being thick with fear and I thought, and after it happened to Gary all I could think of was my God this shouldn't have happened for a poor kid to be beaten to death in the Basement of a Dublin city prison.... It haunts me to this day what happened to Gary Douch. I have no doubt that neglect played a massive part in it.”*

In relation to Gary Douch, he told the Commission that he had known Gary Douch well, that he stood out because he was very young and in funny ways he could occasionally be a nuisance, he told us that Gary couldn't pass his door without coming in and asking for things, like chocolate, cigarette papers and such, but that he had good time for him and was very upset about his death particularly for his family.

The prisoner went on to tell the Commission that he recalled having a piece of cannabis in his possession on the occasion he recounts above, which he shared with Stephen Egan:

*“I arrived back from the Medical Unit, as I said, and a friend of mine, who had been in Mountjoy who I had been a next door neighbour on the landing for a long time, we would have been really good friends, sent me down a piece of cannabis down to the basement, he knew I'd probably be stuck down there, I think I was down there the whole weekend. So that was the only thing, that piece of cannabis was the only thing that appeased Stephen Egan. But another prisoner who was in the cell, and I don't know who it was, said to me a couple of days later when we were both out of there and up in the main prison, he said, “I'm telling you”, he said, “only for you shared that”, he said, “he kept whispering to me he was going to take it off you and beat the fuck out of you” and blah-blah he said.”*

After one night in the Reception area holding cell, Stephen Egan was returned to a cell on C2 on 1<sup>st</sup> October 2005.

Five days later on 6<sup>th</sup> October 2005 Stephen Egan was reported once more, this time for throwing a computer monitor at a Governor in Mountjoy Prison. As a result, he was transferred to Cork Prison on punishment, where he remained for approximately seven weeks.

## **Assault on a Prison Officer, November 2005**

On Sunday 27<sup>th</sup> November 2005 Stephen Egan was brought from Cork to Cloverhill Prison for a court appearance on the following day. The transfer took place in a minivan, with Stephen Egan being one of nine prisoners transferred in total. Accompanying them were ten prison officers and one Assistant Chief Officer.

According to a subsequent report by a Deputy Governor of Cork Prison<sup>42</sup>, the policy in Cork Prison at that time was that “*all disruptive prisoners are three-person escorts and are run separately from any other escort on the day*”. The Commission has heard evidence from a prison officer based in Cork Prison who confirmed that this was the practice in 2005:

*“Q. Again [in] your experience, insofar as separate travel was agreed, it would be provided?”*

*A. Normally it would have been, yes.*

*Q. So even though it might mean two vehicles leaving Cork Prison, that was the agreement and the practice?”*

*A. It was the norm. You can have a couple of people going to different places in Dublin and there would be different transport going”.*

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<sup>42</sup> Report of J Collins to W Connolly, 28 November 2005.



Previous Prisoners Profile forms for Stephen Egan (dated 23 August and 13 October 2005) expressly describe Mr Egan as a disruptive prisoner who requires a three-officer escort. On that basis, he should not have been moved in a van with eight other prisoners.

The escort for the transfer on 27<sup>th</sup> November 2005 was organised by a Chief Officer in Cork Prison. Initially, 9 prison officers and an ACO were detailed to accompany 9 prisoners. The ACO in charge of the transfer, [Assistant Chief Officer A] requested an extra prison officer, on the basis that it was necessary in order to maintain security during toilet breaks on the journey. This request was granted. At that time, [Assistant Chief Officer A] was not aware of the identities of any of the prisoners being transferred.

On the morning of the transfer, [Assistant Chief Officer A] discovered that Stephen Egan was one of the prisoners to be transferred. Being aware that Mr Egan had been in the “D” block of Cork Prison on punishment, [Assistant Chief Officer A] went to the Chief Officer to ask for an additional prison officer to be assigned to the transfer detail. This request was refused, apparently on the basis that no member of staff could be spared from the prison. In evidence to the Commission [Assistant Chief Officer A] stated:

*“I accepted the instruction, because with the amount that was going you don’t have that many spare [officers] on the Sunday... so if I was going to get an extra one, someone else was going to be short in the jail. So if he [the Chief Officer] could do it, I imagine he would have done it”.*

As the transport van neared the Rathcoole area of Dublin, Stephen Egan assaulted one of the prison officers, by placing his rigid metal hand-cuffs over her head and around her throat. The female prison officer in question was, like eight of her fellow officers, handcuffed to a prisoner at the time. Evidence given to the Commission by some of the prison officers who were in the van indicates that there was nothing untoward in Mr Egan’s behaviour prior to the assault. The attack by Mr Egan was completely unexpected by the officers. It took place suddenly and with considerable violence. But for the immediate reaction and intervention of two prison officers in particular, namely [Prison Officer A], whose actions were particularly heroic and his fellow [Prison Officer B] who swiftly came to his aid, the victim of Mr Egan’s assault might have suffered serious injury or worse. It has to be remembered that these two courageous officers (and

all bar two personnel on that bus) were handcuffed to other prisoners at the time of Stephen Egan's attack.

It required the intervention of several prison officers and the ACO before Mr Egan's hold on the 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. [Prison Officer B] told the Commission:

*"Stephen Egan would have been struggling violently, he was really resisting. He was a big strong young man and we just had him, for that time we had to pin him until normally when you do that you would hope someone calms down a bit, he didn't."..*

[Prison Officer A] was head-butted three times by Stephen Egan whilst trying to free the prison officer whom Mr Egan had taken hostage. He told the Commission:

*"He was using his head as a weapon. His hands were coming up and he was bucking like a mule trying to get loose..."*

*So [Assistant Chief Officer A] asked us could we hold him and we said just get us to Dublin, we'll take care of him. So we held him. So I was across his upper body up around the shoulder leaning in. So I had to keep my head into his face because he was trying to turn around and bite. He ended up actually biting through a steel watchband I had on, bit that, bit it open".*

On arrival at Cloverhill, Stephen Egan continued to struggle violently and had to be carried by several officers into a holding cell. [Prison Officer B] told the Commission:

*"We were alerted a number of minutes afterwards by Cloverhill staff that as soon as we had headed towards the nurses' station in reception that he had started to smear himself and the cell with excrement, his own excrement".*

[Prison Officer A] described the movement of Stephen Egan from the transport van into Cloverhill to the Commission as follows:

*“We couldn’t get Stephen Egan onto his feet out the normal exit because [he was] too big, too strong and unbelievably violent. So the decision was made we’d open the [fire] exit. We brought him out and we had to flip him then to get the handcuffs off the front to around the back because if you held them on the front, he was going to take someone again with the head. So we had a major problem getting him from Cloverhill then into the holding cells. Within three minutes inside in the holding cell he excreted onto himself, banging the door, head-butting it ... and screaming that he wasn’t coming back to Cork”.*

A form on Mr Egan’s medical file indicates that he was later moved from the holding cell in Reception at 4.15 p.m. and placed in a close supervision or safety observation cell. The reason given on the form was: “*danger to others*”. The form was signed by a nurse officer. Stephen Egan remained in the close supervision cell until 4.10 p.m. on the following day, 28<sup>th</sup> November 2005. Entries on PRIS, the computerised records system, do not record where Mr Egan was on either 28<sup>th</sup> or 29<sup>th</sup> November. On 30<sup>th</sup> November he is recorded as being in a cell on the “security” side of D2 wing – that is, the section of D2 which houses difficult or violent prisoners. He remained there for the next three days.

The IPS Director of Operations was made aware of the incident on the day it occurred (27<sup>th</sup> November 2005) and requested a report from the management of Cork Prison. On the following day, 28<sup>th</sup> November 2005, Deputy Governor James Collins of Cork Prison requested a report from [Assistant Chief Officer A], the officer in charge of the escort. Following receipt of a two-page report from [Assistant Chief Officer A], Deputy Governor Collins prepared a report for the IPS which summarised the facts of the incident and pointed out that the transport had been carried out in breach of prison policy concerning the escort of disruptive prisoners. Deputy Governor Collins also indicated that written statements would be obtained from the staff involved.

The incident was formally recorded by the prison officers involved in the incident using P.19 forms – the standard forms which are used to record breaches of discipline by prisoners. Two such forms were completed at Cloverhill Prison on the day of the assault. One related to the attempted escape and hostage-taking, the other reported Stephen Egan’s violent resistance to the attempt by [Prison Officer A] to restrain him.

Also on 28<sup>th</sup> November the Prison Officers Association (POA) met with Deputy Governor Collins to discuss the incident and in particular, why Stephen Egan had not been given a separate three-man escort. POA representatives at the meeting reminded Deputy Governor Collins that two weeks prior to the incident, the POA had complained about prisoners being downgraded too easily in terms of security risks.<sup>43</sup>

Written statements were submitted to the Governor of Cork Prison by the various prison officers involved in the incident. These reports were received on various dates between December 2005 and February 2006.

The incident was also reported to the Gardaí in Naas Garda Station on the evening of 27<sup>th</sup> November 2005 by [Assistant Chief Officer A]. A Garda investigation was carried out and Stephen Egan was charged in relation to his assault on the female prison officer in the van. He was also charged with assaulting [Prison Officer A], who in attempting to restrain Mr Egan had sustained injuries to his lower back, neck, and right arm. When the case came to be heard in July 2007 Stephen Egan pleaded guilty to assaulting the female prison officer, for which he received a sentence of three years imprisonment. The charge in relation to his assault on [Prison Officer A] was dropped.

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<sup>43</sup> Minute of POA meeting with Deputy Governor Collins, 28 November 2005.

## December 2005 – July 2006

The following table summarises Stephen Egan’s movements around the prison system for the six months preceding his transfer to the Central Mental Hospital on 5<sup>th</sup> July 2006.

DATE	TRANSFER TO	REASON
02/12/2005	Mountjoy	Transfer for “security reasons”.
25/01/2006	Cloverhill	On remand following court appearance.
16/03/2006	Mountjoy	Transfer for “security reasons”.
04/06/2006	Midlands	On punishment following multiple disciplinary incidents (setting fire to cell, flooding cell, assault on prison officer).
22/06/2006	Mountjoy	Transfer for “security reasons”.
05/07/2006	Central Mental Hospital	Transfer under s.15 Criminal Law (Insanity) Act 2006.

On 2<sup>nd</sup> December 2005 Stephen Egan appeared before the Circuit Criminal Court. He was committed to Cloverhill but then transferred to Mountjoy that same day, for “*security reasons*”. On 9<sup>th</sup> December 2005 he was placed in a special observation cell (also known as a “strip” cell) on C2 wing at his own request. On 17<sup>th</sup> December 2005 he set fire to the cell, claiming visual and auditory hallucinations. He was moved to another special observation cell, also on C2 wing.

Stephen Egan was reviewed by a consultant psychiatrist on 19<sup>th</sup> December 2005, who reported that there were no medical reasons to continue to keep him in a special observation cell. Nonetheless, his medical records indicate that he remained in the cell until 25<sup>th</sup> January 2006, when he was transferred to Cloverhill Prison. This is confirmed by entries on the computerised Prisoner Records Information System (PRIS) used by the Irish Prison Service.

Daily medical notes during that time indicate that from 21<sup>st</sup> December 2005 until 3<sup>rd</sup> January 2006 Stephen Egan was kept in the special observation cell for “*management reasons*”. A note for 3<sup>rd</sup> January 2006 indicates that a decision was taken to move him out on that day, subject to a suitable location being found. Daily medical notes for the next seven days state that he “*may*

*come out*” or is “*allowed out*”, but it seems that he was not moved at this time. A medical note dated 11<sup>th</sup> January elaborates:

*“May come out – staying at own request – no psychiatrist”.*

Further medical notes for 15<sup>th</sup>, 16<sup>th</sup>, 17<sup>th</sup>, 19<sup>th</sup>, 21<sup>st</sup>, and 22<sup>nd</sup> January indicate no essential change in the situation.

The medical aspects of Stephen Egan’s treatment during this period are considered further in the next chapter of this report. For the present, it is sufficient to note that Mr Egan was kept in a special observation cell for a period in excess of one month during December 2005 and January 2006 and that this appears to have been done for reasons of management rather than as a result of any medical or psychiatric direction.

IPS documentation disclosed to the Commission shows that Egan was brought before the Dublin Circuit Criminal Court on 25<sup>th</sup> January 2006 in connection with a robbery charge. The matter was adjourned and he was remanded in custody to Cloverhill Prison. According to the PRIS computer record he was placed in a close supervision cell on the “security” side of D2 wing – that is, the side of D2 which was reserved for troublesome or disruptive prisoners.

On 15<sup>th</sup> February 2006 Stephen Egan submitted a written request for a transfer to Midlands Prison. At that time he was a remand prisoner, due to be sentenced on 27<sup>th</sup> July 2006. The Department of Justice approved Mr Egan’s transfer request, on the basis that it would take place after he was sentenced.<sup>44</sup>

On 3<sup>rd</sup> March 2006 Mr Egan was moved from D2 wing to a cell on one of the ordinary prison wings. On 7<sup>th</sup> March he was moved back to a strip cell on the “security” side of D2. On a form filled out by the supervising officer, the stated reason was “*danger to others*”. One day later he was moved again, this time to a special observation cell (formerly referred to as a padded cell) on the “vulnerable” side of D2 – that is, the side of D2 used to house prisoners exhibiting

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<sup>44</sup> In the event, this anticipated transfer did not take place. At the court hearing on 27<sup>th</sup> July the sentencing of Mr Egan was postponed until 20<sup>th</sup> October 2006. By that time, the killing of Gary Douch on 31<sup>st</sup> July 2006 had altered the situation irrevocably.

mental or physical vulnerabilities. The stated reason on this occasion was “*Dirty protest. Danger to self & others*”. According to the form filled out by the supervising officer, Stephen Egan was moved out of the special observation cell on 10<sup>th</sup> March 2006. However, this conflicts with the PRIS computer record, which indicates that he remained in the special observation cell until 16<sup>th</sup> March 2006, at which point he was transferred out of the prison altogether.

On 15<sup>th</sup> March 2006 Stephen Egan was approved for transfer from Cloverhill to Mountjoy Prison. The Transfer Request Form which was faxed to the IPS from Cloverhill described the reason for the transfer as “*a swap for security reasons*”. The transfer request is marked “approved” by the relevant IPS official. The Commission was told by the IPS that this approval was merely an approval in principle, and that no formal request was made by Cloverhill Prison for a Ministerial order authorising the transfer. However, the use of a Transfer Request Form is in accordance with the procedure outlined in an IPS circular to all prison Governors dated 21 September 2005. It contains a date for the proposed transfer, a reason for the transfer and, in the Commission’s view, must be interpreted as a formal transfer request. As a matter of law, no prisoner can be transferred to another prison without the formal sanction of either the Minister for Justice or a court of law. It is a matter of great concern to the Commission that this transfer apparently took place without the necessary formal legal authority. Nor is it the only such instance of which the Commission is aware. This issue will be returned to at a later stage of the Commission’s report.<sup>45</sup>

Gatekeeper’s records from Mountjoy Prison show that Stephen Egan was transferred there on Thursday 16<sup>th</sup> March 2006. However, entries in the Prisoner Records Information System (PRIS) record him as arriving at Mountjoy on 18<sup>th</sup> March, two days later. This error, the reason for which is unknown, is further cause for concern in relation to the documenting of inter-prison transfers.

According to PRIS, Stephen Egan was kept in a holding cell in the Reception area of Mountjoy until 1<sup>st</sup> April 2006 – a period of 15 days. However, written records kept at Mountjoy Prison show that this entry in PRIS is incorrect: Mr Egan was kept in the Reception area for a brief period following his arrival, but was placed in a cell on C2 wing by 10.45 a.m. that morning. He

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<sup>45</sup> See chapter 5.5 below

remained on C2 wing until 15<sup>th</sup> April 2006, when he was moved to a single cell in the “B Base” area.

On 20<sup>th</sup> May 2006, Egan was reported for setting fire to his cell in “B Base”. He said he did it “*to get out of the Base*”. On 27<sup>th</sup> May, Stephen Egan was moved to a cell on C3 Wing and then to a holding cell in the “B Base”, where he was again reported, this time for throwing water at a prison officer. On 30<sup>th</sup> May, he was reported once more, this time for flooding the holding cell. He told prison officers he did it because he wanted to be moved.

On 4<sup>th</sup> June 2006 Stephen Egan was transferred to Midlands Prison on punishment. During that time he was reported again, this time for being involved in a fight with another prisoner. He was returned to Mountjoy on 22nd June 2006. It is not clear in what part of the prison Stephen Egan was placed on his arrival, as PRIS does not record his being in Mountjoy until 24<sup>th</sup> June, two days later. On that date he was placed in a special observation cell in the “B Base” following his involvement in another fighting incident. Mr Egan appears to have remained in that special observation cell until 5<sup>th</sup> July 2006, when 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.

Prior to the introduction of the computer-based Prisoner Healthcare Management System (PHMS) in 2010 / 2011, the primary source of medical information regarding a prisoner was a paper medical file. This file was supposed to travel with the prisoner in the event of his being transferred to another prison. However, it is clear from the documentation disclosed to the Commission that this did not always happen in the case of Stephen Egan.

In the event that the medical file did not arrive with the prisoner, a new file would be opened by the receiving prison. Any newly created documents or notes would be stored in this temporary file and then added to the main medical file when it arrived. As a result, medical files were often not in chronological order. This was the case with Stephen Egan's file.

From examining the file and other documentation disclosed to it by the IPS and the National Forensic Mental Health Service, the Commission is aware that there are some documents, copies of which should be contained in Mr Egan's paper medical file, that are missing from the file as it

currently exists.<sup>46</sup> There may be other documents or medical notes missing of which the Commission is unaware.

## **Psychiatric History of Stephen Egan, 2000 – 2005**

In Stephen Egan's prison medical file, as disclosed to the Commission, the earliest entry on a Psychiatric Continuation Sheet dates from November 2001, when Mr Egan was at Fort Mitchel.

There is some evidence of psychiatric intervention prior to this time. An undated medical record from Mr Egan's prison medical file states, under the heading, 'History of Psychiatric Illness':

*"Seeing psychiatrist in Trinity House, Lusk, last seen approx 6/12 ago".*

Documentation received from the Mater Hospital indicates that he was seen by a consultant psychiatrist at the hospital in or around January 1998, following treatment for a drug overdose. Documentation disclosed to the Commission from Trinity House indicates that in May 1999 Stephen Egan was offered the opportunity to see a psychiatrist there but declined. However, he did attend sessions with a counsellor on a twice-weekly basis from May 1999 until his discharge from Trinity House in March 2000.

The first psychiatric continuation sheet entry on Mr Egan's prison medical file, dated 21<sup>st</sup> November 2001, records details of Stephen Egan's personal history, including his home background and relationships. The next entry, dated 5<sup>th</sup> December 2001, notes that a request for sleeping tablets was refused.

There are no further entries in relation to Stephen Egan's psychiatric health until 14<sup>th</sup> July 2003, at which time he was in St Patrick's Institution. That entry contains details of Mr Egan's

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<sup>46</sup> These include the prescription sheet detailing Stephen Egan's prescribed medication from 14 July 2006, and a letter from [Consultant Psychiatrist G], Acting Consultant Psychiatrist to the GP at Cloverhill Prison concerning a psychiatric review carried out at the prison on 17<sup>th</sup> July 2006. See chapter 2.5 below.

personal history including drug use and anger management, and concludes, “*No overt psychosis*”.

Five days later on 19<sup>th</sup> July 2003 Stephen Egan was committed to Mountjoy Prison for the first time. The committal details form, under the heading ‘Psychiatric History’, simply states “*no*”. On 20<sup>th</sup> July 2003 Stephen Egan was seen by the GP on duty in Mountjoy, who noted that Mr Egan had a history of depression for which he had been prescribed Librium and sleeping tablets. The GP prescribed a withdrawal from both prescriptions over one week and counselled Mr Egan regarding the use of benzodiazepines and sleeping tablets. He also requested that Mr Egan be reviewed by a psychiatrist. A subsequent note added to the GP’s written request for a psychiatric review states:

“*Seen 21/7/03*  
*Not for review.*”

This note is signed but the signature is unclear.

Stephen Egan was next seen by psychiatric services on 2<sup>nd</sup> September 2004 in Midlands Prison, at his own request. The relevant entry on the prisoner’s medical file states:

“*Self referral to psychiatric services. Interviewed in cell in punishment block as he had caused some damage to his own cell... Says he is short tempered and would like something to help him relax. Smoked hash as recently as last night according to himself. No evidence of any psychotic symptoms. Mood subjectively and objectively fine. Advised to refrain from smoking hash*”.

On 3<sup>rd</sup> 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 identities of the prison officer and the medical team member who visited Mr Egan are not recorded in Mr Egan’s prison medical file. The relevant medical notes state:

“*Called to see Stephen. Officer concerned. Stephen states he is ok. His cell was very untidy, he appears hyperactive, states he can’t sleep...*”

The documentation disclosed to the Commission does not indicate whether there was any further medical or psychiatric follow-up to this visit. We cannot assume that Mr Egan was referred to the Psychiatric In-reach Service at this time.

On 27<sup>th</sup> November 2005 Stephen Egan assaulted a prison officer during a transport from Cork Prison to Cloverhill Prison. He continued to struggle violently with prison officers for the remainder of the journey, and smeared himself and his cell with excrement on being placed in a holding cell at Cloverhill. He was kept overnight in a close supervision cell because of the risk he posed to others. Prison records do not show where he was kept on 28<sup>th</sup> / 29<sup>th</sup> November 2005, but on 30<sup>th</sup> November he is recorded as being in a cell on the “security” side of D2 wing.<sup>47</sup>

Notwithstanding the unexpected, unprovoked and violent nature of Mr Egan’s assault on the prison officer, on the transport from Cork and the fact that his behaviour continued to escalate bizarrely, 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 27<sup>th</sup> November until his transfer to Mountjoy Prison on 2<sup>nd</sup> December 2005. Nor does he appear to have been referred to the Psychiatric In-reach Service during this period.

The Commission notes that on a number of occasions while being treated at the Central Mental Hospital in August-September 2006, Stephen Egan himself described the incident on 27<sup>th</sup> November 2005 as marking the beginning of his mental health problems. On 3<sup>rd</sup> August 2006 (three days after the death of Gary Douch), it was noted:

*“Said he has been experiencing voices from ‘screws’ since ‘my head opener’ in a prison van several months ago”.*

In the course of a psychiatric review on 6<sup>th</sup> September 2006 it was noted:

*“He said he only became aware of the beasts and ‘the signal’ when he had the ‘head opener’ while trying to escape from the van”.*

During a further review on 8<sup>th</sup> September 2006 the following was noted:

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<sup>47</sup> See above p. 130 et seq.

*“Gives inconsistent [accounts] of his experience of ‘head opening’ which he states the MJP [Mountjoy Prison] POs [Prison officers] did (he heard something and ‘just knew’ it had happened. No physical sensation associated) after he had taken the female P.O. hostage”.*

It is possible that in these interviews Mr Egan was being self-serving in seeking retrospectively to place his violent outburst on 27<sup>th</sup> November 2005 in a context of mental illness. Nonetheless, the Commission remains of the view that his behaviour during and after the escape attempt was such that he should have been referred to the Psychiatric In-reach Service at that time. This was not done.

The question of the origin, nature, and development of Stephen Egan’s mental health problems is addressed in more detail in chapter 2.4 of this report, which considers his care and treatment at the Central Mental Hospital in July 2006.

## **Mountjoy Prison, December 2005 – January 2006**

On 2nd December 2005 Stephen Egan was transferred from Cloverhill to Mountjoy Prison. This transfer followed the incident referred to above in which he had attempted to take a female prison officer hostage whilst travelling in a van from Cork to Cloverhill Prison on 27<sup>th</sup> November 2005.

### ***Placement in Special Observation Cell***

On 9<sup>th</sup> December 2005, one week after his arrival at Mountjoy Prison, Stephen Egan requested to be placed in a special observation cell. He was placed in a “strip” cell on C2 wing.<sup>48</sup> A medical note dated 10<sup>th</sup> December states: *“Very vacant, monosyllabic tone”*. A note dated 14<sup>th</sup> December states:

*“S/b [Doctor B] – awaiting review*

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<sup>48</sup> That is, not a padded cell, but a single-occupancy cell from which furniture and fittings have been removed.

*[Consultant Psychiatrist A] – remain on ob in spec cell”.*

[Doctor B], who was the registrar to [Consultant Psychiatrist A], wrote to [Doctor A], GP for Mountjoy on 13<sup>th</sup> December 2005 as follows:

*“I reviewed the above named gentleman as part of the Visiting Psychiatry Service on 12.12.05. Review was requested due to the fact that Mr Egan was reported as being ‘vague and distracted’...*

*I attempted to review Mr Egan in the strip cell but he refused same”.*

It was agreed that Stephen Egan would remain in the special observation cell until such time as he was reviewed by [Consultant Psychiatrist A].

A further note on Stephen Egan’s medical file indicates that a member of the Psychiatric In-reach team reviewed him on 15<sup>th</sup> December 2005. The note states:

*“Remains in strip cell.*

*Note [history] of violent behaviour and on protection.*

*Spoke with prison officer on [kidnapping]*

*Further episode of aggressive behaviour when cell opened, took 5 officers to return him to cell.*

*Not felt to be safe to open cell to conduct interview...”*

The note concludes:

*“Appears he needs to remain in strip cell currently due to safety issues.*

*Keep under review.*

*Will warn [Consultant Psychiatrist A] re situation”.*

A medical note for 16<sup>th</sup> December 2005 states:

*“Egan in special cell – sitting on bed will not answer questions / remain under review  
obs in special cell”*

A medical note for 17<sup>th</sup> December 2005 states:

*“Seen in sp cell. No med complaints. / Review by Psych. On Mon”.*

A medical note for 18<sup>th</sup> December 2005 states:

*“reviewed in sp cell*

*Set fire to his cell in M’joy y’day.*

*Says he did it because he saw ‘snakes coming out of the toilet’. Also claims auditory  
hallucinations. Seems alert, calm, and orientated.*

*Review by psychiatry a.m.”*

[Consultant Psychiatrist A] reviewed Stephen Egan on 19<sup>th</sup> December 2005. In a letter to [Doctor A], GP at Mountjoy he stated:

*“When seen he was coherent and oriented. There was no evidence of paranoia or  
thought disorder...”*

*There are no medical indications for Mr Egan to remain in the strip cell. It is likely that  
he may have been recently intoxicated which accounted for the bizarre behaviour. We  
will arrange to review him as required”.*

Based on this review – and in particular, on the fact that no evidence of a mental disorder had been elicited – [Consultant Psychiatrist A] decided not to prescribe any anti-psychotic or anti-depressant medication.

It is not clear to the Commission why [Consultant Psychiatrist A] considered intoxication as a likely explanation for Stephen Egan’s behaviour. Mr Egan had been in a strip cell, in conditions akin to solitary confinement for ten days prior to [Consultant Psychiatrist A]’s review. It is difficult to see how he would have acquired the means to become intoxicated under those

circumstances. If intoxication was considered a likely explanation for his behaviour on 18<sup>th</sup> December 2006 (the day before [Consultant Psychiatrist A] reviewed him), a urine test could have been requested to confirm the presence of drugs or alcohol in Stephen Egan's system. It appears that this was not done.

The Commission's query regarding the use of intoxication as a potential explanation was brought to the attention of [Consultant Psychiatrist A], who in a written submission gave the following explanation for his views:

*"...my clinical view was that Mr Egan was in withdrawals following intoxication, most likely due to his benzodiazepine use prior to being placed in the isolation cell and not acute intoxication per se. Suffering from drug withdrawals was the most likely explanation for Mr Egan's clinical presentation at that time.*

*Visual hallucinations such as 'snakes coming out of the toilet' are more characteristic of a withdrawal state rather than an acute psychotic state. Mr Egan has a well-documented history of using benzodiazepines, sleeping tablets and a history of drug-seeking behaviours. As the Commission correctly pointed out, Mr Egan had been in 'conditions of solitary confinement for ten days prior to [Consultant Psychiatrist A]'s review'. Therefore a urine analysis test would not have been of any assistance in making a diagnosis when seen by me."*

*Mr Egan's symptoms had settled by the time of my review on 19<sup>th</sup> December 2005 and there was no clinical indication for him to be prescribed medication at that time."*

Documentation on Stephen Egan's prison file indicates that, notwithstanding [Consultant Psychiatrist A]'s opinion that it was not medically necessary for Mr Egan to remain in the strip cell, a decision was made to keep him there for "management reasons". Notes on Stephen Egan's medical file indicate that although a decision was made to move him out of the cell on 3<sup>rd</sup> January 2006 (subject to a suitable location being found) in fact he remained in the strip cell until 25<sup>th</sup> January 2006, when he was transferred to Cloverhill Prison. Daily medical notes indicate that this was at least partly due to Mr Egan's unwillingness to leave the strip cell.



In an interview with Stephen Egan, conducted on 8<sup>th</sup> September 2008 in anticipation of his trial for the murder of Gary Douch, Consultant Forensic Psychiatrist Professor Tom Fahy noted the following description by Mr Egan of his behaviour during the period of December 2005 – January 2006:

*“Mr Egan informed me that when on remand in Mountjoy Prison in December 2005 he began to experience psychotic symptoms. He was on remand on a charge of armed robbery. In addition, he had recently tried to escape from a prison van. Because of the escape attempt he was placed in isolation. He says that on December 1<sup>st</sup> he heard a voice saying ‘get the sheets ready’. His interpretation of this experience was that others were planning to hang him. While in a stripped cell, the frequency and intensity of the voices increased. He believed that the voices emanated from the box-shaped structure under the cell mattress. He thought that there was a demon in the box. He began to hear voices stating that they were going to kill his family. He felt that if he left the strip cell, his family would be killed. He remained in this cell for two and a half months. He says that he was not depressed or suicidal at the time, but was frightened. He said that he also started to hear his family screaming. He would look out of the window to try to find the origin of these sounds. He said that he became convinced that his family were going to be killed, possibly because of his antagonistic behaviour in the prison or as punishment for his escape attempt.*

*Mr Egan said that he also began to hear voices talking to his mother on the phone, stating that he was on heroin, and that ‘the only way I was going out was in a box’. He believed that ‘they had my family two doors down and were trying to saw them in half’. He said that on one occasion he made a desperate effort to reach their cell. He said that he could not tell staff at the prison about his experiences as ‘I thought they were in on it. I couldn’t trust them’”.*<sup>49</sup>

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<sup>49</sup> Psychiatric Report on Stephen Egan dated 8 October 2008, prepared by Professor Tom Fahy MD MPhil FRCPsych at the request of the Chief Prosecution Solicitor.

[Consultant Psychiatrist A], in his evidence to the Commission, expressed the view that the use of strip cells for non-medical, security purposes could be a legitimate management response in circumstances where the prisoner concerned posed a high risk of harm to others:

*“Q: Is the strip cell the place to use for management reasons?”*

*A: ...I think that is legitimate. If somebody is at high risk of harm to others and he has been cleared from a medical point of view, the strip cell – I think that is legitimate, yeah.*

*Q: There are provisions about the use of the strip cell and rules, and all of that.*

*A: Yes... everybody in the strip cell is reviewed... by both the Governor and the GP, on a regular basis”.*

However, [Consultant Psychiatrist A] also pointed out that the social isolation and sensory deprivation associated with long stays in such cells were inimical to mental health and could have exacerbated some of Stephen Egan’s mental health problems:

*“A: ...The strip cell, you are quite correct, in that it does carry with it an inherent risk of someone becoming psychotic...”*

*Q: You see because of what we have seen, again from the records is... he is spending the beginning of 2006, quite a considerable amount of time in the strip cell, and there is a review on 9<sup>th</sup> February 06 and it is noted that he had depression... is some of this developing out of those kinds of conditions?*

*A: Yeah, I have no doubt that some of his condition is exacerbated by social isolation and sensory deprivation. It is not congenial to good health to be in a strip cell”.*

## **Cloverhill Prison, February – March 2006**

Following an appearance in Dublin Circuit Criminal Court in connection with a robbery charge, Stephen Egan was remanded to Cloverhill Prison on 25<sup>th</sup> January 2006. He was reviewed there

by [Consultant Psychiatrist B] on 1<sup>st</sup> February 2006. [Consultant Psychiatrist B] noted details of Mr Egan's background history including his drug use, but the review was terminated abruptly by Stephen Egan before a full assessment could be made. In a letter to the GP at Cloverhill dated 2<sup>nd</sup> February 2006 [Consultant Psychiatrist B] stated:

*"It may be that Mr Egan is presenting with a paranoid psychosis for that reason he should remain on D2 until a clinical opinion may be formed."*

A medical note for 5<sup>th</sup> February 2006 records that Stephen Egan's father telephoned the medical unit at Cloverhill to express his concern that Stephen had refused a visit on the previous day. The note continues:

*"Spoke to Stephen on D2 – wouldn't elaborate on why he refused visit, states he's 'grand'. Appeared vague with? Poverty of thought. Observed sitting in recreation alone with head in hands. Staff report deterioration in mood, weight loss + no interaction. Observed to have shaved beard off.*

*For review by psych team tomorrow".*

### ***Decision to Prescribe Medication***

Stephen Egan was reviewed by [Consultant Psychiatrist C], a member of the Psychiatric In-reach team, on 9<sup>th</sup> February 2006. It seems that Stephen Egan's prison medical file was not in Cloverhill at that time: [Consultant Psychiatrist C]'s report of her review noted that only "limited details" of Mr Egan's forensic history were available, and that the inmate medical file seen by her was a new one. From this one concludes that the psychiatric review carried out by [Consultant Psychiatrist A] in December 2005 at Mountjoy was not available to either [Consultant Psychiatrist B] or to [Consultant Psychiatrist C] when they reviewed Stephen Egan on 1<sup>st</sup> and 9<sup>th</sup> February 2006 respectively.

[Consultant Psychiatrist C]'s report, in the form of a letter to the GP at Cloverhill dated 14<sup>th</sup> February 2006, gave details of Stephen Egan's background history and his current presentation, including an examination of his mental state. Under the heading 'Impression and recommendations' the report stated:

*“... My overall impression was that Mr Egan was both depressed and psychotic. I have prescribed Escitalopram 10 mgs daily and Olanzapine 10 mgs nocte. I plan to contact his family for a collateral history. He is currently safe to remain in an ordinary location on D2. Our staff will continue to review him”.*

Escitalopram is an anti-depressant; Olanzapine is an anti-psychotic medication.

In her evidence to the Commission [Consultant Psychiatrist C] commented on this part of her report, stating:

*“By ‘an ordinary location’ I meant that he was safe to be in a shared cell on D2 as opposed to a single cell or in a strip or pad cell”.*

In relation to the necessity for on-going review, [Consultant Psychiatrist C] told the Commission:

*“Well, as I said, there were members of the In-reach team attending the majority of days between Monday and Friday. The recommendation was that he would be seen by – I didn’t specify, therefore I can’t say whether I meant the next person who’s in or whether I meant in approximately a week. I didn’t specify, but that he would be listed for review by our service”.*

### ***Administration of Medication***

Drug administration records from Cloverhill indicate that Mr Egan took the prescribed medication daily from 9<sup>th</sup> to 16<sup>th</sup> February 2006. From 17<sup>th</sup> February to 3 March 2006 he is noted as refusing to take the medication. No further attempts to administer the medication are recorded after 3<sup>rd</sup> March. It is accepted that prisoners cannot be forced to take medication against their will. Nonetheless, it is surprising that Stephen Egan’s consistent refusal to take his prescribed medication does not seem to have been brought to the attention of the Psychiatric In-reach Service; or if it was, that no further psychiatric review was carried out.

In this instance he only appears to have taken medication for a very brief period of seven days.

[Consultant Psychiatrist B], in his evidence to the Commission, emphasised the importance of communicating such information, stating:

*“In that individual’s best interests it would be important to communicate that medication wasn’t being taken...The people who administer the medication, who know that the medication is being taken or not, are the nursing staff. So more than the prison officers, they would be the critical person to communicate worries about medication.”..*

[Consultant Psychiatrist B] expressed particular concerns in relation to prisoners on Olanzapine, stating:

*“There are some medications which may be more worrying than others with regard to the speed by which someone might relapse, Olanzapine being one...*

*There is no reliably predictable comment one can make about a situation where you stop Olanzapine and you suffer from a particular mental illness and that within a particular time period you may be expected to relapse... relapse can occur rapidly, but it doesn’t occur reliably rapidly for everyone who might stop Olanzapine. Certainly I have come across patients who have become quite ill very quickly, one or two of whom have gone to serious violence”.*

### ***Further Psychiatric Review***

Notwithstanding [Consultant Psychiatrist C]’s recommendation in her report of 14<sup>th</sup> February 2006 that Stephen Egan remain on D2 and be subject to on-going psychiatric review, there is no record of Mr Egan being seen by the Psychiatric In-reach Service from 9<sup>th</sup> February 2006 until 26<sup>th</sup> June 2006 – some 4 months later – when he was seen in Mountjoy Prison following a request from a GP that he be reviewed.

The Commission is of the view that this was neither acceptable nor was it good practice in the circumstances.

The HSE have expressed the view to the Commission that the onus was solely on the IPS, in that they should have re-referred Stephen Egan to the HSE Psychiatric In-Reach Service again

following his move to Mountjoy. The Commission considers that this should not be required nor considered good practice nor in this instance be regarded as a valid interpretation of what the Consultant Psychiatrist, [Consultant Psychiatrist C], a member of the HSE In-Reach team envisaged for her patient Stephen Egan, following her assessment of him on the 14<sup>th</sup> February 2006, particularly having regard to her written instruction that he remain on D2 and be subject to on – going psychiatric review, which clearly was intended to provide continuity of care and review, without the need for re-referral.

The absence of any on-going review is particularly puzzling given that on 8<sup>th</sup> March 2006 Stephen Egan was moved to a special observation cell on the “vulnerable” side of D2 where he remained until at least 10<sup>th</sup> March 2006, and possibly (according to the PRIS computer record) until his transfer to Mountjoy on 16<sup>th</sup> March 2006. The stated reason for placing him there was that he was a danger to himself and to others.

The Commission has been given to understand that prisoners placed in a special observation cell on D2 in such circumstances would be reviewed as a matter of priority. In his evidence to the Commission, [Consultant Psychiatrist A] described his routine in attending Cloverhill as follows:

*“The system... was that there was a white board up with the high level of obs [i.e. the special observation cells], those two or three cells there, and the strip cells... I wrote them down on a note, the nurse would give me the charts, we would go around together, and I would routinely review everybody”.*

Yet there is nothing in the documentation disclosed to the Commission to indicate that Stephen Egan was reviewed by any member of the Psychiatric In-reach Service between 9<sup>th</sup> February 2006 and 16<sup>th</sup> March 2006, including the period when he was in a special observation cell. A note on Mr Egan’s prison medical file indicates that he was seen by the prison GP for a fungal infection on 10<sup>th</sup> March 2006: the GP noted him as “*feeling well*” on that occasion.

The Commission discussed the apparent absence of on-going psychiatric review with [Consultant Psychiatrist C], who commented as follows:

*“Q: In terms of the on-going review by the Psychiatric Service, the In-reach Service, it doesn’t appear that the Commission has any note of any further review by the In-reach Service. It would also appear, from information available to us, that he was non-compliant with medication on foot of your prescription. Assuming he didn’t take the medication, should [he] still be pencilled in for review?”*

*A: Yes.*

*Q: And if a person is to leave your service in the sense that he is discharged from care that would be formally noted. Am I right in thinking that?”*

*A: You mean if a member of our team saw him and believed he no longer needed review?”*

*Q: Yes.*

*A: Yes, that would be formally noted. The absence of that is indicated, in that it simply didn’t occur”.*

### ***Transfer from D2 Wing***

The Commission has also been told by members of the Psychiatric In-reach Service, namely, [Consultant Psychiatrist A] and [Mental Health Nurse A], a Community Psychiatric Nurse, that it was their understanding that a prisoner could not be moved from D2 without the written sanction of a clinician. Yet it seems from the available records that Stephen Egan was moved from D2 on either 10<sup>th</sup> or 16<sup>th</sup> March 2006 without the approval, written or otherwise, of either a prison GP or a member of the Psychiatric In-reach Service. The Commission has further discovered that his subsequent transfer directly from D2 to Mountjoy prison also took place without medical or psychiatric consultation or approval. As [Consultant Psychiatrist C] pointed out in her evidence to the Commission:

*“The last assessment was to stay in D2”.*

The process by which Stephen Egan went from D2 wing at Cloverhill to Mountjoy on 16<sup>th</sup> March 2006 without medical or psychiatric consultation alarmingly mirrors what occurred later

but with tragic and terrible consequences on 29<sup>th</sup> July 2006, when Stephen Egan was moved directly from D2 to Mountjoy Prison, again without consulting the relevant healthcare personnel.

This sequence of events exposes a serious deficit in the interaction between prison management and the Psychiatric In-reach Service. It appears that there was no actual policy or protocol in place to cover such an eventuality where it was intended to transfer a prisoner under psychiatric care to another prison. It beggars belief that moving a prisoner who was under the care of the Psychiatric service could have proceeded without even the courtesy of consultation and an opportunity to advise on or put in place appropriate arrangements for the handover. But in this case, it is clear that no such consultation or communication took place.

*The Commission explored this issue further in the following way with [Consultant Psychiatrist D], head of the Psychiatric In-reach Service at Cloverhill Prison: -*

*“Q: One issue which has arisen, more so in the Cloverhill end at this period, is the interaction and the exchange of information between, say, the In-reach Psychiatric Service, the in-prison medical service and the prison management in terms of potential clashes between the operational management of a prisoner and the medical or clinical requirements of a prisoner. Clearly if a person is on a waiting list for the CMH, I assume that at no stage would be possibly be transferred other than to the CMH, or is that the case?”*

*A: Inter-prison transfers are entirely a matter for the IPS. That’s a view you would need to take up with their management. But any decision regarding a transfer between prisons is taken by the Irish Prison Service. There are various reasons why they might do that, for example overcrowding issues and things like that”.*

The issue of transfers taking place from D2 wing, Cloverhill Prison without psychiatric consultation was also raised with [Consultant Psychiatrist A], who told the Commission:

*“A: ...I would not be routinely involved...in those decisions... Nor, as I understand it, would my colleague [Consultant Psychiatrist D], who is there at the moment, be routinely involved in decisions of transfer. I have been a consultant here since 2001, I*



*have never been asked about a prison transfer in eight or nine years, ever, in this case or any other case.*

*Q: So you wouldn't be consulted, but would you regard it as a matter of relevance that you might be? Should there be a process that specifically requires [consultation]?*

*A: Yes, I think that would be helpful...*

Issues surrounding the transfer of prisoners between prisons are considered further in Part 5.5 of this report.

## **Mountjoy Prison, March – June 2006**

Stephen Egan was transferred to Mountjoy Prison on 16<sup>th</sup> March 2006. He was placed in a cell on C2 wing. On 15<sup>th</sup> April 2006 he was moved to a single cell in the “B Base”. On 20<sup>th</sup> May 2006 Stephen Egan set fire to his cell in the “B Base”. The documents disclosed to the Commission do not record whether he was reviewed by the Psychiatric In-reach team at Mountjoy, but a note on his medical file dated 22<sup>nd</sup> May states:

*“Damaged own cell – no psychotic problem at present”.*

On 23<sup>rd</sup> May 2006, Stephen Egan is noted as having no medical problems, but refusing to come out of the special observation cell. On 25<sup>th</sup> May 2006 he is noted as being in the special cell “*at own request*”. On 30<sup>th</sup> May he is noted as being in the special cell for “*management reasons*”.

Stephen Egan was transferred to Midlands Prison on 4<sup>th</sup> June 2006 for disciplinary reasons. He returned to Mountjoy on 21<sup>st</sup> June. On 24<sup>th</sup> June 2006 he was placed in a special observation cell in the “B Base” for “*management reasons*”, having been reported for fighting.

### ***Psychiatric Review***

On 26<sup>th</sup> June 2006 Stephen Egan was reviewed by [Consultant Psychiatrist E] of the Psychiatric In-reach Service at the request of a GP in Mountjoy. [Consultant Psychiatrist E]’s notes of this visit commenced as follows:

*“Referred by GP because of anxiety.*

*Referral stated he had no past psychiatric [history]. However there is a letter written by [Consultant Psychiatrist C] in CHP [Cloverhill Prison] in February, where Mr Egan appears to have been acutely psychotic. Has a [history] of polysubstance abuse but recent urine toxicology x3 are clear. Does not appear to be still on the medication prescribed in Cloverhill”.*

[Consultant Psychiatrist E] noted thought disorder, pressure of speech, irritability, and descriptions of on-going auditory hallucinations. In reporting his findings to the GPs at Mountjoy he concluded:

*“His insight is poor. He does not believe he is unwell or requires medication. My impression is that he is acutely psychotic. We obviously need to exclude drug induced psychosis however his last three urine toxicologies were clear.”*

He recommended that Stephen Egan be recommenced on Olanzapine 10mgs nocte, that he remain in the special observation cell in “B Base” and that he be placed on a waiting list for a bed in the Central Mental Hospital.

Stephen Egan was reviewed again on 29<sup>th</sup> June 2006, this time by [Consultant Psychiatrist D]. A letter from [Consultant Psychiatrist D] to the GP at Mountjoy makes it clear that [Consultant Psychiatrist D] was aware of the psychiatric reviews carried out in December 2005 and February 2006. Having summarised the results of his review [Consultant Psychiatrist D] concludes:

*“Mr Egan presents as suffering from an acute manic psychotic episode. The sudden onset is suggestive of a drug-related cause...*

*Mr Egan remains on the waiting list for the Central Mental Hospital. He has been offered but declined oral olanzapine medication. He will be reviewed on a regular basis pending his transfer.*

*I have requested that a drug screen be taken”.*

In his evidence to the Commission [Consultant Psychiatrist D] stated:

*“Based on my examination of Mr Egan I formed the opinion that he was suffering from an acute manic episode. But it was not possible to be certain as to the cause for this episode given his history of significant substance abuse. It was possible that this might be drug related.*

*In addition at that time he presented as extremely bulky and muscular. He denied using steroids at that time. That was something that was possible. He subsequently did say that he had used steroids in the past”.*

Referring to [Consultant Psychiatrist E]’s recommendation that Stephen Egan be recommenced on Olanzapine, [Consultant Psychiatrist D] expressed the view that to do so would have been difficult, given Egan’s reluctance to take medication at that time.

The Commission finds it difficult to understand the apparent readiness of [Consultant Psychiatrist D] to accept that Mr Egan’s psychotic behaviour at this time could have been drug-related, in circumstances where four separate urine toxicology analyses carried out between 4<sup>th</sup> and 18<sup>th</sup> June 2006 found no evidence of drug consumption. The Commission’s concerns in this regard were brought to the attention of [Consultant Psychiatrist D], who in a written submission responded as follows:

*“This comment relates to my examination of Mr Egan at Mountjoy Prison on 29<sup>th</sup> June 2006... I would contest that a person with a documented history of extensive substance misuse having had a negative drug screen 11 days previously should not make it in any way ‘difficult to understand’ why the possibility of substance intoxication or withdrawal would not be considered as a possible cause for acute manic symptoms. That prisoners in Mountjoy Prison have managed to gain access to illicit drugs while in custody under the regime then pertaining is and was a matter of public record. Furthermore Mr Egan had a number of P19s recorded regarding possession of drugs while in prison custody.”*

A further review of Stephen Egan was carried out on 3<sup>rd</sup> July 2006 by a Community Mental Health Nurse attached to the Psychiatric In reach Service, [Mental Health Nurse A]. [Mental Health Nurse A] also prepared a document known as a “pre-admission assessment” for the

Central Mental Hospital. Under the heading, 'Plan', [Mental Health Nurse A]'s assessment states:

*"Remain in strip cell.*

*On waiting list for CMH.*

*To liaise with [Consultant Psychiatrist A] re current presentation – needs urgent admission.*

*For review again this week".*

Stephen Egan was admitted to the Central Mental Hospital on 5<sup>th</sup> July 2006. The Commission has been informed that the average waiting period for admission 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 at that time.

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

### **Chronology of Treatment**

#### **5<sup>th</sup> July 2006**

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

The consultant psychiatrist with primary responsibility for Stephen Egan's treatment while at the Central Mental Hospital (CMH) was [Consultant Psychiatrist F]. [Consultant Psychiatrist F] interviewed Stephen Egan at approximately 5.30 p.m., having previously apprised herself of the contents of the pre-admission assessment completed by Community Mental Health Nurse [Mental Health Nurse A].

[Consultant Psychiatrist F]'s assessment described Stephen Egan as un-cooperative on arrival, requiring the assistance of prison officers to escort him to his room. [Consultant Psychiatrist F] took the decision that he should be kept in seclusion, isolated from other patients in the hospital. This decision was based on Stephen Egan's history of violence and on the fact that he had to be assisted from the prison transport van to the ward. In the circumstances, [Consultant Psychiatrist F] formed the opinion that he was likely to pose a serious risk because of the level of his agitation and his lack of cooperation.

Under section 69 of the Mental Health Act 2001, seclusion of a patient at the CMH is not permitted unless it is determined to be "*...necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others*". The section also provides that such seclusion must comply with rules to be drawn up by the Mental Health Commission. The first such set of rules was not issued until November 2006, four months after Stephen Egan's first admission to the CMH.

Following the passing of the Mental Health Act 2001, the Central Mental Hospital helpfully created and implemented a written Seclusion Policy in May 2001 which would otherwise have awaited the Mental Health Commissions Rules drawn up in November 2006.

Seclusion was defined as:

*“...the placing of a patient (except during the hours fixed generally for the patients in the institutions to retire for sleep) in any room alone and with the door locked or fastened or held in such a way as to prevent the egress of the patient”.*

Seclusion is described in the CMH Policy as a measure of last resort, to be used only when all other intervention approaches have failed.

[Consultant Psychiatrist F] formed the clinical impression that Stephen Egan was “*acutely psychotic*”.<sup>50</sup> She prescribed a 25mg dose of Olanzapine to be administered daily and authorised his continued management in seclusion, “*because of the high risk of violence to others*”. He took the prescribed medication on the evening of the 5<sup>th</sup> of July 2006.

## **6<sup>th</sup> July 2006**

[Consultant Psychiatrist F] reviewed Stephen Egan at 9.10 a.m., noting that he had slept well through the night. She found Mr Egan to be quite co-operative, though he questioned his need to be in the Central Mental Hospital and to be taking medication. At 9.20 a.m. [Consultant Psychiatrist F] reviewed a computer printout of Stephen Egan’s prison disciplinary record, which had been obtained for the CMH by Community Mental Health Nurse [Mental Health Nurse A] from [Chief Officer A] in Cloverhill. [Consultant Psychiatrist F] noted in particular

*“...the history of serious violence to others and attempted absconding”.*

On that basis, she formed the opinion that Mr Egan presented

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<sup>50</sup> Quotations in this chapter, unless otherwise stated, are taken from a written chronology, prepared by [Consultant Psychiatrist F] for the Commission, of her care and treatment of Stephen Egan from 5–14 July 2006.

*“...a serious security risk and that this therefore, warranted cautious management”.*

[Consultant Psychiatrist F] reviewed Stephen Egan again at 3 p.m. Her psychiatric case notes described his demeanour as follows:

*“Orientated in time, place, and person. Fully alert. Became more irritable as interview progressed, esp. when issue of him taking prescribed medication raised on a number of occasions”.*

[Consultant Psychiatrist F] further noted:

*“Refusing oral meds today. Remains psychotic with impaired thinking, perceiving and judgement. Requires administration of neuroleptic medication to alleviate symptoms and restore positive mental health.*

*Untreated acute major mental illness is also additional risk factor of future physical violence in this patient”.*

[Consultant Psychiatrist F] stated to the Commission:

*“In light of [Mr Egan] refusing oral medication, I prescribed the neuroleptic intramuscular medication Clopixol Acuphase (Zuclopenthixol Acetate) 100 mgs stat for treatment of acute psychosis. This medication was given... at 17.00 hours... His management in seclusion was continued and I instructed that he was to be offered further oral medication the following day”.*

## **7<sup>th</sup> July 2006**

Stephen Egan was reviewed by [Consultant Psychiatrist F] at 9.20 a.m. He stated that he had slept well. He was reviewed again at 1.15 p.m.

[Consultant Psychiatrist F] stated to the Commission:

*“My impression was that overall, he appeared more settled, in that he was less irritable but [I] maintained that he was a potential risk of violence to others and therefore authorised his on-going management in seclusion”.*

[Consultant Psychiatrist F] stated to the Commission that while staff offered Mr Egan oral medication during the day on her recommendation, he refused to ingest it. She stated that she did not consider the further administration of intramuscular medication because Clopixol Acuphase is long-acting over a few days and that she preferred to leave the patient settle.

Stephen Egan continued to be reviewed on a four-hourly basis thereafter. He accepted and took oral medication in the evening, though he stated it would be the last time he did so.

## **8<sup>th</sup> July 2006**

[Consultant Psychiatrist F] reviewed Stephen Egan at 3.50 p.m., noting that he had slept well the previous night and had slept a lot during the day. She stated to the Commission:

*“My impression was that Mr Egan was responding to medication but that the risk of violence to others remained, and on that basis I authorised his further management in seclusion. I continued his Olanzapine”.*

[Consultant Psychiatrist F] stated that at interview Mr Egan appeared objectively less tense, that he was co-operative and appropriate and that there was no evidence of “pressure of speech” – a term used to describe an accelerated rate of speech.

Stephen Egan was reviewed by duty registrars at 7 p.m. and 11.25 p.m. In evidence to the Commission [Consultant Psychiatrist F] summarised the duty registrars’ findings as including *“mild pressure of speech, thought disorder and preoccupation with rapes”.*

In response to a question from the Commission as to whether this represented deterioration in Stephen Egan’s condition, [Consultant Psychiatrist F] agreed that Mr Egan was not as settled he had been earlier.



## **9<sup>th</sup> July 2006**

[Consultant Psychiatrist F] saw Stephen Egan at 12.05 p.m., noting that he had again slept well and that he had taken his oral medication on the previous night. She stated to the Commission:

*“My opinion was that he was less irritable and agitated, with less pressured speech but that he remained preoccupied with paranoid beliefs regarding rapes. I discussed Mr Egan’s care plan with unit nursing staff. It was agreed that in view of the objective improvement in his mental state and compliance with oral medication, and to facilitate further assessment, Mr Egan was to have a period of exercise in the single yard that afternoon. This still constituted conditions of seclusion in that egress was not readily available to him and necessary protocols were fulfilled”.*

The duty registrar reviewed Mr Egan at 9.50 p.m., noting that his behaviour was very co-operative and that he had taken his oral medication.

## **10<sup>th</sup> July 2006**

Stephen Egan was reviewed by duty consultant [Consultant Psychiatrist D] at 12 p.m. [Consultant Psychiatrist D] told the Commission:

*“He denied problems with his mood, though objectively he appeared to be elated or a little high in mood. He was disinhibited, somewhat irritable, but was not guarded. His speech was pressured. He presented as paranoid. He was alert and oriented. His insight appeared to be poor and I felt that he was suffering from a likely manic episode, although I noted that staff reported that he appeared much more settled since admission and that he was conversing much more normally”.*

In relation to Stephen Egan’s sleep pattern [Consultant Psychiatrist D] commented to the Commission as follows:

*“I noted that he was described by staff as having slept well the previous evening. That would be relevant because where a person is elated, truly elated, one of the cardinal*

*features of this is a reduced need for sleep. Typically somebody who is acutely manic would not be sleeping normally”.*

At the request of [Consultant Psychiatrist F], Stephen Egan was seen at 3.30 p.m. by Professor Harry Kennedy, Clinical Director of the CMH in order to provide a second opinion regarding Mr Egan’s current management – in particular, as to whether it was appropriate to continue his care in seclusion.

In his contemporaneous note of this meeting Professor Kennedy recorded the following information:

*“10.7.06 15.30 Seen for second opinion at request of [Consultant Psychiatrist D].*

*S.15(2) Criminal Law (Insanity) Act 2006 Patient in seclusion.*

*Admitted from Base at MJP [Mountjoy Prison] on 5/7/06.*

*Patient has been accepting oral Olanzapine 25mg N [Noctae] after initial reluctance.*

*At interview – patient says he had been in seclusion at Midlands Prison for a prolonged period. A few weeks ago he was moved to MJP.*

*In MJP he learned that another inmate was being bullied so he assaulted the bully, knowing this would create a disturbance so that the inmate who was being bullied could then assault the inmate who was bullying him. This is what happened. He was led away after his (initial) assault. When he heard the (secondary) disturbance ‘kick off’ he then created further disturbance. He therefore was secluded for a long time.*

*He used cannabis, but not recently, he says.*

*He has an elaborate story about how a collection of ‘young ones’ were being raped by ‘a beast’ and he was trying to help them but the police were too slow to act.”*

Under the heading ‘Mental State Examination’ Professor Kennedy noted:

*“Appearance & Behaviour: Good rapport.*

*Talk: Very pressured, with some occasional shifts of theme.*

*Mood: Decreased sleep, appetite normal.*

*Subjective: ‘Fine, great.’*

*Objective: Pressured, slightly grandiose, unlikely to tolerate checks or frustrations.*

*Denies current grudges / no evidence of ideas of self-harm.*

*Thoughts: Believes his thoughts are available to all following the above episode and altercation with ‘the blue corner’ i.e. prison officers.*

*Abnormal beliefs and interpretation: See above regarding thought broadcast and ‘the blue corner’.*

*Abnormal experiences: Says he has heard voices from all parts of his cell in MJP. Still hears it. ‘Not bad voices.’*

*Insight: I’m not mad.*

*I’m not mentally ill.*

*Sentence of 4/12 for absconding from Cloverhill Court now finished.*

*On remand for robbery – co-accused got 3 years for a more serious offence he says – has served 13/12 so believes he will be released.*

*Is happy to accept Olanzapine, helps sleep.”*

Approximately 30 minutes after his interview with Mr Egan concluded, Professor Kennedy was asked by two staff nurses to listen to a conversation they were having with Mr Egan through the door of his seclusion room. Professor Kennedy did so and recorded in his notes:

*“Patient [speech] was not pressured. Patient explained to staff he wanted the form for MJP to launch a ‘mandamus’ with court. MJP could pay the €15 fee out of his credit there. He advised staff that he has no reason to assault them, his issue is with the people he lives with – ‘you are gentlemen’.”*

Professor Kennedy stated to the Commission that his first conclusion on examining Stephen Egan was that Mr Egan was *“currently hypomanic – in other words, manic but not extremely so”*, and that Mr Egan was *“clearly able to control this when medical staff are not present”*.

With regard to risk assessment, Professor Kennedy stated that Stephen Egan admitted deliberately orchestrating *“critical incidents”* with other prison inmates and that he was *“heavily committed to prison culture, drug culture”*. Professor Kennedy noted Mr Egan’s history of escaping from custody and his history of violent behaviour. With regard to the current risk management plan, Professor Kennedy confirmed that Mr Egan’s current management was proportionate to the risk as assessed by [Consultant Psychiatrist F]. Professor Kennedy agreed with Stephen Egan’s current care in seclusion and was of the opinion that Mr Egan was not safe to mix with other patients. He increased the dosage of Olanzapine to 30 mgs for hypomania.

Professor Kennedy’s note concluded with the following recommendations:

*“Not yet safe to mix with others... As mental state recovers can allow increasing periods of association with extra staff. Early return to prison when mental state stable”.*

Stephan Egan was reviewed again by the duty registrar at 8.40 p.m.

## **11<sup>th</sup> July 2006**

Stephen Egan was reviewed at 8.50 a.m. by [Consultant Psychiatrist D], who in his evidence to the Commission summarised his conclusions at that time as follows:

*“I felt that his [Mr Egan’s] mood remained elevated. He said at that time that he had slept poorly the previous evening. His speech continued pressured. However, in the outward expression of his mood he appeared less disinhibited than the previous day. On that day he said that he had been hearing voices, the voice of another prisoner he referred to as ‘the beast’ and others. He was unable to describe the content and I noted that the previous day he denied such experiences. He said that he had been set up by a conspiracy of Gardaí, prison officers, psychiatrists and other people, although he denied feeling threatened or at risk. He denied any thoughts or plans to harm himself or others. His insight again appeared poor. The impression was that he remained hypo-manic with elevated mood, although it was considered whether it was possible that he might have been exaggerating symptoms somewhat. It was felt nonetheless that he continued to pose a significant risk to others and I recommended again that seclusion be continued”.*

When questioned by the Commission as to why Stephen Egan might have been considered to have been exaggerating symptoms, [Consultant Psychiatrist D] stated:

*“Two things led to those concerns which are written in the notes. One was the inconsistency in the pattern regarding the description of his sleep and the second would be the apparently new presentation of hallucinations when these had not been described in previous contacts with him”.*

This is not a view shared by the Commission. A medical note in Stephen Egan’s prison medical file for 18 Dec 2005 records auditory and visual hallucinations.

In terms of CMH records, [Consultant Psychiatrist C] reported claims of hearing voices (14 Feb 2006).

[Consultant Psychiatrist E] also referred to auditory hallucinations in his review at Mountjoy on 28 June 2006.

It may be that [Consultant Psychiatrist D] was not aware of these reports.

[Consultant Psychiatrist F] reviewed Stephen Egan at 12.20 p.m. with her registrar. She noted that Mr Egan's sleep had been disturbed on the previous night, but that in general his symptoms appeared to be settling gradually.

At 4.40 p.m. Mr Egan was seen by Professor Kennedy, who recorded the following impression in his notes:

*"Mr Egan is much less pressured in speech. He said he did not sleep last night and would sleep better if he had a room of his own and access to the gym. I have advised him that we will know he is recovered when he has had a good night's sleep. In view of his current medication I think he is probably sleeping quite well now. It would be helpful to record sleep tonight. If remains as clear and coherent as this we can review his need for further seclusion. NB: He did sleep last night as observed by staff so the nurses had reported to me he had slept the night before. To review tonight. Requests and claims appear goal directed".*

In his evidence to the Commission Professor Kennedy commented on this note as follows:

*"In other words his claim he wasn't sleeping seemed to me to be making a point probably that he wanted more medication".*

Professor Kennedy's notes of this interview with Mr Egan concluded:

*"Review reintegration into prison system early".*

## **12<sup>th</sup> July 2006**

[Consultant Psychiatrist D] reviewed Stephen Egan at 9.20 a.m., noting that his mood appeared to be settling. Mr Egan told [Consultant Psychiatrist D] that he had slept well and was eating well.

[Consultant Psychiatrist F] saw Stephen Egan at 2.20 p.m. In her note of this visit she recorded:

*"Improvement sustained.*

*Slept well. Fully co-operative.*

*Compliant with meds [i.e. medication] although remains reluctant regarding same”.*

In relation to the paranoid beliefs which Mr Egan had previously demonstrated, [Consultant Psychiatrist F] noted:

*“With prompting – reverted back to beliefs about ‘things that happened’ in the community – but easily distracted and brought back to neutral topic”.*

When asked by the Commission to explain the significance of this finding [Consultant Psychiatrist F] explained that Mr Egan was less preoccupied with paranoid beliefs and that he was able to engage in other areas of discussion as opposed to remaining preoccupied as he had been reported to be in the past.

In her notes [Consultant Psychiatrist F] recorded that Stephen Egan expressed a desire to leave the CMH and return to Mountjoy Prison:

*“Asking to get out of current room. Would also like to go back to Mountjoy – ‘Nothing wrong – I didn’t ask to come here’”.*

In relation to his on-going compliance with medication, [Consultant Psychiatrist F] noted:

*“States emphatically he will not comply with meds upon return to prison”.*

In terms of on-going care and management, [Consultant Psychiatrist F] proposed extending Mr Egan’s periods of exercise in the yard *“up to maximum possible within staff resources”*, but otherwise to continue his management in seclusion. [Consultant Psychiatrist F]’s note concluded:

*“If further sustained normalization of mood – may be well enough to return to prison within a few days”.*

## 13<sup>th</sup> July 2006

[Consultant Psychiatrist F] reviewed Stephen Egan at 4.50 p.m. In her notes she recorded the following:

*“Slept well. Co-operative with current management. Seen in single yard – exercising since 12.30 hrs.*

*Presented as calm, co-operative, very appropriate in affect.*

*No evidence [of] agitation or over activity.*

*No pressured speech.*

*No bizarre / paranoid ideas expressed.*

*Asked about possibility of early return to prison +*

*? Cloverhill vs. Mountjoy as former now only remand facility.*

*Follow up care plan discussed with patient + agreed to be reviewed by forensic in-reach service + would give consideration to complying with gradual ↓ [reduction of] medication”.*

In terms of his continued care and treatment at that stage, [Consultant Psychiatrist F] noted:

*“C/T [continue] current management + meds.*

*R/V [review] morning? Fit to return to prison + confirm which”.*

Stephen Egan was reviewed again at 7.15 p.m. by [Consultant Psychiatrist A], who recorded the following notes:

*“Believes there is a conspiracy against him based in MJP [Mountjoy Prison]. Request to be returned to prison.*



*Believes his main problem is one of anger.*

*Plan: To remain in seclusion [with] periods of trial association”.*

## **14<sup>th</sup> July 2006**

[Consultant Psychiatrist A] saw Stephen Egan again at 9.15 a.m. He noted that Mr Egan was still requesting a return to prison. His note concluded:

*“For review by team later today”.*

[Consultant Psychiatrist F] reviewed Mr Egan at 11.50 a.m. Her notes record the following:

*“Seen – sat up immediately to engage, smiling.*

*Asked, ‘Have you any news for me?’ i.e. if being discharged.*

*Presented as calm, relaxed; with appropriate affect.*

*No pressured speech...*

*Normothymic mood.*

*Not expressing paranoid or bizarre beliefs.*

*Fit to return to prison + agreeable to attend for psychiatric review next week & to c/t [continue] meds in interim.*

*Meds likely to be gradually ↓ [reduced] over next few weeks.*

*Dx [Diagnosis]: Manic episode”.*

[Consultant Psychiatrist F] informed Professor Kennedy of her clinical opinion as to Stephen Egan’s suitability for returning to prison. As Clinical Director of the CMH, it was Professor Kennedy’s responsibility under s.18 of the Criminal Law (Insanity) Act 2006, to form an opinion

as to whether Stephen Egan no longer required inpatient treatment and care at the CMH, prior to any discharge taking place.

Professor Kennedy reviewed Mr Egan himself at 6.30 p.m. From his review Professor Kennedy concurred with [Consultant Psychiatrist F]'s opinion, stating in his notes:

*“Seen in small exercise yard.*

*Reviewed with a view to return to custody in CHP [Cloverhill Prison]...*

*Appearance and behaviour cheerful, friendly, and appropriate; talk normal rate and form; mood normal; no evidence of hostility and self-harm...*

*Now gives a clear account. Says he wanted to come to CMH so that someone would listen to him, as no one would listen to him in MJP [Mountjoy Prison]. Now feels satisfied that he has explained himself and has been listened to.*

*Wants to return to CHP [Cloverhill Prison], get his case dealt with”.*

Professor Kennedy formed the opinion that Stephen Egan no longer required inpatient care or treatment at the CMH and could be returned to Cloverhill Prison. Mr Egan was discharged from the Central Mental Hospital shortly thereafter.

A discharge summary prepared under [Consultant Psychiatrist F]'s instructions by her registrar cited the final diagnosis as being one of

*“acute mania with psychotic symptoms”.*

The discharge summary also referred to Stephen Egan's need for continuing medication and further review following his return to prison.

The circumstances of Mr Egan's discharge from the CMH, the content of the discharge summary and other matters in relation to his transfer to Cloverhill Prison are discussed more fully in the next chapter of this report.

The diagnosis of “*acute mania with psychotic symptoms*” is defined by the World Health Organisation in its *International Classification of Diseases* (ICD – 10) as follows:

*“Mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy, or inappropriate to the circumstances, and out of character.*

*In addition... delusions (usually grandiose) or hallucinations (usually of voices speaking directly to the patient) are present, or the excitement, excessive motor activity, and flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication”.*<sup>51</sup>

The Commission notes that this diagnosis in ICD – 10 forms part of a subset under the heading ‘Manic episode’, and is used for persons who have had only a single such episode. Individuals who have had more than one episode come under a separate diagnosis of “*bipolar affective disorder*”.

It appears therefore that as of 14<sup>th</sup> July 2006, Stephen Egan’s treating psychiatrists at the CMH did not appear to have considered any of his symptoms and recorded behaviour prior to June 2006 to have constituted a manic episode within the definition of ICD – 10.

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<sup>51</sup> ICD –10 (WHO 2010), F30.1 –30.2.

# **Expert Examination of the Chronology of Stephen Egan's Care and Treatment at CMH**

## **by Dr Lelliot and Professor Fahy**

In addition to the information and observations provided by the various psychiatrists who saw Stephen Egan during his stay at the Central Mental Hospital, the Commission has also had the benefit of reports by two independent consultant psychiatrists from England, Dr Paul Lelliott and Professor Tom Fahy.

### **Report of Professor Fahy**

Professor Fahy is Professor of Forensic Mental Health at the Institute of Psychiatry in London. In 2008 he was commissioned by the Chief Prosecution Solicitor's Office to prepare a psychiatric report on Stephen Egan in advance of Mr Egan's trial for the murder of Gary Douch. The report was completed on 8<sup>th</sup> October 2008.

In the course of preparing his report Professor Fahy interviewed Stephen Egan at Midlands Prison on 8<sup>th</sup> September 2008. He also reviewed a book of 91 statements prepared in relation to the murder charge, together with a copy of the Central Mental Hospital's medical records relating to Mr Egan. In his report, Professor Fahy noted that the CMH records as reviewed by him were incomplete:

*"The clinical records do not contain copies of the psychology assessments, including the personality disorder interviews and the psychopathy assessment. It would be helpful to obtain the full set of CMH records, including these papers".*

## Report of Dr Lelliott

Being required by its Terms of Reference to conduct an examination of the chronology of psychiatric treatment of Stephen Egan, the Commission formed the view that it would need expert advice to assist it in such an examination. With this in mind Dr Paul Lelliott, a consultant psychiatrist from the UK, was appointed as an adviser pursuant to section 8 of the Commissions of Investigation Act 2004 to assist the Commission in reviewing and evaluating all the information made available to the Commission concerning Stephen Egan's interactions with the Central Mental Hospital and associated psychiatric services. Dr Lelliott is an eminent psychiatrist who has devoted much time, research, and expertise to the development of best practice models of psychiatric care.

Dr Lelliott is not a forensic psychiatrist, but has specific experience in that field in addition to his expertise in systemic quality improvement, which encompasses all aspects of mental healthcare, forensic or otherwise.

In a report of his advice to the Commission Dr Lelliott summarised this experience as follows:

*“Although I am not a forensic psychiatrist, I do have some knowledge and experience of the organisation of forensic mental health services, about standards relating to service provision and about the characteristics of mentally disordered offenders.*

*I was instrumental in establishing the Quality Network for Forensic Mental Health Services and remain responsible for its work programme. The Network coordinates standards-based reviews of forensic services for the purpose of quality improvement<sup>52</sup>.*

*Every forensic service in England (both NHS and independent sector) is contractually required to participate in the Quality Network and services from a number of other jurisdictions also participate; including the Central Mental Hospital at Dundrum.*

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<sup>52</sup> <http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/forensicmentalhealth.aspx>

*Although it is not my clinical specialty, I have undertaken clinically-oriented research about mentally disordered offenders which has resulted in publications in good quality peer-review journals. I was the principal investigator in a study of the characteristics of mentally disordered offenders in London<sup>53</sup> and in research about the importance of recognising and treating co-existing substance misuse problems in patients in medium secure units.<sup>54</sup>”*

Although the practice of psychiatry in a prison environment presents certain practical problems that are not encountered in general psychiatry – in particular regarding access to patients – every prisoner has the same rights in relation to mental health care as any other citizen of the State.

This principle is enshrined in the United Nations General Assembly’s 1991 Resolution, *Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*:

*“Principle 1*

*1. All persons have the right to the best available mental health care, which shall be part of the health and social care system...*

*Principle 20 Criminal Offenders*

*1. This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.*

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<sup>53</sup> Lelliott P, Audini B, Duffett R. (2001) Survey of patients from an inner-London health authority in medium secure psychiatric care. *British Journal of Psychiatry*, 178: 62–66.

<sup>54</sup> Durand M, Lelliott P, Coyle N. (2006) Availability of treatment for substance misuse in medium secure psychiatric care in England: a national survey. *Journal of Forensic Psychiatry and Psychology* 17: 611 –625.

2. *All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances...*"

The principle of equivalent care in and out of prison settings has been expressly adopted in Ireland by the Mental Health Commission:

*"We consider the principles of equivalence of care, the right to treatment facilities as far as possible in, or near to, one's own home or community and the right to be treated in the least restrictive environment 'commensurate with the degree of risk posed to themselves and others' (Royal Australian and New Zealand College of Psychiatrists, 2001) in particular to be the basic principles informing all our deliberations".<sup>55</sup>*

It is precisely because Dr Lelliott's experience extends beyond forensic specialties to encompass general standards of quality in mental healthcare systems that he was chosen by the Commission to advise in relation to the mental healthcare aspects of the Commission's work. The Commission took the view that given the professional sensitivities involved that a fully independent external expert was needed to conduct the peer review of the clinical management of Stephen Egan.

As a matter of courtesy, the choice of Dr Lelliott for appointment to assist and advise the Commission under section 8 of the 2004 Act in these matters was canvassed with the Clinical Director of the CMH, Professor Kennedy, at an early stage in the Commission's work. No objection was made by Professor Kennedy at that time to the choice of Dr Lelliott as an advisor to the Commission.

Dr Lelliott was provided with copies of all documentation disclosed to the Commission by the Central Mental Hospital, as well as transcripts of the evidence given by relevant witnesses at hearings before the Commission. Dr Lelliott was also provided with other relevant documents including a copy of Mr Michael Mellett's report on the circumstances surrounding the death of

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<sup>55</sup> Forensic Mental Health Services for Adults in Ireland (Mental Health Commission, 2006)

Gary Douch, and a summary of relevant background information prepared by the Commission for Dr Lelliott.

Having reviewed the above materials, Dr Lelliott set out his views in a report for the Commission. At the outset of his report he states:

*“This report is based on my reading of documentation that has been gathered by the Commission in the course of its work...*

*The opinions that I express in this report are based solely on the content of these documents. I have not interviewed Stephen Egan and so have not assessed his mental state myself. I would also state that my clinical practice is in the field of general adult psychiatry. Therefore, although I have twenty years’ experience as a consultant psychiatrist, I have limited knowledge of forensic mental health services or of prison healthcare”.*

## **Observations on the Care and Treatment of Stephen Egan**

Observations made by Professor Fahy and Dr Lelliott and relating to issues of concern to the Commission are set out below under the relevant headings, together with responses from the Clinical Director of the CMH, Professor Kennedy and other relevant persons.

### **Diagnosis**

Dr Lelliott notes that the psychiatrists who assessed and treated Stephen Egan from February 2006 onwards proposed a number of diagnoses for his mental disorder. These included “*paranoid psychosis*”; being “*depressed and psychotic*”; suffering from “*an acute manic psychotic episode*”; possible “*drug-induced psychosis, steroid-induced psychosis or schizo-*



*affective disorder*"; *"dissocial personality disorder"*; and *"schizoaffective paranoid psychosis"*. Dr Lelliott notes:

*"It is not unusual for a psychiatrist to proffer a range of diagnoses for a patient or for different psychiatrists to take a different view or for the diagnosis to be revised over time. This is particularly likely when the patient has potential co-morbid problems such as multiple drug use and a co-existing personality disorder"*.

### ***Personality Disorder***

Based on his review of the documentation provided to him by the Commission, Dr Lelliott expresses the view that Stephen Egan has *"a dissocial personality disorder"*.

Professor Fahy, in his report of 8<sup>th</sup> October 2008, is also of the view that Stephen Egan satisfied the standard clinical diagnostic criteria for an adult antisocial personality disorder. He states:

*"Mr Egan's antisocial personality disorder is at the severe end of the diagnostic spectrum, as evidenced by the early onset of his oppositional and antisocial behaviour, the frequency, and seriousness of his offending behaviour, his poor employment record, and his lack of engagement with pro-social activities or peers outside of institutional settings. I note that the CMH psychologist also gave Mr Egan a high score on a measure of psychopathy, which is a variant of antisocial personality disorder characterised by impulsive, irresponsible, and exploitative behaviour and deficiencies in empathy, guilt, and remorse"*.

### ***Mental Illness***

With regard to the issue of a possible mental illness, Dr Lelliott states in his report to the Commission:

*"The information contained in the medical record up to 30<sup>th</sup> November 2007 suggests that Mr Egan has both a dissocial personality disorder and a severe psychotic illness. In my opinion, the most likely diagnosis for the latter is paranoid schizophrenia. However, the presence at times of symptoms of disturbed mood would support an alternative*

*diagnosis of schizoaffective disorder. The information does not support a diagnosis of mania...*

Based on the information available to him, Dr Lelliott expresses the view that Stephen Egan's psychotic illness seemed to have started at some time during 2005.

Dr Lelliott notes that between 9<sup>th</sup> February 2006 and 15<sup>th</sup> May 2007 Stephen Egan displayed a range of symptoms of mental illness, including abnormal beliefs, auditory hallucinations, the experience of his thoughts being interfered with, and disturbance of mood. Dr Lelliott notes a relationship between the prevalence of such symptoms and absence of medication, stating:

*"The case records suggest that the symptoms listed above improved during times when Mr Egan was taking antipsychotic medication and worsened when he stopped medication".*

However, Dr Lelliott also sounds a note of caution in this regard, stating:

*"Although the records suggest a clear association between his taking medication and amelioration of psychotic symptoms... even when having taken medication continuously for some months, Mr Egan sometimes reported symptoms of mental illness".*

Professor Fahy, in his report of 8<sup>th</sup> October 2008, expresses a view similar to that of Dr Lelliott in relation Stephen Egan's mental illness. He states:

*"Mr Egan's comprehensive clinical records indicate that he developed a psychotic illness in December 2005, and that this condition continued during most of 2006. He continues to exhibit residual features of this illness".*

Professor Fahy continues:

*"He was seen by psychiatrists and psychiatric nurses in the prison in early 2006 and these records clearly indicate that he was in the process of developing a severe mental illness... the onset of Mr Egan's mental illness was characterised by a mixture of depressive and psychotic symptoms.*

*...The clinical records suggest that by the time of his transfer to hospital the initial depressive features (present at the end of 2005 / beginning of 2006) had been replaced by a clinical picture that was more suggestive of a manic phase with prominent psychotic features”.*

He concludes:

*“While Mr Egan’s underlying personality disorder may have influenced his behaviour and the expression of his psychotic illness, there is no good clinical reason to doubt that he has suffered from a mental illness that was prominent during much of 2006”.*

Professor Fahy goes on to state that in his view, the most appropriate diagnosis for Stephen Egan’s psychiatric illness was one of “*schizoaffective disorder*”.

The view taken by Dr Lelliott and Professor Fahy, that Stephen Egan’s medical records indicate symptoms of a severe mental illness developing during the early part of 2006, is strongly contested by the Clinical Director of the Central Mental Hospital, Professor Kennedy. In a written submission to the Commission dated 3<sup>rd</sup> December 2010 Professor Kennedy states:

*“Dr Lelliott lists the opinions of five psychiatrists up to 14/7/06... None give as their opinion that Mr Egan had schizophrenia. These and the other notes referred to by Dr Lelliott are all in keeping with a bi-polar illness, including [Consultant Psychiatrist C]’s note of a depressive state with hallucinations and the many subsequent symptoms of mania such as grandiosity, pressure of speech and irritability”.*

Professor Kennedy goes on to state:

*“It is clear from the summary of prison notes that Mr Egan had not had five months continuous symptoms prior to admission. On 9/2/06 Mr Egan appeared depressed and psychotic in the context of co-morbid substance misuse”*

However the Commission notes that although in [Consultant Psychiatrist C]’s report of her 9/2/06 meeting with Egan notes that he “had a history of polysubstance abuse” – but she also noted that “He denied any use in the past two months since arrival in Cloverhill Prison.” In the section of her report headed ‘Impression and recommendations’, [Consultant Psychiatrist C]

gave her overall impression and assessment that he was “depressed and psychotic” but did not mention substance abuse in this context.

Professor Kennedy goes on to state:

*“On 26/6/06 he had appeared pressured in speech and irritable, with delusions and hallucinations. On 29/6/06 he had deteriorated with flight of ideas, irritability, elation and paranoid beliefs. On 3/7/06 matters had deteriorated further.*

*All this is compatible with an episode of depression which responded to appropriate treatment followed some months later by an acute episode of mania with psychotic features commencing in or about 26/6/06”.*

He concludes:

*“Mr Egan was depressed in February, he was manic in June. There is no evidence of abnormal mental state between these two observations”.*

With regard to the symptoms cited by Dr Lelliott in support of a diagnosis of schizophrenia, Professor Kennedy states:

*“Dr Lelliott does not list the ICD – 10<sup>56</sup> diagnostic criteria for mania at all. Had he done so he would have shown that the symptom lists overlap with the symptom list in the criteria for schizophrenia. As before he avoids completely the other essential elements in the diagnostic criteria such as duration, course and exclusion criteria. In my opinion all the features he lists in this section are either typical of or compatible with mania...”*

Professor Kennedy also criticises Dr Lelliott for citing symptoms which post-date Stephen Egan’s discharge from the Central Mental Hospital in July 2006.

Regarding Professor Fahy’s diagnosis of schizoaffective disorder, Professor Kennedy states:

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<sup>56</sup> ICD –10 is the latest version of a World Health Organisation (WHO) publication, the International Classification of Diseases, which was adopted by the World Health Assembly in May 1990 and came into use in WHO member states in 1994. See <http://www.who.int/classifications/icd/en/> for further information.

*“In my view there is little difference between a diagnosis of mania and schizoaffective disorder”.*

In a written response dated 4<sup>th</sup> January 2011 to the observations of Professor Kennedy cited above, Dr Lelliott comments as follows:

*“The fact that I disagree with Professor Kennedy about the diagnosis should not be interpreted as me criticising either his expertise or his judgement. Professor Kennedy is an experienced and respected psychiatrist – as are his consultant colleagues at CMH. They diagnosed mania on the basis of the information available to them and of repeated examinations of Mr Egan’s mental state. They did not have the benefit of hindsight about the subsequent course of Mr Egan’s illness.*

*Some symptoms and signs are present in both mania with psychotic symptoms and schizophrenia. For this reason it can be difficult to distinguish one from the other; particularly in the absence of information about the course of the disorder – either before first contact with mental health services or subsequent to first presentation. However, I would question Professor Kennedy’s statements that ‘there is little difference between a diagnosis of mania and schizoaffective disorder’ (paragraph 4.7). Psychiatric opinion is divided about the concept of schizoaffective disorder, about its relationship to bipolar disorder and to schizophrenia and about its classification. However, ICD – 10 places schizoaffective disorder in the same diagnostic category as schizophrenia – F20 – 29 ‘schizophrenia, schizotypal and delusional disorders’ and not in the same category as bipolar disorder – F30 – 39 ‘mood (affective) disorders’. Unlike with mania, a diagnosis of schizoaffective disorder can only be made if definite schizophrenic symptoms are present. Also, schizoaffective disorder is included as a ‘related disorder’ in the NICE<sup>57</sup> guideline on the treatment and management of schizophrenia.*

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<sup>57</sup> National Institute for Health and Clinical Excellence (NICE), an organisation set up by the National Health Service (NHS) in the U.K. to provide independent guidance on health matters. This includes the publication of clinical guidelines containing recommendations on the appropriate treatment and care of people with specific diseases and conditions. See <http://www.nice.org> for further information.

*Recommendations about the treatment of schizophrenia made by NICE also apply to schizoaffective disorder”.*

With regard to Professor Kennedy’s view that Stephen Egan did not show continuous psychotic symptoms for five months during 2006, Dr Lelliott comments:

*“It is true that, although psychiatrists recorded the presence of psychotic symptoms at various times between December 2005 and July 2006, there were times when Mr Egan did not report the presence of symptoms and there was a period between 9<sup>th</sup> February 2006 and 26<sup>th</sup> June 2006 when Mr Egan was not seen by a psychiatrist. Professor Kennedy interprets this absence of evidence of on-going symptoms as being ‘compatible with an episode of depression which responded to appropriate treatment followed some months later by an acute episode of mania with psychotic features commencing in or about 26/6/06’ (paragraph 6.58 of his response).*

*In the absence of a record, it cannot be proved one way or the other whether Mr Egan would have reported symptoms had he been interviewed during this period. Also, because he was not seen for four and a half months after having been prescribed medication (an antidepressant – Escitalopram and an antipsychotic – Olanzapine) it is not possible to say whether and how he responded to treatment. However, the fact that he only took the medication prescribed by [Consultant Psychiatrist C] on 9<sup>th</sup> February 2006 for seven days and was not seen for further follow-up does not support the view that any symptoms he had at that time would have been adequately treated”.*

Finally, commenting on the relative significance of the divergent views as to the correct diagnosis, Dr Lelliott observes:

*“This discussion [of diagnosis] is not greatly relevant to the treatment that Mr Egan received during his first admission or to the course of his response to that treatment; the same antipsychotic medication is used to treat schizophrenia, schizoaffective disorder and mania in the acute phase and generally, the florid symptoms of these disorders might be expected to respond over a broadly similar timescale.*

*The relevance of the discussion is that Mr Egan's history and symptoms before and during his first admission to CMH were complex and presented a mixed picture. This has implications for my conclusions about the length of hospitalisation".*

### ***Authenticity of Psychotic Behaviour***

In his report of 8<sup>th</sup> October 2008, Professor Fahy notes references in the CMH clinical record to the possibility that Stephen Egan may have been faking or exaggerating psychotic symptoms during 2005 / 2006. However, Professor Fahy dismisses these concerns, stating:

*"There are some case note entries at the end of this brief first admission suggesting that Mr Egan's clinical presentation displays some inconsistencies, and that his reports of symptoms may have been 'goal directed'. However, these comments do not withstand close scrutiny, as Mr Egan had not indicated that he wanted to get out of prison to hospital in the first place, and once in the hospital he quickly requested a return to prison.*

*If his symptoms were 'goal directed', it is far from clear what Mr Egan's goal was.*

*Instead, the obvious explanation for his behaviour in the prison and at the CMH, and for his report of auditory hallucinations and persecutory beliefs is that he was in the throes of a psychotic illness".*

Professor Fahy goes on to state:

*"In conclusion, there is overwhelming clinical evidence that Mr Egan developed a psychotic illness in December 2005. The initial presentation of his illness was characterised by prominent mood disturbance, persecutory beliefs and auditory hallucinations. Mr Egan's account of his psychotic symptoms has shown a consistent theme from the onset of his illness... His symptoms are well documented in highly detailed records from the prison and from his first and second admissions to CMH.*

*While it has been noted that his account of his symptoms is sometimes at odds with his presentation to nursing staff, I do not think that this is an unusual or remarkable feature,*

*especially as there have been periods (other than the incident involving Mr Douch) where Mr Egan has shown a behavioural response to his psychotic symptoms (i.e. attempting to set his cell on fire, his description of confrontation / assaults on other prisoners and his hostility during the initial phase of his two admission to CMH)”.*

Dr Lelliott, in his report to the Commission, also notes that doubts were expressed on occasion by the psychiatrists treating Mr Egan as to whether his psychotic symptoms were genuine. He observes:

*“The grounds for these doubts seem to be (i) that there were discrepancies in the accounts that Mr Egan gave about his psychotic symptoms to different staff at different times... (ii) that he appeared to only report psychotic symptoms to psychiatrists and was observed by nurses to be calm between interviews... (iii) that ‘there was no observation by staff of any response to abnormal or external stimuli’ and (iv) that ‘psychological investigations... contained evidence of feigned symptoms”.*

However, Dr Lelliott goes on to point out that there were entries in the case records which serve to contradict the impression of feigned symptoms, stating:

*“At times Mr Egan did exhibit his symptoms to people other than psychiatrists. These included his mother, prison officers and the prisoners who shared the cell with him on the night of the killing of Mr Douch...”*

*There are several reports by prison staff of altered behaviour prior to a referral for assessment by a psychiatrist.*

*There are occasions when Mr Egan refuses to talk with a psychiatrist or appears reluctant to discuss his symptoms”*

In relation to Stephen Egan’s psychotic symptoms being observed by psychiatrists but not by nurses, Dr Lelliott comments:

*“...Mr Egan’s agitated behaviour and altered mood seemed to occur mainly when he was talking about his psychotic symptoms. It is perhaps understandable therefore that he appeared more agitated when being interviewed by psychiatrists who asked probing*



*questions about his beliefs. There are a number of entries in the case record, both before and after the killing of Mr Douch, that describe the effect on Mr Egan of such questions.”..*

Dr Lelliott further notes:

*“There is no indication in the case records of a reason why Mr Egan should feign his psychotic symptoms. The case record does not support a number of possible motives, namely that:*

*Mr Egan wished to reside at Central Mental Hospital in preference to prison, or wished to escape from a threat in prison. The opposite is true. While in hospital, Mr Egan makes repeated requests to be returned to prison...*

*Mr Egan intended to use a plea of insanity to influence his trial for murder. On a number of occasions, Mr Egan does talk about expecting to be convicted of manslaughter rather than murder but the reasons he gives are that there is no evidence that he intended to kill Mr Douch and that there is doubt about who struck the fatal blow...*

*Mr Egan wished to obtain prescribed medication. Although Mr Egan has a history of polysubstance abuse, his attitude to the antipsychotic drugs he is prescribed is markedly ambivalent. At times, he is markedly hostile to medication; at others he complies grudgingly; at others he appears to accept it because he notices a beneficial effect on his psychotic symptoms”.*

Dr Lelliott concludes:

*“Although at times during this admission the ward team commented on apparent inconsistencies in Mr Egan’s presentation, and speculated that he might be exaggerating his symptoms, I can find no evidence that they concluded that Mr Egan might be feigning symptoms until after the killing”.*

The Commission notes that this view is supported by the fact that the Discharge Summary prepared in respect of Stephen Egan’s return to prison on 14<sup>th</sup> July 2006 gave the diagnosis on

discharge as being one of “*acute mania with psychotic symptoms*”, and made no reference to the possibility of symptoms being feigned or exaggerated.

In a written response to the reports of Professor Fahy and Dr Lelliott, CMH Clinical Director Professor Kennedy states that the psychiatrists treating Stephen Egan at the CMH in July 2006 did consider the possibility that Mr Egan may have been exaggerating symptoms, but that this did not affect their diagnosis of his condition. Professor Kennedy refers in particular to observations of Stephen Egan’s behaviour on 10<sup>th</sup> July, stating:

*“Although during a long interview with me on 10<sup>th</sup> July Mr Egan had pressure of speech, half an hour later nursing staff called me to hear his mode of speech when conversing with them, in the absence of doctors. His speech was then not pressured and appeared rational. This suggested that Mr Egan exaggerated symptoms when speaking to doctors. I did not however conclude that Mr Egan had no illness”.*

Professor Kennedy goes on to state:

*“Dr Lelliott says ‘there appears to have been a degree of inappropriate uncertainty about the validity of Mr Egan’s reported symptoms’ ...my assessment and the assessment of others was that Mr Egan may have been exaggerating symptoms. There was no uncertainty about the diagnosis of mania. No reasonable reading of the notes could conclude that there was”.*

### ***Treatment in Seclusion***

Stephen Egan was kept in seclusion for the entirety of his stay at the Central Mental Hospital from 5<sup>th</sup> – 14<sup>th</sup> July 2006. In his evidence to the Commission, [Consultant Psychiatrist A] indicated that keeping a patient in seclusion for this length of time would be unusual:

*“...everyone is different of course, but the general scenario would be three to four days in seclusion, they respond to medication. If they are a risk of harm to others, this is related to mental illness, and they are gradually given periods of trial association and monitored closely. So, for him to be in seclusion for that length of time would be uncommon...”*

[Consultant Psychiatrist F], Stephen Egan's principal treating psychiatrist during this period, explained the decision to keep Stephen Egan in seclusion as follows:

*"Most people would be in seclusion for less than a period of 72 hours, indeed maybe 24 hours. So, it is not – we obviously try to get people out of seclusion as early as possible, but we have to make that decision on a risk assessment basis, and depending on their mental state and the risk that they might represent to others..."*

*Obviously it is more appropriate for somebody to be associating with the general body of patients in a unit, and that would be how we try to manage the majority of our patients from a therapeutic point of view. In Mr Egan's case he was managed in seclusion, initially because of the acuteness of his mental state, but I also noted that the risks which Mr Egan represented of serious violence to others existed outside of the context of mental illness... My reasoning for maintaining his seclusion was because I felt he represented a serious risk of violence to others. Exacerbated by his mental illness, but that pre-existed [his illness]".*

In his report to the Commission Dr Lelliott commented on this aspect of Stephen Egan's treatment as follows:

*"Throughout his stay at the Central Mental Hospital, Mr Egan was kept in seclusion... The staff at the Central Mental Hospital had no opportunity to observe Mr Egan's behaviour when in the company of other patients. He was discharged from seclusion in hospital back to prison with no assessment having been made of his mental state and behaviour when in the company of others. However, I acknowledge that Mr Egan has a long history of previous violent behaviour that mostly relates to factors other than his mental illness and that this appears to be the principal reason that Mr Egan was kept in seclusion while at the Central Mental Hospital".*

In a written response to Dr Lelliott's report, Professor Kennedy comments on the issue of seclusion as follows:

*"Mr Egan was technically covered by the rules of seclusion but for substantial periods of time was out of the seclusion room in the exercise yard or using bathroom facilities, as*

*Dr Lelliott acknowledges. During these periods and while in seclusion Mr Egan would have been interacting frequently or constantly with staff. Dr Lelliott accepts that Mr Egan's long history of violence in prison was mostly related to factors other than his mental illness and that this was the main reason he was kept in seclusion... Other patients had to be kept safe from Mr Egan who presented an exceptional risk for non-psychiatric reasons".*

Regarding the fact that Mr Egan was discharged directly from conditions of seclusion at the CMH back to the prison system, Professor Kennedy states:

*"The CMH is a hospital for the treatment of mental illness in conditions of therapeutic security. When the illness has been treated, it is not the role of the CMH to detain someone who remains dangerous for non-psychiatric reasons – that is the proper role of a prison service".*

### ***Length of Stay***

In the course of the Commission's hearings, the psychiatrists who treated Stephen Egan at the Central Mental Hospital were asked to comment on what, to a lay person, might seem a conspicuously short period of hospitalization for Stephen Egan in July 2006 – a total of nine days.

Stephen Egan's principal treating psychiatrist, [Consultant Psychiatrist F], made the following observations concerning his length of stay in July 2006:

*"Well, Mr Egan was commenced on medication and treatment when he came to us... [He] was compliant, and received medication throughout his nine-day admission to use. I formed the opinion that his mental state had improved on that medication, and indeed looking back on my chronology of his progress, he had shown sustained – not full and total resolution of his symptoms, but sustained response to medication for approximately six days prior to his return to prison. So, I felt that his mental state had improved sufficiently for his care to be continued in the prison setting, contingent on appropriate services being available back in prison".*

In his oral evidence to the Commission Professor Harry Kennedy observed:

*“...to be quite unambiguous about this, I am quite happy with the length of stay up to 14<sup>th</sup> July. I think it was appropriate to his needs at the time, it was neither too long nor too short – it was correct”.*

Professor Kennedy went on to state:

*“The decision [as to] when he is ready to discharge is an individually variable decision... It is an individual decision made on individual factors. It is a fact that the natural history of mania can respond that quickly, particularly if it is not such a severe illness. He was described fairly consistently as hypomanic, not manic. It is not surprising that he would respond to 30mg of Olanzapine quite quickly. Olanzapine is a modern, very effective and very potent drug. It is very satisfactory in all sorts of ways.*

*We looked at biological indicators of recovery, the best of which in mania is his sleep pattern. You will notice in all those... careful inquiry about his sleep pattern and it seems to have come right fairly early on”.*

Professor Kennedy concluded by stating:

*“The decision was a considered decision. He was reviewed by three consultant psychiatrists prior to him going. I am satisfied that in this individual case the individual assessment was made he no longer needed treatment in hospital and he could safely be managed in Cloverhill. I can’t say more than that”.*

On the question of whether nine days represented an unusually short length of time for someone with Stephen Egan’s symptoms to be kept at the Central Mental Hospital, Professor Kennedy told the Commission:

*“Essentially there are two populations that pass through the Central Mental Hospital. There are people admitted from prisons, particularly from remand prisons for whom the average length of stay is reasonably short and there are people found not guilty by reason of insanity or transferred under a number of longer term provisions for whom the average length of stay is very long”.*

Professor Kennedy referred to a survey which was carried out of CMH admissions and discharges between January 1997 and December 2002. During that period there were 747 completed admissions, of which 16.9% were discharged within nine days or less. During that period, 74 patients were discharged with a diagnosis of mania. Of those, 17% were discharged within nine days or less, with 83% staying for more than nine days.

The length of Stephen Egan's stay in the Central Mental Hospital in July 2006 was also considered by Professor Tom Fahy in his report for the Chief Prosecution Solicitor dated 8<sup>th</sup> October 2008, and by Dr Paul Lelliott in his review prepared for the Commission in June 2010.

Professor Fahy, in a section of his report entitled '*Comment on Mr Egan's Psychiatric Treatment*', makes the following observation concerning the nine-day period for which Stephen Egan was treated at the CMH:

*"This is an unusually short treatment episode for a first episode of psychotic illness. There appears to have been a degree of inappropriate uncertainty about the validity of Mr Egan's reported symptoms, despite the fact that these symptoms could be traced back over several months and despite the absence of any obvious secondary gain to be obtained from reporting such symptoms".*

Professor Fahy's conclusion that there was "*inappropriate uncertainty*" regarding Stephen Egan's symptoms appears to be based on references in the CMH notes to the possibility that some of Mr Egan's symptoms were not genuine. As we have seen, Professor Kennedy does not deny that the possibility of faked symptoms was considered, but states firmly that this consideration did not affect the final diagnosis of mania.

Dr Lelliott, in his report to the Commission, begins his consideration of the length of Stephen Egan's stay at the CMH by stating:

*"This section is written on the basis that the team at the Central Mental Hospital believed that Mr Egan was suffering from acute mania with psychotic symptoms".*

He goes on to state:

*“Mr Egan’s first admission to the Central Mental Hospital lasted nine days. In my opinion, this is quite a short time for a first admission of a man believed to be suffering from the most severe form of mania. According to ICD 10:*

*‘Manic episodes usually begin abruptly and last for between 2 weeks and 4 – 5 months (median duration about 4 months)’.*

*However, as Professor Kennedy... and [Consultant Psychiatrist D]... point out in their evidence, lengths of stay for people with mania vary widely and some require only a short admission. I agree with the views expressed by Professor Kennedy... [Consultant Psychiatrist F]... and [Consultant Psychiatrist D] that length of stay is not pre-determined on the basis of diagnosis but is influenced by a range of factors that relate to the individual patient in question”.*

In a written submission to the Commission, CMH Clinical Director Professor Kennedy takes issue with Dr Lelliott’s view that nine days was *“...a short time for a first admission of a man believed to be suffering from the most severe form of mania”*, stating:

*“Leaving aside the question of whether Mr Egan had ‘the most severe form’ of mania, it is not the case that severity at presentation, even in a first episode normally leads to longer duration of admission. At the risk of stating the obvious, the duration of admission is determined mainly by the time it takes to treat the illness. This will vary enormously from individual to individual but it is generally recognised that the more florid the symptoms and the more acute the illness at presentation the quicker and the more completely the symptoms will resolve. This is true both for schizophrenia and for mania”.*

Dr Lelliott in his report to the Commission identifies a number of factors which he says might have led to Stephen Egan being kept in the CMH for a longer period. Referring firstly to the nature of Mr Egan’s mental disorder, Dr Lelliott states:

*“The presence of symptoms that are not typical of mania, the possibility that Mr Egan had experienced psychotic symptoms for five months before his admission (there is no record of his mental state as assessed by a psychiatrist between 9<sup>th</sup> February 2006 and*

*26<sup>th</sup> June 2006 but it is possible that he remained psychotic throughout this period) and the complicated interaction between psychosis, personality disorder, substance misuse and violence might have warranted a more prolonged period of observation and assessment”.*

In a written response to this, Professor Kennedy comments as follows concerning the complexity of Stephen Egan’s presentation:

*“Dr Lelliott, because of his lack of relevant expertise, is not aware that this is the normal profile for almost all admissions to this, and to all forensic mental hospitals. This is also the norm in Irish remand prisons, and sentenced prisons and internationally”.*

The Commission’s view is that Professor Kennedy’s assertion is of dubious value, having regard to the unlikelihood that a complex profile such as Mr Egan’s could ever be regarded as the norm in considering whether Mr Egan should have been detained for a longer period of observation at the CMH.

In any event, the Commission regards Mr Egan’s profile as a departure from the norm even by the CMH standards when the statistics cited by Professor Kennedy indicate that most of their patients diagnosed with mania<sup>58</sup> stay at the CMH for periods greater than nine days.

In relation to Mr Egan’s response to treatment during his stay at the CMH, Dr Lelliott notes in his report to the Commission:

*“The clinical record gives inconsistent reports of Mr Egan’s mental state shortly before and after his discharge on 14<sup>th</sup> July 2006. As early as the 8<sup>th</sup> July, psychiatrists assessing Mr Egan recorded that he ‘appears to be responding to medication’ and by 11.15 a.m. on 13<sup>th</sup> July it is noted for the first time that he appears to be free of symptoms. However, as late as 19.15 on 13<sup>th</sup> July, another psychiatrist records that ‘he believes there is a conspiracy against him based in MJP’ and the nursing note reports that ‘pressure of speech [is] evident during [this] interview’. On the 17<sup>th</sup> July 2006, three days after his discharge to Cloverhill Prison, [Consultant Psychiatrist G], a consultant psychiatrist,*

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<sup>58</sup> i.e. 83% of patients between January 1997 and December 2002 – see above p.195.



*recorded that ‘he reported hearing ‘the Beast’ talking to him in his cell. He described second person auditory hallucinations. He denied third person, commentary or command hallucinations. He also reported thought insertion and thought broadcast’. In her examination of his mental state at that time, [Consultant Psychiatrist G] found Mr Egan to be ‘restless’ and ‘a little irritable’, ‘his speech was pressured. There was evidence of thought disorder. He expressed persecutory delusions regarding a cover up involving ‘the Beast’ and prison staff. He reported thought interference in the form of thought insertion and thought broadcast... He reported auditory hallucinations... His insight into his illness was very poor’. She concluded that he ‘remained elated and psychotic’. At this time, the evidence suggests that Mr Egan was still taking a high dose of Olanzapine (30mg daily).*

*Overall, my conclusion is that Mr Egan was in only partial remission at the time of his discharge from the Central Mental Hospital on 14<sup>th</sup> July 2006”.*

On the issue of Stephen Egan’s mental state, Professor Kennedy does not agree with Dr Lelliott that the clinical record shows inconsistent reports of mental state before and after discharge from the CMH. In a written submission to the Commission Professor Kennedy states:

*“The decision to discharge was made on the basis of the clinical assessments at the CMH; it cannot have been made on the basis of mental state after discharge. The descriptions of mental state are bound to vary to some extent when different clinicians describe mental state at different times. Mental state varies from time to time when recovering. There is however a clear pattern of progressive improvement over the period of the admission as documented... It is particularly obvious that Mr Egan responded quickly and markedly to moderate doses of anti-psychotic medication, with prolonged sleep. This would not have occurred if his illness was very severe or slow to resolve. It is clear evidence that Mr Egan’s symptoms responded readily and quickly to appropriate treatment”.*

With regard to the apparent continuance of symptoms following his discharge from the CMH, Professor Kennedy comments:

*“Patients commonly have residual symptoms on recovery, which are often reports of memories of symptoms and the distress they caused rather than active symptoms... Complete absence of all symptoms would be extremely rare in any setting”.*

In response to Dr Lelliott’s conclusion that Stephen Egan was “*in partial remission*” at the time of discharge, Professor Kennedy states:

*“Dr Lelliott gives no definition for what he means by ‘partial remission’ at the time of discharge... ‘Remission’ in schizophrenia requires this ‘response’ to be sustained for six months. It is not normal practice anywhere, in general adult or forensic services to keep a patient in hospital for a further 6 months after they have achieved full symptom response. This would merely lead to institutionalisation. It would be considered wrong to detain such a patient such a patient in hospital who was indicating and desire to leave and be followed up, as Mr Egan was consistently for some days prior to his discharge...”*

Responding to Professor Kennedy’s observations on this issue, Dr Lelliott states:

*“The case record supports Professor Kennedy’s view that Mr Egan’s symptoms improved substantially during his admission and with treatment with antipsychotic medication. However, I remain of the opinion that it also suggests that he was in only partial remission at the time of his discharge. As I state in my report the case record suggest that, although the first report that he was symptom-free was made at 11.15 on 13<sup>th</sup> July, at 19.15 on that same day it was noted in the medical record that ‘he believes there is a conspiracy against him based in MJP and the nursing note reported that “pressure of speech [is] evident during [this] interview”. This is less than 24 hours before his discharge’”.*

With regard to whether the symptoms exhibited by Mr Egan on the day of his discharge and on occasions thereafter in Cloverhill should be described as “residual symptoms on recovery”, Dr Lelliott observes:

*“In my opinion, the most likely explanation for Mr Egan continuing to report symptoms identical to those recorded during his admission to CMH, and to show the same type of*

*agitated behaviour associated with those beliefs, is that, although he had improved in response to being treated with medication, he was still ill”.*

### ***Risk of Violence***

It is common case among all the psychiatrists who gave evidence to the Commission that Stephen Egan’s propensity for violent behaviour should not be ascribed solely to his mental health problems, and that he remained a risk to others even when well. According to [Consultant Psychiatrist F], this continuing risk was a major factor in the decision to keep Mr Egan in seclusion for the duration of his stay at the Central Mental Hospital.

The Commission questioned [Consultant Psychiatrist F] as to whether this risk of violence, which existed independently of any mental illness, played any part in the decision to discharge Mr Egan from the CMH back to the prison system on 14<sup>th</sup> July 2006. [Consultant Psychiatrist D] responded as follows:

*“No, my decision to discharge Mr Egan was made following full consideration of his clinical presentation and progress over the course of his admission. That opinion was based on my opinion, my own clinical judgement, information and feedback from the multi-disciplinary team, which would have included the nursing staff on the unit, and my own team, who would have seen him with me, and assessments of a number of medical colleagues, as outlined. Which confirmed an improvement, and a sustained improvement, over approximately a week, in Mr Egan’s mental state. My decision was also made with full consideration to risk assessment, in relation to risk of harm to self and to others.*

*My decision also was made with full consideration as to what access Mr Egan was likely to have to appropriate aftercare in the prison system.*

*My decision to send him back was not based on the risk, which obviously, as I say was there, historically very clearly, of violence to others”.*

On the issue of whether and to what extent Stephen Egan’s mental illness might affect an assessment of the risk of violence which he posed to others, Dr Lelliott observed in his report to the Commission:

*“A number of factors suggest that Mr Egan poses a high risk to others regardless of the presence of a mental illness. He has committed many violent acts, he has dissocial personality disorder, he has a long history of substance misuse and there are factors in his childhood... that are predictive of future violence and offending behaviour. These features are not readily amenable to or modifiable by intervention by mental health services.*

*However, there are in addition, features of Mr Egan’s mental illness that had manifested themselves by the time of his first admission that might be independent risk factors for violence towards others. These include:*

- Paranoid delusions about plots against him by individuals with whom he will have contact (other prisoners, psychiatric staff and prison staff)*
- Auditory hallucinations directed at him by others*
- A previous history of at least one act of violent behaviour (setting fire to his cell on 18<sup>th</sup> December 2005) apparently in response to symptoms of mental illness*
- Agitated behaviour when actively considering his delusional beliefs*
- History of poor compliance with medication*

*Although these factors, singly or in combination, do not reliably predict future violence, they might lead clinicians to decide to keep a patient in hospital for a longer period of observation, including of the patients’ interactions with others, and to them being more certain of the stability of remission before discharge”.*

Dr Lelliott returned to this issue in the conclusions of his report for the Commission, stating:

*“There are features in Mr Egan’s history, presentation and response to treatment that suggest that he might have benefited from a longer stay in the Central Mental Hospital for fuller assessment and treatment. Specifically:*

- *The likely long duration of psychotic symptoms prior to admission*
- *The presence of a complex mix of psychotic symptoms, substance misuse and personality disorder*
- *The presence of symptoms that are inconsistent with the working diagnosis of mania*
- *The presence of symptoms that might be considered to increase the risk of violence*
- *A lack of knowledge about how Mr Egan's paranoid beliefs would cause him to behave in the company of others*
- *The apparent continuing presence of psychotic symptoms at the time of discharge*
- *A history of poor compliance with medication*
- *Doubt about the likelihood of him receiving adequate psychiatric care after discharge back into the prison system"*

When Stephen Egan was returned to the Central Mental Hospital in August 2006 following the death of Gary Douch, a particular form of risk assessment instrument known as Historical-Clinical-Risk Management– 20 [HCR– 20] was employed to assess the risk of violence associated with Mr Egan. When he was discharged from the CMH to Midlands Prison in October 2006, a copy of the HCR– 20 report was sent to the receiving prison. It is not clear from the documentation disclosed to the Commission whether a similar HCR– 20 assessment was carried out during Stephen Egan's first stay at the CMH from 5th – 14th July 2006.

In a written submission to the Commission, Professor Kennedy responded to Dr Lelliott's comments regarding the risk of violence and Stephen Egan's length of stay at the CMH in July 2006, stating:

*"Dr Lelliott has correctly read the risk factors and distinguishes between illness related risk factors and non-illness related risk factors. Some of those risk factors he ascribes to mental illness are incorrect, as he is venturing outside his expertise. Dr Lelliott is wrong*

*to say that ‘they might lead a clinician to decide to keep a patient in hospital for a longer period of observation, including of the patients’ interactions with others’ since it would be wrong to expose other mentally ill patients to the considerable risk posed by Mr Egan. It was for this reason that Mr Egan was kept from other patients... Dr Lelliott is speaking outside his expertise when discussing the relationship between risk of violence and length of stay – he has no knowledge or experience of treatment in conditions of special therapeutic security”.*

It is not clear from Professor Kennedy’s submission which specific risk factors he is referring to when he says that some are incorrectly ascribed to mental illness by Dr Lelliott.

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

### **Discharge from Central Mental Hospital**

Stephen Egan was discharged from the Central Mental Hospital on Friday 14<sup>th</sup> July 2006 and was brought directly to Cloverhill Prison.

Mr Egan's discharge from the CMH was governed by section 18 of the Criminal Law (Insanity) Act 2006, which came into effect on 1<sup>st</sup> June 2006. The section provides:

*“Where the clinical director of a designated centre forms the opinion in relation to a prisoner detained in the centre pursuant to section 15 that he or she is no longer in need of in-patient care or treatment he or she shall, after consultation with the Minister, direct in writing-*

*(a) the transfer of the prisoner back to the prison from which he or she was transferred to the centre, or*

*(b) the transfer of the prisoner to such other prison as the Minister considers appropriate in all the circumstances of the case”.*

### **Opinion of Clinical Director**

Following a review of Stephen Egan carried out at 11.50 a.m. on Friday 14<sup>th</sup> July 2006, his treating psychiatrist [Consultant Psychiatrist F] formed the opinion that he was ready to be discharged from the CMH. However, under section 18 of the 2006 Act, the discharge of a patient from the Central Mental Hospital is a function, not of the patient's treating psychiatrist but of the Clinical Director of the hospital, who must himself be of the opinion that in-patient care or treatment at the CMH is no longer needed. The clinical director in this instance was Professor Harry Kennedy. Following [Consultant Psychiatrist F]'s recommendation, Professor Kennedy

reviewed Stephen Egan himself at 6.30 p.m. on the evening of Friday 14<sup>th</sup> July 2006 and declared him to be fit for discharge.

In addition to certifying that Stephen Egan no longer needed to be treated or cared for at the CMH, it was also necessary for the Clinical Director to make a written direction as to which prison Mr Egan would be returned on his discharge. In a note of his review of Mr Egan carried out on the evening of 14<sup>th</sup> July 2006 Professor Kennedy referred to Cloverhill rather than Mountjoy as the prison to which Mr Egan would be returning:

*“Fit to return to CHP → decertified.*

*Advised to continue on Olanzapine 30mg N [nocte] and nil else.*

*Review in in-reach clinics, taper dose over  $\approx 3/12$ ”.*

The reference to “*nil else*” was explained by Professor Kennedy to the Commission as referring to the use of illegal “street” drugs. The phrase, “*taper dose over  $\approx 3/12$* ” reflected Professor Kennedy’s view that the dosage of Olanzapine might gradually be lowered over approximately 3 months, subject to on-going in-reach review.

Professor Kennedy told the Commission that at the time of this review on 14<sup>th</sup> July 2006, his understanding was that Stephen Egan’s status had changed from sentenced to remand prisoner during his stay at the CMH, and that as a remand prisoner, he would as a matter of practice be sent to Cloverhill rather than to Mountjoy.

[Consultant Psychiatrist F] was adamant in her evidence to the Commission that the decision to discharge Stephen Egan had been influenced to some extent by her understanding that he would be going to Cloverhill. [Consultant Psychiatrist F] stated:

*“My expectation was that he would be returning to Cloverhill Prison, where he would have access to appropriate level of aftercare, and that he would continue to receive on-going treatment for residual symptoms... I was aware that there was quite a comprehensive service, in reach service to Cloverhill Prison... I was very much aware that it was a very well-resourced and structured aftercare location to which I was discharging him”.*



[Consultant Psychiatrist F] also told the Commission:

*“I wanted to confirm that he could go back to Cloverhill only. I would not have discharged him back to Mountjoy”.*

In evidence to the Commission, Professor Kennedy did not state expressly, as [Consultant Psychiatrist F] had, that he would not have discharged Stephen Egan back to Mountjoy. Rather, he told the Commission that from his point of view the question had not arisen, as by the time he came to review Mr Egan on the evening of 14<sup>th</sup> July 2006, it had been settled that the latter would be going to Cloverhill Prison:

*“A: Just to be clear about that it was confirmed to me... that it was Cloverhill he would be going to*

*A: ...the decision we were looking at was – ‘is he ready to go back to Cloverhill?’ It is a different decision to the decision ‘is he ready to go to Mountjoy’ – that is a different decision and it was Cloverhill we were addressing...*

*Q: Would it have been a different decision if the only options so to speak were a return to Mountjoy, would it have been clinically supported for him to go at that point to Mountjoy knowing what you know about the environment he was going back to?*

*A: It is very difficult to answer that. It is really beyond answering.*

*Q: But it never came within the parameters of any decision you had to make anyway?*

*A: Not in reality, no...”*

## **Administrative Procedures**

The administrative aspects of Stephen Egan’s discharge from the CMH were the responsibility of the Acting Mental Health Act Administrator at the hospital (hereinafter referred to as “the Administrator”). In a statement to the Commission, the Administrator gave the following account of the procedures followed on this occasion:

*“I recall that I was informed by [Consultant Psychiatrist F] (Mr Egan’s Consultant) on the 14<sup>th</sup> July 2006 that Mr Egan was to be discharged. As is my usual practice I checked the register of residents and I noted that Mr Egan had been transferred to the Central Mental Hospital from Mountjoy Prison. I also noted that he was a remand prisoner and that I had recorded in the register that he was ‘rem and sent’. This means that he was remanded and sentenced. Remand prisoners would normally be transferred to Cloverhill but because he had come from Mountjoy I contacted that prison. I don’t know what time I made the call but I would usually make such calls in the morning. I do not know who I spoke to but I would normally ring the general office. I asked the person who answered the phone where Mr Egan should be returned to because he was a remand prisoner. I recall that I was informed that he was to be returned to Cloverhill Prison.*

*I then contacted Cloverhill Prison. I don’t know who I spoke to but again I would usually ring the general office. I informed the person who answered the phone that I had been told by Mountjoy Prison that Mr Egan was to be transferred back to Cloverhill. Although I don’t recall the details of the conversation I have a vague recollection that the personnel at Cloverhill said that they would speak to Mountjoy about it... I don’t remember being contacted again by Cloverhill Prison”.*

It appears from the above passage that the HSE employee from the CMH involved was not aware of the view expressed by [Consultant Psychiatrist F] that Mr Egan should be discharged to Cloverhill only. In fact, the first contact made was with Mountjoy Prison, and if Mountjoy had been willing to take Mr Egan, it is possible that he would have been returned there.

The Commission has received conflicting evidence concerning the identity of the person at Mountjoy who spoke with a HSE employee at the CMH on 14<sup>th</sup> July 2006, and the available records are insufficient to resolve this conflict. Nor has it been possible to confirm the identity of the person at Cloverhill who spoke to the HSE employee at the CMH either, on that day.

## **Consultation by the Clinical Director with the Minister for Justice**

A written direction by the Clinical Director of the CMH (which in practical terms is a Discharge Certificate) could not be perfected pursuant to Section 18 of the 2006 Act until a consultation

had taken place with the Minister for Justice in relation to which prison the prisoner should be discharged from the Central Mental Hospital (the “designated centre” for the purposes of the section). The discharge certificate signed by Professor Kennedy in relation to Stephen Egan avers that a consultation did take place, but the Commission has been unable to confirm the nature and extent of any such consultation.

The Commission wrote to the Department of Justice on 6<sup>th</sup> May 2010 seeking clarification of the procedures in place to fulfil the necessity for consultation under s.18 of the 2006 Act. In a response dated 1<sup>st</sup> July 2010 the Department’s Prison Policy Division indicated that in fact, no procedure for consultation was in place in 2006 or in subsequent years:

*“...notices under this section are not sent to the Prisons Policy Division of the Department... but are in fact sent to the Headquarters of the Irish Prison Service (IPS) in Longford...*

*...up to recently no specific official of the Irish Prison Service had been delegated with the responsibility for the performance of functions under section 18. The procedure was as follows:*

*In order to be returned to custody, the Central Mental Hospital must first declare the prisoner fit to return to the prison.*

*Once the prisoner is decertified the prison is notified by the Central Mental Hospital that s/he is to be returned to custody. This notification is generally by phone call to let the prison know that an escort must be arranged to collect and return the prisoner. The escort is in all cases arranged by prison staff.*

*The medical file from the Central Mental Hospital will travel with the prisoner back to the prison.<sup>59</sup> This will contain information with regard to the prisoner’s care and medication for the attention of the medical team at the prison.*

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<sup>59</sup> The Commission notes that this is not strictly correct. The Central Mental Hospital keep their own files on patients, and prison medical files are not sent with a prisoner to the CMH. When a prisoner is returned from the

*Following the transfer, the Central Mental Hospital fax details of the prisoner transfer to the Operations Directorate. The information given is fairly limited and includes such details as the name and address of the prisoner, date of admission and certification, name of psychiatrist, and the date of examination. This information is stored in a file in the directorate and recorded on an excel spreadsheet for statistical purposes...*

*The CMH does not consult with Operations Directorate of the IPS prior to returning a prisoner to custody.*

*A review of these procedures has recently been carried out. In that regard the Minister has now decided to designate Mr Fergal Black, Director of Healthcare at the IPS, as the appropriate official to address the requirements of section 18. I understand Mr Black has since requested a meeting with Professor Kennedy of the CMH to discuss arrangements”.*

It appears from the above that the Department of Justice have no record of any consultation taking place with the Clinical Director of the CMH regarding Stephen Egan’s proposed discharge in July 2006. Furthermore, as a matter of practice in 2006 and thereafter, such communications as took place between the CMH and the Irish Prison Service in relation to proposed discharges from the CMH were seen by the IPS and the Department as a process of notification rather than consultation. From this, the Commission is driven to the conclusion that the consultation requirement under section 18 of the 2006 Act was not adequately or meaningfully engaged in prior to Stephen Egan’s discharge from the CMH on 14<sup>th</sup> July 2006.

## **Contact between Cloverhill and Mountjoy Prisons**

As stated earlier, an administrator at the Central Mental Hospital initially contacted Mountjoy Prison and was told that Stephen Egan should be discharged to Cloverhill as a remand prisoner.

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CMH to the prison system, the document that travels with them is a Discharge Summary prepared by the CMH, which contains the necessary information regarding on-going care and treatment.

The CMH administrator then contacted Cloverhill to inform them of the prospective arrival of Mr Egan.

At some point after this a governor in Mountjoy Prison, Mr Sylvester Salley, received a telephone call from the Governor of Cloverhill Mr Tom Somers concerning Stephen Egan. Governor Salley told the Commission:

*“...the request was made to me to take him back to Mountjoy... I refused. I said ‘I cannot take him because we don’t have facilities for him, and we are not medically equipped for this lad’, and because we were aware of his background from previous – he had burned all his bridges, as you would say, in the prison. We had sent him to the Central Mental Hospital from Mountjoy... he was in very poor health. So on 14<sup>th</sup> July, I received the request from Tom Somers, and I told him ‘I am not taking him back. I cannot take him back to Mountjoy’”.*

Following this refusal by Governor Salley, Governor Somers telephoned the Governor of Mountjoy, John Lonergan and asked him, in effect, to override Governor Salley’s decision. Governor Salley told the Commission:

*“About that afternoon John Lonergan came out to my office and asked me to consider taking Stephen Egan back to Mountjoy Prison, because Tom Somers, the Governor Class 1 in Cloverhill, rang him and asked him to take him back. I discussed it with John and I said ‘under no circumstances could we’, because I knew Cloverhill, I knew their capabilities, which were far superior to us in Mountjoy, and John agreed and he refused. That is not within John Lonergan’s personality or character, because he is very open to taking prisoners from other prisons... but in this case he refused based on my recommendation to him”.*

In evidence to the Commission Governor Somers said that he had been made aware on 14<sup>th</sup> July 2006 that Stephen Egan was either back in Cloverhill Prison or was due to come back. He recollected contacting a Governor in Mountjoy to ask if they would take Mr Egan back. When asked if he recalled ringing Governor Lonergan, Governor Somers stated:

*“Governor Lonergan probably wouldn’t be somebody who I would ring ever about transfers. Because, you know, he probably wouldn’t be involved in the day-to-day running of wings and the operation of wings. But it is entirely possible that I rang and maybe in the context of another call for some other matter asked him was he familiar with the issue of the transfers of Stephen Egan and would he agree to take him back”.*

Governor Somers had only taken up his position as Governor of Cloverhill on 17<sup>th</sup> March 2006. At that time Stephen Egan was in Mountjoy Prison, having left Cloverhill on 16<sup>th</sup> March 2006. For some years prior to this appointment Governor Somers had been a governor in Arbour Hill prison and in the Curragh prison. He had also spent a period of eight months working in the Prison Service headquarters. He had no cause to deal with Stephen Egan during this time. When asked by the Commission why he might have sought to have Mountjoy Prison take Stephen Egan on 14<sup>th</sup> July 2006, Governor Somers stated:

*“...I was not familiar with Stephen Egan and I had never met him. Following his arrival in Cloverhill, it was brought to my attention by some of the senior staff, some of the Chief Officers and perhaps some ACOs that this was a chap who had posed significant management problems and that if we moved him down into the main prison, the wings, it might well give rise to serious difficulties for us.*

*I think in that context that – allied to the fact that he had gone from Mountjoy to the CMH – that would be the reason, the prime reason for making that call. I would rely greatly upon the advice of my senior grades, my Chief Officers. They would become aware of material information through their day-to-day dealings with prisoners in the wings. And they would bring that to my attention”.*

Given that Governor Somers’ telephone contact with Mountjoy on 14<sup>th</sup> July 2006 took place before Mr Egan had even left the Central Mental Hospital, it must be assumed that the discussions between Governor Somers and his officers regarding Stephen Egan would have taken place prior to his arrival at Cloverhill.

Expanding on the “significant management problems” posed by Stephen Egan, Governor Somers referred to the fact that Mr Egan, when he eventually did arrive at Cloverhill on 14<sup>th</sup> July 2006, was placed on D2 wing. He continued:

*“...It would be our policy in Cloverhill that people who come from the CMH go to D2 for a period of assessment, for a period of review, including medical review. That is why he was there. As I say, there would have been concerns expressed by senior uniformed grades in the prison about his potential return into the main prison population. Bearing in mind, the accommodation in Cloverhill is primarily based on three-man cells. If he was returning into the main prison, it’s very likely he would be going into a three-man cell. Because of previous difficulties that the staff would have experienced in terms of his management they would have had concerns about that”.*

Governor Somers told the Commission that keeping Stephen Egan on D2 wing indefinitely would also have caused problems:

*“One of the things about D2 is it fills many functions in Cloverhill. It acts as an assessment centre for people who come off the streets who are maybe high on drugs, who are in withdrawal, who have mental issues, psychiatric issues... It also holds some people who may have been moved there for disciplinary reasons... It holds people who are under protection who have come into the prison and have been charged with serious offences... who cannot be put into our protection units... As D2 is quite limited – it has accommodation for 27 prisoners... You have to keep people passing through; you can’t just park people up there. In addition the regime is just not suitable for long stay prisoners. They are in a very small confined unit, with a small exercise yard, and a number of small recreation rooms featuring a TV. That’s what’s there”.*

In a written submission Governor Somers expressed the view that Stephen Egan’s history as a troublesome prisoner made him particularly unsuitable for a long stay on D2 wing:

*“[D2 wing] regularly held up to ten different groups who for a variety of reasons could not be allowed to circulate together – accordingly, the introduction of an apparently disruptive, volatile and generally troublesome prisoners such as Stephen Egan on a potential long stay basis would be a significant cause of concern to both management and staff and would in my view have inevitably led to a serious incident.”*

The evidence before the Commission indicates that at the time when negotiations were taking place between Cloverhill and Mountjoy Prison as to Stephen Egan’s placement – that is, the

morning and afternoon of 14<sup>th</sup> July 2006 – neither prison had yet received a discharge summary or other medical information from the CMH concerning Stephen Egan’s condition and his need for on-going treatment and review. Nor was it made clear to either prison that the consultant who had overseen Stephen Egan’s care at the CMH had a clear preference for Cloverhill and did not want him discharged to Mountjoy.

It can be deduced from this that the concerns expressed by management at Cloverhill Prison were not based on any specific information received from the Central Mental Hospital or the prison medical staff as to Stephen Egan’s need for on-going psychiatric care and treatment, but arose solely from the fact that Stephen Egan had a past history as a “*management problem*” within the prison system. Governor Somers confirmed this in a written submission, stating:

*“I must point out that at no time prior to or subsequent to the transfer of Stephen Egan to Cloverhill Prison on 14<sup>th</sup> July 2006 was I aware of any advice, request, direction or otherwise to the effect that he should be located on D2 for medical, psychiatric or therapeutic reasons. I should also point out that at no time did I receive or have sight of any correspondence from the Clinical Director or any of his staff at the CMH. Consequently and insofar as I am concerned, the decision to locate Stephen Egan on D2 upon his arrival at Cloverhill was, in the first instance in line with our policy for all transfers from the CMH and his subsequent stay on D2 was for operational and management reasons.*

*The Commission will be aware that notes and correspondence on a prisoner’s medical file are confidential and that Prison Governors depend on the Prison Medical Officer or senior nursing grade to bring any relevant or significant information regarding a prisoner to his attention. In the absence of any such information and based upon the advice of my senior grades, I saw Stephen Egan as a disruptive prisoner who was not suited to location in the main wings of the prison, but who, given that he was in the prison should be located on the security side of D2 for control and management reasons.”*

In this regard the Commission notes that two of the most serious incidents involving Stephen Egan – his escape from Cloverhill courthouse in July 2005 and the subsequent excrement-



throwing incident in the same courthouse later that month took place while he was under the aegis of staff from Cloverhill Prison. Cloverhill staff would also have been aware of his attempted hostage-taking while en route from Cork to Cloverhill Prison on 27<sup>th</sup> November 2005. In those circumstances it is understandable that senior management at Cloverhill might be reluctant to take custody of Stephen Egan if it could be avoided.

In relation to Mountjoy Prison, the concerns voiced by Governor Salley were twofold – firstly, a lack of appropriate cell accommodation and secondly, a lack of adequate medical resources for Mr Egan at Mountjoy. Again, it should be emphasised that, beyond the simple fact that he was coming from the CMH, Mountjoy staff were not aware of Mr Egan’s specific care requirements going forward. However, Governor Salley has made it clear in his evidence to the Commission that he personally did not believe Mountjoy had the physical or medical resources to manage Stephen Egan at that time.

## **Arrival of Stephen Egan at Cloverhill Prison**

Following Professor Kennedy’s review at 6.30 p.m. Stephen Egan was brought from the CMH to Cloverhill Prison, arriving at 7.25 p.m.

Professor Kennedy informed the Commission that it was not unusual for transfers to take place at such a late hour, as the CMH is reliant on the availability of prison transport for such transfers. In practice, this means that transfers to and from the CMH take place either very early in the morning (before prisoners are brought to court) or in the evening, when all court runs are finished.

Accompanying Stephen Egan on his transfer was a handwritten letter from Professor Kennedy, which was duly placed in Stephen Egan’s prison medical file. Stephen Egan’s prison medical file also contains a typed Discharge Summary Form, dated 14<sup>th</sup> July 2006, prepared by [Consultant Psychiatrist F]’s registrar on the instructions of [Consultant Psychiatrist F]. It appears that this Discharge Summary was sent by fax to Cloverhill on Tuesday 18<sup>th</sup> July 2006.

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, written at 10 p.m. on 14<sup>th</sup> July 2006, states:

*“Returned from CMH. Straight to D2 from reception. Not seen by nursing staff in reception”.*

The nurse officer who wrote the above note, [Nurse Officer A], told the Commission in evidence that he himself would have arrived at the prison some time around 7.30 in order to commence a night shift at 8 p.m. He cannot remember how he came to find out that Stephen Egan had not been seen in reception.

The computerised Prisoner Records Information System (PRIS) does not record Stephen Egan’s arrival at Cloverhill on 14<sup>th</sup> July; nor does it indicate where he spent that night. The first relevant entry places him in a holding cell at the Reception area on 15<sup>th</sup> July and then in a cell on D2. The most likely explanation for this discrepancy is that the 15<sup>th</sup> July 2006 represents the date on which the computer entry was made, rather than the date on which Mr Egan in fact arrived at the prison.

The Commission has been unable to establish why Stephen Egan 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 [Doctor C], one of three GPs serving Cloverhill Prison at that time.

## **Management of Stephen Egan at Cloverhill Prison**

Stephen Egan was placed on the “security” side of D2 wing at Cloverhill on 14<sup>th</sup> July 2006 and he remained there until he was transferred to Mountjoy Prison on 29<sup>th</sup> July 2006.

In evidence to the Commission, the Governor of Cloverhill Mr Tom Somers recalled meeting Stephen Egan for the first time on D2 wing on 15<sup>th</sup> July 2006, and again on 25<sup>th</sup> July 2006. He told the Commission:

*“...while he was on D2 through 15 days or so ... I think I dealt with two infractions of the rules. I think they were both for fighting, but of a minor nature and I think the sanction I imposed would be something like 14 nights deprivation of recreation, which is a fairly minor penalty. They weren’t significant incidents, but nevertheless, they were two disputes with other prisoners”.*

The documentation disclosed to the Commission does not contain any reports in relation to these incidents. The Commission has been told by [Chief Officer A] from Cloverhill that not all instances of misbehaviour in prison result in disciplinary reports (known as “P19 reports”) being issued:

*“A: You know, what we try and do is get them to appease with each other and usually they shake hands and say it’s all over with and we leave it at that.*

*Q: So there can be references to fights but [they are] not necessarily the subject of a formal P19?*

*A: Not necessarily a P19, no.*

*Q: Or even a formal record of it in any other way?*

*A: No”.*

In this instance however, both [Chief Officer A] and [Assistant Chief Officer B], who had responsibility for D2 in July 2006, do not recall any particular incident involving Stephen Egan during that period.

The Commission notes that Stephen Egan himself, in an interview conducted by consultant psychiatrist Professor Tom Fahy on 8<sup>th</sup> September 2008, said that he was involved in two fights following his return from the CMH in July 2006. Professor Fahy reported:

*“Mr Egan was returned to Cloverhill Prison from CMH. He says that he spent eight days at the prison. During that time he was involved in two fights:*

*One fight was with a man who had 'Sabrina' tattooed on his arm. Sabrina is Mr Egan's sister's name. 'I thought I heard him talk about her'.*

*'A young fellow looked at me. I thought from his name that he may have been involved in my brother's shooting'. Mr Egan says he attacked this man and may have fractured his cheekbone".*

Professor Fahy noted that Mr Egan's account of these incidents "...is not corroborated in any records that I have seen".

The Governor's Parade books, which note any requests made of Governors during their daily rounds of the prison, record a number of interactions with Stephen Egan during this period, as follows:

*"15/7/2006 Re-activate phone. (24 hour obs. Doctor)*

*17/7/2006 Wishes to apply for an order of mandamus + judicial review.*

*18/7/2006 requested a move to C wing – discussed*

*20/7/2006 requested [illegible]*

*21/7/2006 seen. No requests.*

*25/7/2006 requested recreation – discussed.*

*28/7/2006 R. move to C – Noted – approved when vacancy arises"*

The Commission questioned a number of relevant Cloverhill staff as to their view of Stephen Egan during this period. [Assistant Chief Officer B] told the Commission:

*"I was obviously aware that he was troublesome... there are a lot of prisoners you would feel confident around and confident working with and talking to and everything else – I wouldn't have had that same confidence with Stephen Egan. He was obviously somebody that... I would have been concerned about him and his whereabouts, and what he was doing, and each time he was unlocked, of course".*

In relation to the placement of Stephen Egan on the security side rather than the vulnerable side of D2, [Assistant Chief Officer B] stated:

*“The vulnerable section is an area that is always quite full, [with] very, very limited vacancies. I think, I suppose with previous knowledge of Stephen Egan, knowing his history and the fact that he was troublesome; the security side would have been... a natural side to put him on. He can be seen on either side by psychiatrists”.*

The Commission also heard evidence from Liam Dowling, a Governor level 2 in Cloverhill. Governor Dowling was on leave at the time Stephen Egan arrived from the Central Mental Hospital. He returned to work on 25<sup>th</sup> July 2006. Governor Dowling told the Commission that on 29<sup>th</sup> July 2006, when he was consulted regarding the proposed transfer of Stephen Egan to Mountjoy, he was not aware that Egan had been in the Central Mental Hospital. Nor was he aware of the psychiatric reviews of Mr Egan which had been carried out in Cloverhill in February 2006. Governor Dowling told the Commission that as far as he was aware,

*“Stephen ... had never had any psychiatric attention in Cloverhill”.*

All of the above suggests that Stephen Egan was regarded by non-medical staff in Cloverhill as a management problem with potential security risks, rather than as a vulnerable prisoner with mental health issues. This was certainly the case prior to his stay in the Central Mental Hospital, and the Commission considers that Mr Egan’s time in the CMH did not alter the view held by management in Cloverhill that he was to be managed primarily as a security risk.

## **Treatment of Stephen Egan at Cloverhill Prison**

### **Medical Treatment**

As previously stated, the medical notes on Stephen Egan’s prison file indicate that he was not seen by any member of the medical staff when he arrived at Cloverhill on 14<sup>th</sup> July 2006. He was reviewed by [Doctor C] (one of three GPs then attached to Cloverhill) on the following morning, 15<sup>th</sup> July 2006.

It is not clear what documentation, if any, [Doctor C] had available to him at that point, apart from Professor Kennedy's handwritten letter of 14<sup>th</sup> July 2006, which travelled with Stephen Egan to Cloverhill. The Commission has been unable to establish the date on which Stephen Egan's prison medical file was transferred from Mountjoy Prison to Cloverhill. The typed Discharge Summary from the Central Mental Hospital, prepared by [Consultant Psychiatrist F]'s registrar on the instructions of [Consultant Psychiatrist F], was not sent to Cloverhill until 18<sup>th</sup> July.

[Doctor C] did have access to Professor Kennedy's handwritten letter of 14<sup>th</sup> July 2006, headed "*Stephen Egan dob 27/9/83*". It reads as follows:

*"Thank you for accepting Mr Egan. He was admitted to CMH on 5/7/03 [sic] into a hypomanic presentation. He has settled well on Olanzapine 30mg nocte but needs to continue on this for some 2 weeks further before reducing the dose with a view to eventual discontinuation. He would also benefit from regular urine screens".*

More detailed information is contained in the Discharge Summary prepared under the instructions of [Consultant Psychiatrist F]. Under the heading, 'Risk Management... Risk to others' the Discharge Summary states:

*"No current thoughts of harming anyone else, but has a significant past history of engaging in dissocial activities and physical violence toward others".*

Under the heading, 'Risk of non-compliance' it states:

*"Risk of non-compliance with medication in future due to limited insight into illness and current reluctance to take medication".*

The medication prescribed on discharge is noted as Olanzapine 30mgs nocte. Finally, under the heading 'Recommendations and Follow-up' the Discharge Summary states:

*"- Patient will be reviewed in the prison clinic by our team next week.*

*- Compliance with medication will be essential for maintaining mental health.*

*- Random urine screening for drugs to detect and discourage illicit substance misuse”.*

[Doctor C] saw Stephen Egan again at Cloverhill on 16<sup>th</sup> and 17<sup>th</sup> July 2006. Mr Egan was noted as being well, with no complaints. The medical notes indicate that during this time, Stephen Egan was being kept in a strip cell at lock-up. Prisoners kept in the strip cells or special observation cells on D2 were visited every day by the doctor as a matter of rule.

## **Administration of Medication**

Stephen Egan’s prison medical file, as disclosed to the Commission, contains two documents from Cloverhill Prison which relate to the administration of medication during the period 14 – 28<sup>th</sup> July 2006. The first is a Drug Prescription Sheet which contains a single entry in relation to the prescribing of Olanzapine. The amount prescribed is 30mg *nocte* (as per the instructions of the Central Mental Hospital) and the prescription is signed by [Doctor C]. The date on which the prescription is recorded as having commenced is unclear, but is either the 14<sup>th</sup> or 15<sup>th</sup> July 2006. [Doctor C] himself has told the Commission that he would not have signed the prescription sheet until the 15<sup>th</sup>, as he did not see Stephen Egan on the 14<sup>th</sup> July 2006.

The second, related document is a Drug Administration Record, with dates entered from 14<sup>th</sup> to 28<sup>th</sup> July 2006. There are entries for each day except 22<sup>nd</sup> July 2006 (where no entry is recorded) indicating that Mr Egan was given his prescribed medication at 7.30 p.m. daily. However, some doubt is cast on the reliability of this record by the fact that there is an entry recording the administration of Olanzapine at 7.30 p.m. on 14<sup>th</sup> July 2006, notwithstanding the fact that Stephen Egan did not arrive at Cloverhill until 7.25 p.m. that evening. Further, [Doctor C] did not sign off on a prescription sheet until the following morning.

## **Psychiatric Treatment**

The first psychiatric review of Stephen Egan following his return from the Central Mental Hospital was conducted by [Consultant Psychiatrist G], Acting Consultant Forensic Psychiatrist on 17<sup>th</sup> July 2006. On 18<sup>th</sup> July 2006 [Consultant Psychiatrist G] wrote to [Doctor D], a GP at Cloverhill with an account of the interview, in which she stated:

*“Mr Egan has been managed in a strip cell at lock-up times since his return to Cloverhill Prison. Staff in D2 reported that he is irritable if challenged or if needs not quickly met. However, they did not report any aggressive outbursts since his return to Cloverhill Prison”.*

Stephen Egan was noted as having been “quite co-operative” during the interview. He denied any illicit drug use and said he had been compliant with his prescribed medication. He reported auditory hallucinations and thought interference, and expressed persecutory delusions. In terms of her overall impression [Consultant Psychiatrist G] wrote:

*“My impression was that Mr Egan remained elated and psychotic. He had little insight into his illness but is compliant with anti-psychotic medication”.*

Under the heading ‘Plan’ [Consultant Psychiatrist G] wrote:

- “1. I did not make any changes to Mr Egan’s medication. He remains on Olanzapine 30mg daily.*
- 2. I would recommend that he is managed in a strip cell at lock up times with normal association during the day.*
- 3. He will be reviewed on an on-going basis by the In Reach Prison Psychiatry Service”.*

A copy of [Consultant Psychiatrist G]’s letter is amongst the documentation disclosed to the Commission by the Central Mental Hospital. However, no copy was found on Stephen Egan’s prison medical file and it is not clear when the letter was received in Cloverhill.

An unsigned note on Stephen Egan’s prison medical file dated 18<sup>th</sup> July 2006 states:

*“Allowed out of strip”.*

The Commission has been unable to establish who made this decision to let Stephen Egan out of the strip cell, and on what basis. [Doctor C] told the Commission that he would have been the GP on duty at the prison on 18<sup>th</sup> July 2006, but he does not know who made this decision. It



would seem that the decision was not made by the Psychiatric In-reach Service, as [Consultant Psychiatrist G]’s report recommends that Egan remain in the strip cell at lock-up.

The Commission has been unable to confirm whether Stephen Egan was in fact moved from the strip cell on 18<sup>th</sup> July. On the one hand, the fact that there are no entries on his medical file for 19<sup>th</sup> July suggests that he was moved – otherwise a prison doctor would have been obliged to visit him on that day. On the other hand, the Prisoner Records Information System (PRIS) indicates that he was not moved until 20<sup>th</sup> July, when he went to another cell on the security side of D2.

In any event it is clear that Egan did not leave D2 wing altogether, as he was seen there by [Consultant Psychiatrist A] on 20<sup>th</sup> July 2006. In a letter of that date to [Doctor D] at Cloverhill [Consultant Psychiatrist A] stated:

*“I reviewed the above named at my clinic in Cloverhill Prison today 20.07.06. He was being managed on the D2 landing. Mr Egan was recently returned from the Central Mental Hospital on 14.07.06. Previously he had a hypomanic presentation and settled on medication.*

*At interview today on D2 there was no evidence of an obvious mental illness. He appeared calm and settled. He is being prescribed Olanzapine...*

*I note when he was previously reviewed by [Consultant Psychiatrist G] that there remained on-going concerns about possible auditory hallucinations. While in Dundrum he remained preoccupied with ‘a cover up’. I have no psychiatric recommendations to make at this point however he will require on-going review by the Psychiatric Services and would benefit from regular urine monitoring”.*

[Consultant Psychiatrist A] told the Commission that there were three aspects to the required “on-going review”:

1. daily observation by nursing staff
2. visits by the Community Psychiatric Nurse
3. a weekly review by a consultant psychiatrist

Apart from the Drug Administration Record, there is no documented evidence that Stephen Egan was seen by any member of the medical staff or the Psychiatry In-reach Service from 21<sup>st</sup> July 2006 until his departure from Cloverhill on 29<sup>th</sup> July 2006.

The Commission has spoken to the Community Psychiatric Nurse (CPN) who was working in Cloverhill at that time. Prison records show that he attended Cloverhill on 18<sup>th</sup> – 21<sup>st</sup> July, and also on 25<sup>th</sup>, 26<sup>th</sup> and 28<sup>th</sup> of the month. In each case, he attended at the prison for two hours and would have spent that time seeing prisoners, except for 26<sup>th</sup> July 2006, when he attended a multi-disciplinary meeting. The Community Psychiatric Nurse told the Commission that he has no record of visiting Stephen Egan between 14<sup>th</sup> and 29<sup>th</sup> July 2006. If he had done so, he has no doubt that he would have recorded notes of the visit.

[Consultant Psychiatrist A] saw Stephen Egan on 20<sup>th</sup> July 2006. At that time [Consultant Psychiatrist A] visited Cloverhill on a weekly basis, every Thursday afternoon. He told the Commission that he would have seen Mr Egan again on 27<sup>th</sup> July 2006 but for the fact that Stephen Egan happened to be in court on that day.

Stephen Egan may have been discussed at a weekly multi-disciplinary meeting held at Cloverhill to discuss prisoners on D2, but no minutes of those meetings were kept. The Community Psychiatric Nurse attending Cloverhill told the Commission:

*“We didn’t have a secretary there. It was just where all the disciplines got together and had a chat about the particular clients on D2, the particular people. There was no note taken, there was no minutes taken. The names would be discussed and we would draw up a list of the people that needed urgent review on that particular day or that particular week”.*

The Commission has been told that since that time, the Psychiatric Service at Cloverhill have implemented a spreadsheet system which records every client’s name, diagnosis, charge, upcoming court dates, particular mental health issues and a treatment plan.

## Observations on Psychiatric Treatment of Stephen Egan at Cloverhill

In a report of 8<sup>th</sup> October 2008 prepared in the context of the pending trial of Stephen Egan for the murder of Gary Douch, consultant forensic psychiatrist Professor Fahy expressed concern regarding the decision to discharge Stephen Egan back to Cloverhill Prison after only nine days in the Central Mental Hospital. Highlighting the particular need for appropriate aftercare in such circumstances, he stated:

*“The critical factor in analysing the appropriateness of the decision to transfer him back to prison on 14<sup>th</sup> July concerns the quality of psychiatric outreach that was available to him in the prison. A decision to discharge a patient from a secure environment after only nine days of treatment would need to be based on an assumption that there was [a] high quality of medical and nursing input available at the prison. On a more basic level, a safe and appropriate discharge in such circumstances can only be made if the prison can offer a reasonable level of continuity of care and, as a fundamental, be able to offer continuity of prescribed antipsychotic medication”.*

In a report to the Commission dated 26<sup>th</sup> September 2010 Dr Paul Lelliott, a consultant psychiatrist appointed to assist and advise the Commission in relation to Stephen Egan’s mental health care and treatment, made a number of observations concerning the decision to discharge Mr Egan from the Central Mental Hospital on 14<sup>th</sup> July 2006, his treatment in Cloverhill and his subsequent transfer to Mountjoy Prison. Dr Lelliott stated:

*“At the time of his discharge, the clinical team at the Central Mental Hospital appeared confident that the psychiatric in-reach team would provide on-going care of an appropriate intensity and did not anticipate that Mr Egan might be transferred to Mountjoy Prison soon after his discharge.*

*There are grounds for suggesting that, based on information available at the time of Mr Egan’s discharge on 14<sup>th</sup> July, both of these assumptions were optimistic.*

*Firstly, Cloverhill is a prison and the point is made repeatedly in the evidence to the Inquiry that movement of prisoners with mental illness is under the sole control of the*

*prison authorities. His likelihood of being transferred was increased by the fact that he was due in court (27<sup>th</sup> July) to be sentenced soon after his discharge from the Central Mental Hospital.*

*Secondly, events between 14<sup>th</sup> July 2006... and 29<sup>th</sup> July 2006 (when he was transferred from Cloverhill Prison to Mountjoy Prison having received no input from the in-reach team for nine days) area remarkably similar to events that had happened previously with regard to Mr Egan's mental healthcare. On 9<sup>th</sup> February 2006, Mr Egan had been assessed as psychotic at D2 Cloverhill Prison, prescribed medication and recommended for continuing care by the psychiatric in-reach team. On the 16<sup>th</sup> March 2006 he was transferred to Mountjoy Prison without reference to the psychiatric in-reach team and not having been seen by the in-reach team during the previous five weeks".*

Dr Lelliott concluded:

*"The information available suggests that it might be considered premature to have discharged Mr Egan on 14<sup>th</sup> July 2006, after a stay of nine days at Central Mental Hospital, directly from a regime where he was being assessed by psychiatrists several times a day, and was under constant supervision and observation by trained psychiatric nurses, to a prison which employed few psychiatric nurses, where the consistency, intensity and continuity of psychiatric follow-up was far from guaranteed and where there was a significant chance that he would be summarily transferred to another prison without reference to or even notification of the mental health team".*

He added:

*"Mr 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. He was seen twice by a psychiatrist in the 15 days he was at Cloverhill Prison (despite having been assessed as still being psychotic on the 17<sup>th</sup> July 2006 – three days after his discharge from the Central Mental Hospital) and not seen at all during his last ten days at Cloverhill Prison before his transfer to Mountjoy Prison".*

In a written submission to the Commission, Professor Kennedy responded to the views expressed by Dr Lelliott above. In relation to the aftercare provided at Cloverhill Prison, Professor Kennedy stated:

*“My colleagues and I had full confidence in the forensic in-reach service at Cloverhill”.*

He continued:

*“[Consultant Psychiatrist G] who saw Mr Egan on 17<sup>th</sup> July 2006 did not think Mr Egan needed readmission. She appears to have elicited residual or remembered symptoms and she was satisfied that Mr Egan was safely managed in D2 at Cloverhill where he was taking the prescribed antipsychotic medication and abstaining from intoxicants. [Consultant Psychiatrist A] did not elicit any psychotic symptoms and was similarly satisfied”.*

This however does not address the issue of why Stephen Egan was not seen by a member of the Psychiatric In-reach Service for a period of nine days between 20<sup>th</sup> and 29<sup>th</sup> July 2006.

Dr Lelliott in his report to the Commission identified what he described as “... *particular problems with continuity and communication that make consistent aftercare difficult to achieve*”. He referred firstly to the fact that no one psychiatrist retained overall responsibility for Stephen Egan’s mental health care while he was in prison during the period 2005 / 2006:

*“Seven different psychiatrists assessed Mr Egan and gave advice about his treatment and care between December 2005 and July 2006. This does not include his nine-day stay at the Central Mental Hospital when an eighth psychiatrist was responsible for Mr Egan’s care (a number of other psychiatrists were also involved in his care during his time at Central Mental Hospital). The fact that no one psychiatrist, nor any other mental health professional, assumed and retained responsibility for Mr Egan’s on-going care, might have contributed to the fact that during this period there were two spells of discontinuity in his care; the first between 9<sup>th</sup> February and 26<sup>th</sup> June 2006 and the second after the 19<sup>th</sup> or 20<sup>th</sup> July up to the time of the killing”.*

Dr Lelliott also referred to the problems which arise when prisoners are moved between prisons, stating:

*“The practice of moving violent and difficult prisoners between prisons without notice and without reference to their needs for mental healthcare compounds the problem. It also prevents prison medical staff from acting as [a] check to ensure that recommendations about treatment for mental illness are implemented and that psychiatric input continues”.*

Thirdly, Dr Lelliott emphasised the need for effective communication and record-keeping within the prison system, stating:

*“Mental healthcare that is delivered over time by a large of number of healthcare professionals to a patient who moves from setting to setting can only succeed if there are very good systems for communication between the various workers. There appear to have been two factors that hampered communication in the case of Mr Egan that are independent of the problems with continuity described above. The first is the poor quality of the prison health record as described by those giving oral evidence at the hearings... In 2006, prisoners who were transferred repeatedly between prisons often had more than one set of prison health records, the contents of individual records were not filed in a systematic way nor in chronological order and the prison record did not follow a prisoner when he was admitted to Central Mental Hospital. This meant that the care recommendations of a psychiatrist or GP assessing Mr Egan for the first time were never fully informed by the information gathered by doctors who had seen him in the past. The second factor that hampered communication in the case of Mr Egan was the practice of the psychiatric team of not sharing information about the mental health or mental healthcare of a patient with prison officers. Although this is understandable on the grounds of patient confidentiality, it removes another potential mechanism for bringing some continuity into the system and also means that decisions about transfers between prisons are sometimes made with no reference to a prisoner’s need for on-going and coordinated mental healthcare”.*

Regarding to the system as it operated in relation to Stephen Egan in 2006, Dr Lelliott concluded:

*“The total system that is described in the documents relating to the care of Mr Egan in 2006 is incapable of providing high quality, on-going mental healthcare to prisoners with a severe and enduring mental illness. The model of admitting remand prisoners to the Central Mental Hospital for short spells of treatment followed by return to the prison cannot operate safely unless the systemic problems in the prison service that mitigate against continuity of aftercare and effective communication are addressed”.*

In a written submission to the Commission Professor Kennedy commented as follows on the issues raised by Dr Lelliott above:

*“The central principles we are all agreed on are continuity, communication and involvement of the patient. These were being successfully applied in Mr Egan’s case at Cloverhill. The breach of continuity occurred on moving Mr Egan from Cloverhill to Mountjoy; the failure to communicate occurred when this move was not discussed with or communicated to the Cloverhill in-reach team... nor was it communicated to the medical and nursing team at Mountjoy... The omission of antipsychotic medication which Mr Egan was actively involved with, all three breaches were faults of the IPS due to the lack of a central system for allocations and stratification of inmates according to their known risk so as to safely manage those at highest risk of violence. Such a system should be a core competence for any prison system. Failure to involve mental health in-reach services is a further typical aspect of a culture of custody rather than a culture of rehabilitation.*

*There are systemic consequences concerning Dr Lelliott’s criticisms of ‘the total system described’. Dr Lelliott says, ‘the model of admitting remand prisoners to the Central Mental Hospital for short spells of treatment followed by a return to the prison cannot operate safely unless the systemic problems in the prison service that mitigate against continuity of aftercare and effective communication are addressed’.*

*We agree with this and we believe that to a limited extent these have been met at least in Cloverhill Prison though we believe there has as yet been no improvement regarding*

*continuity and communication elsewhere in the prison system. It is essential to note that the CMH staff, doctors, and nurses have excellent systems for communicating with each other within and between prisons and the hospital. The discontinuity occurs because the IPS does not plan, communicate or co-ordinate its own actions. Dr Lelliott appears to be recommending that we abandon the current system of admitting relatively large numbers for limited periods of intensive treatment and then returning them to the prison. He appears to be recommending a switch to the English system of admitting very few people from prison who are then not discharged for some years. This would lead to the near cessation of an effective service to remand and sentenced prisoners in Ireland, as it has in the U.K. Dr Lelliott is advocating a 'high quality / low volume / low risk' service. This can be achieved within existing resources even in the UK only by depriving most patients of any service at all... This is correctly contrasted with the CMH / Irish system of providing a high volume / sufficient quality service for all those in need, to the limit of resources. While the quality of the CMH service has improved markedly in recent years and was high in 2006, the service operates at the limits of risk management as a matter of policy to maximise health gains for this disadvantaged, high morbidity, high risk population.*

*... to change to the system apparently recommended by Dr Lelliott would in our view not serve the best interests of the majority of patients in Cloverhill and other prisons and would merely be self-serving risk aversiveness for clinicians”.*

In a further written report to the Commission Dr Lelliott responded to the above comments as follows:

*“I am not, as Professor Kennedy suggests... ‘recommending that [Ireland’s forensic mental health services] abandon the current system of admitting relatively large numbers [of patients] for limited periods of intensive treatment then returning them to prison [in favour of] a switch to the English system of admitting very few people from prison who are then not discharged for some years’. Although, as stated above, I make no recommendations, I express the opinion that Ireland’s current system of forensic mental healthcare ‘is a good model’ (bottom of page 39). However I go on to say that ‘its success depends on the ability of the mental health service to provide consistent*



*aftercare once a person has returned to prison and of the prison system to operate in a manner that facilitates aftercare’ (page 39/40).*

*I emphasise the latter point at the end of my report when I state that ‘the model of admitting remand prisoners to the Central Mental Hospital for short spells of treatment followed by return to the prison cannot operate safely unless the systemic problems in the prison service that mitigate against continuity of aftercare and effective communication are addressed’”.*

With regard to Mr Egan’s transfer to Mountjoy Prison on 29<sup>th</sup> July 2006, Dr Lelliott observed:

*“I do not blame the forensic mental health service for Mr Egan having been transferred from Cloverhill to Mountjoy on the 29<sup>th</sup> July 2006 nor for the fact that the mental health service was not informed – responsibility for this lies clearly with the prison service. However, [Consultant Psychiatrist A] confirms that what happened to Mr Egan was not unusual. In his letter responding to my report, [Consultant Psychiatrist A] states ‘prison transfers take place on a daily basis within the Irish Prison Service without consultation with the forensic mental health services’. The point I am making in relation to Mr Egan’s care is that, because of this known problem of sudden and unannounced transfer, continuity of mental healthcare cannot be guaranteed at Cloverhill for a prisoner suffering and being treated for a severe psychotic illness, and that this might have been a factor to consider when deciding how early in his treatment to discharge Mr Egan to Cloverhill from CMH”.*

## **Psychological Report**

Although Stephen Egan was not seen by any member of the Psychiatric In-reach Service from 20<sup>th</sup> to 29<sup>th</sup> July 2006, he was, co-incidentally reviewed by an external senior clinical psychologist on 26<sup>th</sup> July 2006 – three days before his transfer from Cloverhill to Mountjoy Prison. [Senior Clinical Psychologist A], a Senior Clinical Psychologist from St Brendan’s Hospital, Dublin was asked by Stephen Egan’s solicitors to interview and assess Mr Egan and to prepare a report in anticipation of a sentencing hearing arising out of a conviction for robbery. The Court hearing was due to take place on 27<sup>th</sup> July 2006.

[Senior Clinical Psychologist A] did not see Stephen Egan in either the D2 interview rooms or the surgery on D1, as was standard practice for prisoners being held on D2. Instead, the interview took place in an ordinary room used for professional, non-medical visits to prisoners:

*“A: Solicitors or barristers or sometimes Probation Officers would see people [there]. There is a row of rooms. You are locked into the room when you are seeing the client and they come in a separate entrance at the back and they are locked in as well. So one is locked in and to get out one presses a button and the Prison Officer outside will come.*

*Q: There was no barrier between you and Stephen Egan was there?*

*A: Well I mean there was a table... a full length table”.*

[Senior Clinical Psychologist A] informed the Commission that he was not familiar with D2 landing or with the facilities available to prisoners there.

The prison officers who accompanied [Senior Clinical Psychologist A] to the visiting room did not say anything to him about Mr Egan. [Senior Clinical Psychologist A] told the Commission:

*“In many ways I wouldn’t expect [them to] because the prison officers who are on the Reception area where you visit the prisoners may not know, I mean may not know the client”.*

[Senior Clinical Psychologist A] had read the Book of Evidence in relation to the court case but did not have access to Stephen Egan’s prison medical file. Going into the interview, 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.

In evidence to the Commission [Senior Clinical Psychologist A] stated that from a very early stage of his meeting with Stephen Egan, he became alarmed at Mr Egan’s condition and concerned for his own safety:

*“A: The report would have been much longer except my main aim within two minutes of meeting him was to get out of the room because it was a very scary meeting and I was*

*locked in. I knew I could press the button. I know the prison officers are very good at letting you out so to speak but they are busy, they are opening doors outside. They are letting people in, they are processing people coming in. it could take up to a minute and I was very concerned about what could happen within that short period of time.*

*Q: And what particularly set your alarm bells?*

*A: Because he was so deluded and his speech was so pressured. He was manic and I thought he was completely deluded. He spoke about 'the beast' which worried me enormously because I felt that if I wasn't careful I would become 'the beast'... I mean I knew I was in trouble and I just wanted to placate the guy, appease him and get out of there as quick as possible. So I spoke to him a little bit about himself and I tried to get him away from these delusional beliefs which fortunately worked and that basically was a short interview and I said to the prison officer as I was leaving that I thought he was unwell. I wouldn't expect the prison officer to in any way act on what I said to him informally because an awful lot of people I think who are in the prison [system] are not well and they have the resources for dealing with them. They have large numbers of people, large numbers of prison officers so they can sort of, in my view, deal with that situation, but as I say my main aim was to get out of that room, preferably in one piece.*

*Q: But given that he – you are a very experienced Clinical Psychologist. Is there a chance here that he was 'hamming it up' a bit for you?*

*A: Absolutely no chance. There is a chance but – ”*

[Senior Clinical Psychologist A] was questioned by the Commission as to whether he had been able to convey to Stephen Egan the purpose of his visit:

*“Q: You told him – did you get through that part of introducing yourself and did you tell him why you were there?*

*A: Yes.*

*Q: And who had sent you?*

A: *Well I would have normally. I can't remember my exact words but I would normally say that 'Your solicitor [Solicitor A] asked me to see you'.*

Q: *Did you discuss the going to Court the next day?*

A: *This man, his speech was so pressured that almost immediately –*

Q: *That took over, did it?*

A: *Oh yes, I mean I knew that this was a very difficult situation.*

Q: *Is there anything that would have made it better for you?*

A: *Well obviously, to have had his clinical notes beforehand".*

In relation to his own experience of patients exhibiting manic behaviour, [Senior Clinical Psychologist A] told the Commission:

*"A: I have worked in psychiatric hospitals since 1979 and normally in a case like this where somebody is quite manic like that they wouldn't necessarily be referred, usually would not be referred to a Clinical Psychologist at that stage until their medical condition has stabilised through medication. So it would be rather rare for a Clinical Psychologist to see somebody when they were totally manic unless they had a diagnosis of bi-polar disorder and I had been asked to see them in a psychiatric hospital because it is assumed they are getting better and at that stage I might see the person but understand, realise that they are bi-polar. When I was in England I headed up a service for people with long term mental health problems. So I would be fairly experienced in identifying psychosis basically...*

Q: *Did he present to you as somebody that was progressing or well?*

A: *Oh he was very unwell the day I saw him".*

On the issue of whether Stephen Egan might have been “*hamming it up*” – that is, faking or exaggerating symptoms in an attempt to obtain a report which might favourably affect his forthcoming sentencing hearing – [Senior Clinical Psychologist A] responded as follows:

*“Q: [At your interview] on the 26<sup>th</sup> July... nothing about his demeanour communicated a kind of calculation?”*

*A: Nothing whatsoever”.*

[Senior Clinical Psychologist A] continued:

*“A: I mean, everything combined to show that this man was dangerous... Unusually – well, not that unusually... he spoke too of having visual hallucinations. I mean he didn’t use those words. He spoke to me of seeing the Devil and he had hallucinations since the previous December and then he made bizarre allegations that a number of people raped a number of women that he knew. I mean he was a scary guy”.*

[Senior Clinical Psychologist A] was questioned by the Commission as to how early in the interview Stephen Egan had begun to display delusional behaviour:

*“Q: How did he start on the delusional aspect? Was it something you asked or did he just kind of launch into it?”*

*A: No, you see this was the most scary thing. He just launched into these things.*

*Q: Because one of the things that had been suggested to us as a possible pattern in his behaviour was that he would only become agitated when people started to question him about his mental health basically. That he was behaving in a relatively normal way for people whose job didn’t include questioning him in that way.*

*A: Well I have been going into prisons for approximately twelve years and really over the years one quickly learns not to do that because just in case there is something... I worked in the Forensic Service in England for a while and you quickly learn techniques – no quick movements, speak slowly, get the measure of the person. So I would never start off an interview by asking a person about their mental health. I would ask him about ‘how are things in here’, you know, and show concern for them, genuine concern too because I am trying to elicit their co-operation, but this man from the minute – he was straight into ‘the beast’ which really worried me”.*

[Senior Clinical Psychologist A] was unsure how long his interview with Mr Egan lasted, but thought he might have been there for 20 minutes:

*“Q: And how did you feel when you got out?”*

*A: I felt it was really important to get this report off to [Solicitor A] [Mr Egan’s solicitor] and I rang up one of the people in the office. She is a receptionist or secretary and I told her that it was really important for the report to be given and that he was unwell... I felt that having it down in writing was the really important thing for the Court”.*

[Senior Clinical Psychologist A] provided the Commission with a copy of his handwritten notes, taken during the interview with Mr Egan. The paranoid beliefs and delusions recorded by [Senior Clinical Psychologist A] in those notes closely resemble those expressed by Mr Egan in the early part of his stay in the Central Mental Hospital – notably a preoccupation with rapes and with an individual whom he named as “the beast”. Similar preoccupations were also noted by prisoners who witnessed Stephen Egan’s fatal assault on Gary Douch in Mountjoy Prison on 31<sup>st</sup> July 2006, and by members of An Garda Síochána who interviewed Stephen Egan following his arrest on 1<sup>st</sup> August 2006.

[Senior Clinical Psychologist A] completed a written report on the same day of his interview with Stephen Egan (26<sup>th</sup> July 2006) and sent it to Mr Egan’s solicitor.

Under the heading ‘Presentation’ [Senior Clinical Psychologist A]’s report stated:

*“Mr Egan was quite agitated during our interview. I formed the impression that his mood was quite elevated. He reported that he was hearing voices, that is, auditory hallucinations. He expressed beliefs about a number of people that I formed the impression were delusional beliefs, that is, false and indeed paranoid beliefs. His speech was pressured. From my experience with working with people with mental health problems in my opinion, Mr Egan is suffering from a severe mental health problem. I formed the impression that he might become aggressive if any of his delusional beliefs were challenged. Given his delusional beliefs I considered it unsafe to question him too much in relation to his behaviour, even though he was coherent at times”.*

Under the heading, ‘Psychiatric History’, [Senior Clinical Psychologist A]’s report stated:

*“He [Stephen Egan] repeated that he had recently been an inpatient in the Central Mental Hospital, Dundrum for a week. He had subsequently been transferred back to Cloverhill. He had been prescribed medication but he was unsure what it was. I had not access to his medical charts in Cloverhill”.*

[Senior Clinical Psychologist A] concluded his report by stating:

*“Mr Egan was agitated during the interview and in my opinion he is currently suffering from a mental health problem. I would recommend that a psychiatric report is obtained from the Central Mental Hospital...”*

In his evidence to the Commission, [Senior Clinical Psychologist A] expressed the view that the appropriate place for Stephen Egan at that time, in his opinion, was in the Central Mental Hospital:

*“A: Dundrum is the only place in my view for him, from what I know of Dundrum. I have been in Dundrum twice in my career but from what I know of the workings of it and from my interfacing with psychiatrists who request assessments from Dundrum in their own psychiatric hospitals the only place for him was Dundrum. There are a couple of units in the grounds of Brendan’s for people who are – St Brendan’s Hospital – for people who are a risk to themselves or a risk to others but he was way beyond that.*

*Q: Really?*

*A: Yes.*

*Q: So you are unequivocal really that he was in a kind of acute psychotic state at that point.*

*A: He was, he was.*

*Q: And you are adamant that he wasn’t ‘hamming it up’?*

*A: Oh no, he wasn't. Everything coming together like the pressured speech, the delusions, the nature of the delusions, quite wild delusions, the visual hallucinations wherever they were coming from, maybe drug abuse, maybe alcohol abuse but that can be part of a psychotic presentation as well. No, he was very ill".*

The Commission first became aware of [Senior Clinical Psychologist A]'s review of Stephen Egan when a copy of Mr Egan's Probation & Welfare file, containing a transcribed copy of [Senior Clinical Psychologist A]'s report, was disclosed to the Commission in 2010. There are no references to [Senior Clinical Psychologist A]'s review either in Stephen Egan's prison files or in the material disclosed to the Commission by the Central Mental Hospital. It appears that in July 2006 both the Psychiatric In-reach Service at Cloverhill and the prison management were not aware of [Senior Clinical Psychologist A]'s concerns regarding Stephen Egan's mental health, and that they remained unaware until the Commission brought [Senior Clinical Psychologist A]'s evidence to their attention in 2010.

Stephen Egan's presentation as recorded by [Senior Clinical Psychologist A] on 26<sup>th</sup> July 2006 raises the question as to whether he was in fact taking his prescribed medication during this period. As mentioned earlier in this report, there is a drug administration record in Stephen Egan's prison medical file which indicates full compliance during this period, but the reliability of that record is called into question by the fact that it has an entry for 14<sup>th</sup> July 2006, despite the fact that the GP who filled out the prescription sheet for Stephen Egan did not see him until the following day (15<sup>th</sup> July).

It should also be noted that the evidence given to the Commission by the medical orderly who interviewed Stephen Egan on his arrival at Mountjoy Prison on 29<sup>th</sup> July 2006 was that Stephen Egan told him he had been prescribed Olanzapine but had not been taking it.

On the other hand, if Mr Egan was taking his medication during this period, then a question arises as to its efficacy.

More fundamentally, [Senior Clinical Psychologist A]'s observations highlight the concerns expressed by Dr Lelliott regarding the apparent failure of the Psychiatric In-reach Service to review Mr Egan between 21<sup>st</sup> and 29<sup>th</sup> July 2006.



Copies of the evidence provided by [Senior Clinical Psychologist A] to the Commission were provided to Professor Kennedy and other relevant psychiatrists for their comments. In a written response, Professor Kennedy commented as follows:

*“Concerning [Senior Clinical Psychologist A]’s record of evidence to the Commission on 1<sup>st</sup> September 2010 it is difficult to avoid the impression that a considerable amount of retrospective interpretation overlays his evidence four years after the interview of the 26<sup>th</sup> July 2006. It is difficult to understand how an experienced clinical psychologist, if as worried at the time as [Senior Clinical Psychologist A] says he was, would not have communicated with the general practitioners in the prison, the nurses present in the prison or the visiting psychiatrists in the prison or clinicians at the Central Mental Hospital... His explanation for why he did not do so does not address this serious question”.*

In a letter to the Commission dated 8<sup>th</sup> November 2010 [Consultant Psychiatrist A], who had seen Stephen Egan on 20<sup>th</sup> July 2006, responded by stating:

*“I have had an opportunity to read the report of [Senior Clinical Psychologist A] and have read the transcript of his oral evidence. I wish to make the point that Mr Egan was aware that [Senior Clinical Psychologist A] was seeing him for the purpose of a Court report. Prisoners are well aware that the elaboration of symptoms has the potential to improve the outcome of their Court case by potentially reducing the length of the sentence imposed.*

*It is noted that the content of the interview between [Senior Clinical Psychologist A] and the prisoner is very different to the content of Mr Egan’s interview with myself. I was seeing him purely for a therapeutic assessment and follow up post-discharge from the Central Mental Hospital. I can recall Mr Egan being reluctant to engage with me at interview. I understood this reluctance to be due to the fact that I was not involved in his Court case. This is in contrast to Mr Egan’s interview with [Senior Clinical Psychologist A]. [Senior Clinical Psychologist A] was very concerned following his interview with Mr Egan. This concern was not communicated to myself or any of the other Visiting Psychiatrists to the prison”.*

The Commission does not agree with the opinion expressed by Professor Kennedy that [Senior Clinical Psychologist A]’s recollection of the encounter with Stephen Egan is subject to “*a considerable amount of retrospective interpretation*”. Both [Senior Clinical Psychologist A]’s contemporaneous notes of the interview and his report prepared on the same day contain information and conclusions – albeit expressed in unemotive language – which support and give credence to his account of the interview as told to the Commission.

It is of course regrettable that [Senior Clinical Psychologist A]’s concerns about Stephen Egan’s behaviour during the interview were not conveyed to the Psychiatric In-reach Service at the time. However, the issue which remains of greater concern to the Commission is that from 21<sup>st</sup> to 29<sup>th</sup> July 2006, no member of the Psychiatric In-reach Service visited Mr Egan, notwithstanding the fact that he was a recently returned patient from the CMH who, on the instructions of both [Consultant Psychiatrist G] and [Consultant Psychiatrist A], was to be reviewed “*on an on-going basis*”.<sup>60</sup> Stephen Egan was under the care of the Psychiatric In-reach Service, not [Senior Clinical Psychologist A], and the fact that [Senior Clinical Psychologist A]’s views were not made known to the Psychiatric In-reach Service does not excuse the apparent failure to keep Stephen Egan under review during the period 21<sup>st</sup> to 29<sup>th</sup> July 2006.

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<sup>60</sup> Report of [Consultant Psychiatrist G], 17<sup>th</sup> July 2006 and report of [Consultant Psychiatrist A], 20<sup>th</sup> July 2006. See chapter 2.5.

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

Stephen Egan was moved from Cloverhill Prison to Mountjoy Prison on Saturday 29<sup>th</sup> July 2006. On the same day five other prisoners, including one referred to hereinafter as “Prisoner B”, were moved from Mountjoy to Cloverhill. The following questions arise:

Was it necessary for Stephen Egan to be transferred from Cloverhill to Mountjoy on 29<sup>th</sup> July 2006?

Was it in the best interests of Stephen Egan that he be transferred from Cloverhill to Mountjoy on 29<sup>th</sup> July 2006?

Was the decision to transfer Stephen Egan to Mountjoy arrived at with any regard to his on-going need for psychiatric care and treatment as set out in the Discharge Summary from the Central Mental Hospital?

Was the transfer of Stephen Egan related in any way to the transfer of Prisoner B and / or the other four prisoners who went from Mountjoy to Cloverhill on the same day?

Were the appropriate protocols and procedures followed in relation to Stephen Egan’s transfer to Mountjoy?

### **Chronology of Transfer**

The process which resulted in the transfer of Stephen Egan from Cloverhill to Mountjoy Prison on 29<sup>th</sup> July 2006 is a complicated one, involving multiple members of staff at both prisons, as well as the Operations Directorate of the Irish Prison Service and a number of other prisoners who were transferred at or around the same time. The following tables set out (i) the personnel involved in the transfer and their respective roles, and (ii) a summary of the events leading up to the transfer, which are dealt with in more detail thereafter.

## IPS personnel:

NAME	ROLE
[Assistant Principal Officer A]	IPS Operations Directorate officer responsible for approving all prison transfer requests on 29 <sup>th</sup> July 2006. Approved transfers of Stephen Egan and other prisoners between Cloverhill and Mountjoy Prisons on 29 <sup>th</sup> July 2006.

## Mountjoy personnel:

NAME	ROLE
Deputy Governor Colm Barclay	Governor on duty, 28 – 29 <sup>th</sup> July 2006. Discussed transfer of Stephen Egan with Assistant Governor Bracken (Cloverhill). Approved transfer of Stephen Egan to Mountjoy.
[Chief Officer B]	CO on duty, 28 – 29 <sup>th</sup> July 2006. Contacted Cloverhill on 28 <sup>th</sup> July to discuss possible transfer of one or more prisoners from Mountjoy to Cloverhill. Arranged transfer of Stephen Egan and other prisoners with [Chief Officer C] (Cloverhill). Visited Stephen Egan in reception area at Mountjoy after transfer had taken place.

## Cloverhill personnel:

NAME	ROLE
Governor Liam Dowling	Discussed transfer of Stephen Egan with Assistant Governor Bracken (Cloverhill). Approved transfer of Stephen Egan to Mountjoy.
Assistant Governor Gerry Bracken	Governor on duty, 28 – 29 <sup>th</sup> July 2006. Discussed transfer of Stephen Egan with Deputy Governor Barclay (Mountjoy).
[Chief Officer C]	CO on duty, 28 – 29 <sup>th</sup> July 2006. Arranged transfer of Stephen Egan and other prisoners with [Chief Officer B] (Mountjoy).
[Assistant Chief Officer B]	ACO on duty, 29 <sup>th</sup> July 2006. Interviewed Stephen Egan to ascertain his willingness to be transferred to Mountjoy.

## **Arrangement of Transfer**

The Commission has been informed that inter-prison transfers were commonly arranged by Chief Officers in the respective prisons. In some cases, negotiations might take place at Governor Level, or a Chief Officer might bring a transfer proposal to the attention of the Governor on duty.

In this instance, the process which resulted ultimately in the transfer of Stephen Egan from Cloverhill to Mountjoy Prison on 29<sup>th</sup> July 2006 was begun by [Chief Officer B] (Mountjoy). On 28<sup>th</sup> July 2006 [Chief Officer B] contacted his counterpart at Cloverhill, [Chief Officer C], with a view to arranging the transfer, not of Stephen Egan, but of another prisoner – referred to in this report as Prisoner B.

### **Prisoner B**

Prisoner B had been committed by the courts to Mountjoy on Thursday 27<sup>th</sup> July 2006 following a two-month sentence for an assault carried out in Wheatfield Prison in 2005. The reason [Chief Officer B] was seeking to move Prisoner B was that there was a standing order in place that prisoner B was not to be accommodated in Mountjoy. This standing order had been in place since July 2003, when Prisoner B had assaulted a prison officer with a syringe during an attempted escape from Mountjoy Prison.

Prior to his arrival at Mountjoy on 27<sup>th</sup> July 2006 Prisoner B had been in Cloverhill Prison, where he was in the midst of serving a two-year sentence handed down on 15<sup>th</sup> March 2006. From the evidence disclosed to the Commission, it seems that this fact was not mentioned by anyone from either Cloverhill or Mountjoy when Mountjoy sought to move Prisoner B on 28<sup>th</sup> / 29<sup>th</sup> July 2006.

## Mountjoy Prison

In evidence to the Commission, [Chief Officer B] (Mountjoy) gave the following account of his communications with Cloverhill on 28<sup>th</sup> and 29<sup>th</sup> July 2006:

*“I spoke to [Chief Officer C] on the Friday, which was 28<sup>th</sup> July, with regard to [Prisoner B]... He informed me that his numbers were also high and that he would need to get rid of Stephen Egan. I said to him I would have to check that one out and I would get back to him. It was late in the evening – we wouldn’t have been able to get a transfer order for the prisoners at that stage in the evening, so I said I would talk to him over the weekend, or possibly during the week about it.*

*On Saturday then I was informed by my Governor that our numbers were very, very high at the weekend. I think it was 524. I was informed that Cloverhill were to take a couple of prisoners off us to reduce the numbers issue that we had. So I rang Cloverhill and I spoke to an ACO – he was an acting Chief at the time, but he would have to check with the Chief that was on duty. He told me he would get back to me. So [then] I received a call from [Chief Officer C] and he told me that they would be in a position to give us a dig out, as they call it. Their numbers were over 400, and generally they didn’t take transfers over 400, but they would be in a position to give us a dig out and take a couple off us”.*

According to [Chief Officer B], his counterpart in Cloverhill, [Chief Officer C], then referred back to the conversation of the previous day conversation concerning Prisoner B and Stephen Egan. [Chief Officer B] responded by saying that he had not yet obtained “clarification” on the proposed swap of the above prisoners, but that he would let [Chief Officer C] know what the position was later on.

[Chief Officer B] told the Commission that he then spoke to Deputy Governor Barclay, who was on duty at Mountjoy that weekend:

*“...I informed him that Cloverhill were in a position to take a couple off us, we needed to get rid of [Prisoner B], and they obviously needed to get rid of Egan, for whatever*

*reason that was. I said ‘Was that okay’ (to go ahead with that swap) and he [Governor Barclay] just said ‘Do whatever you have to do to get the numbers down’.*

*So then I agreed it with [Chief Officer C] that we would take Stephen Egan for [prisoner B] and he would take four others then. He was talking three originally, but we found we had another remand prisoner and he agreed to take the four of them. So we sent five out, they sent Stephen Egan back. But the swap was Stephen Egan for [prisoner B]. The four were just transfers out”.*

It appears that no reasons were given by [Chief Officer C] as to why Cloverhill wished to move Stephen Egan in particular. [Chief Officer B] told the Commission:

*“Sometimes when a transfer is being done you would question why they want to get rid of them. When you know the calibre of prisoner – and I knew Stephen Egan fairly well – I didn’t ask any questions at all. I just assumed that he was causing problems out there and that [he] would be happier in Mountjoy”.*

[Chief Officer B] (Mountjoy) expressed the view that, in general, Stephen Egan was happier and less troublesome in Mountjoy than in other prisons, citing its convenience for family visits as one of “a number of reasons” why this was so. He told the Commission that the main reason he decided to seek Deputy Governor Barclay’s approval for the proposed transfer was that Egan was at that time a remand prisoner, and so would not ordinarily have been accepted into Mountjoy, a committal prison.

Deputy Governor Barclay came on duty at Mountjoy Prison on the morning of Saturday 29<sup>th</sup> July. In evidence to the Commission he recalled speaking with [Chief Officer B], who informed him that the number of prisoners in Mountjoy was considerably over capacity. He instructed [Chief Officer B] to contact other prisons with a view to seeing if they would take some prisoners from Mountjoy:

*“He [Chief Officer B] informed me that he had already contacted Cloverhill and spoken to [Chief Officer C], who was willing to do a deal, and [Chief Officer B] asked me was it okay to, if you like, barter a deal with Cloverhill and I told him to do whatever he had to do to reduce the numbers in Mountjoy on that morning”.*

Deputy Governor Barclay was aware that part of the arrangement ultimately arrived at with Cloverhill was that Stephen Egan would be transferred to Mountjoy. It is not clear if he had been told that the transfer of Egan was arranged in the context of a swap with Prisoner B, rather than as part of a deal to reduce overcrowding at Mountjoy Prison. Deputy Governor Barclay told the Commission:

*“I had dealt with Stephen Egan on numerous occasions in the past... he was certainly disruptive, challenging at times, but was manageable... I knew I couldn’t put him on the D Division, because he had been in similar arguments there before with staff, and indeed other prisoners, but I had no problem in taking him back and exploring other areas of the prison where I could house him at the time”.*

In his evidence to the Commission, Deputy Governor Barclay confirmed that he knew at the time these negotiations were taking place that Stephen Egan had recently been in the Central Mental Hospital. However, he did not know that on the day of Mr Egan’s discharge from the CMH on 14<sup>th</sup> July 2006, both Governor Salley and Governor Lonergan had refused requests from the Governor of Cloverhill to take Egan into Mountjoy. He did not know this because he was on annual leave from 14<sup>th</sup> July and did not return to work at Mountjoy until 22<sup>nd</sup> July 2006. Nor was he aware of Stephen Egan’s on-going care and treatment requirements as set out by the CMH following his discharge, as the following exchange with the Commission indicates:

*“Q: You knew he had been in the Central Mental Hospital?”*

*A: I did, yeah.*

*Q: When he came back, to Mountjoy, were you aware of his medical regime, if any, that had been put in place on his return?”*

*A: No, I wouldn’t have been privy to any medical regime on Stephen. What I would be dependent upon would be the medic flagging any problems that may arise”.*



## Cloverhill Prison

The Commission heard evidence from [Chief Officer C] (Cloverhill) who confirmed that he had received a telephone call from [Chief Officer B] (Mountjoy) on 28<sup>th</sup> July concerning a possible transfer of Prisoner B to Cloverhill. When asked what his response was, [Chief Officer C] stated:

*“My response was that he would have to take one in return... I nominated Stephen Egan“.*

[Chief Officer C] told the Commission that he had *“not that much”* familiarity with Stephen Egan at that time. He knew him as a *“fairly argumentative prisoner”* who *“seemed to get himself into fights with other prisoners”*. [Chief Officer C] was aware that Mr Egan had recently returned from the Central Mental Hospital and was being housed on D2 wing at Cloverhill. [Chief Officer C] did not have any dealings with Stephen Egan during his stay on D2, although he had dealt with him some 3 or 4 months previously, when Mr Egan was housed on C wing:

*“Q: In terms of the information that Stephen Egan was on D2, were you aware how long he had been on D2?”*

*A: I knew he was back from the CMH ten days or so, I think, is what I recollect at the time.*

...

*Q: Had you had any discussions with anyone in the prison as to Mr Egan, or had anyone talked to you about Mr Egan’s status before the 28<sup>th</sup> July?*

*A: No, no. As I say that wouldn’t have been my area. It was on the day, on the Saturday, because I was the only Chief on. If the only chief is on he takes charge of D2 automatically.*

*Q: I see. Whilst you are aware that he had been in the Central Mental Hospital, I think you didn’t have further information as to his diagnosis or his treatment?*

*A: No, no”.*

When asked why he had chosen Stephen Egan to take part in the proposed swap for prisoner B, [Chief Officer C] stated:

*“Because he was taking up a cell on D2. D2 is a very busy landing. The whole idea is to keep people moving”.*

When asked why Stephen Egan in particular was chosen, [Chief Officer C] told the Commission:

*“Well he sprung to mind for his having been moved to Mountjoy on several other occasions without any problem. It was virtually routine”.*

Following a telephone call from [Chief Officer B] (Mountjoy) on the morning of 29<sup>th</sup> July in which the latter sought to transfer a number of prisoners in order to relieve overcrowding at Mountjoy, [Chief Officer C] spoke to the duty Governor of the day in Cloverhill, Assistant Governor Gerry Bracken, informing him of the request. Assistant Governor Bracken rang Mountjoy Prison and discussed the proposed transfers with Deputy Governor Barclay (Mountjoy). Deputy Governor Barclay told the Commission:

*“I spoke to Assistant Governor Bracken... regarding the swap, if you like, and the deal and he said that Stephen Egan hadn’t been any problem and just needed a break...”*

Assistant Governor Bracken’s recollection of the conversation was as follows:

*“He said to me about the transfer. I said, ‘Colm, the Chiefs have organised it themselves; that’s good enough for me’. He said, ‘That’s okay’, and that was the conversation”.*

Assistant Governor Bracken was familiar with Stephen Egan, having dealt with him on a number of occasions over the preceding two years. He was aware that Egan had recently returned from the Central Mental Hospital. He told the Commission that he had conversed with Stephen Egan in D2 on the morning of 29<sup>th</sup> July, and that Mr Egan had asked him about the possibility of moving from D2 to one of the ordinary prison wings at Cloverhill.

Following the telephone conversation with Mountjoy, Assistant Governor Bracken decided to discuss the proposed transfer of Stephen Egan with his immediate superior at Cloverhill, Governor Liam Dowling.

In a report submitted to the IPS Director of Operations in the aftermath of Gary Douch's death, Governor Dowling gives the following account of his involvement with Stephen Egan prior to the discussion with Assistant Governor Bracken:

*"I had returned from my summer annual leave on Tuesday the 25<sup>th</sup> July 2006... I took the parade on Wednesday, Thursday and Friday. Stephen Egan only requested to see me on Friday and he requested a transfer off the landing back to the divisions. He appeared normal and conversed in a normal rational manner regarding same. I informed him that I would consider moving him back to the C division the following week if there were no difficulties in the interim. This is recorded in the Governor's parade book of Friday the 28<sup>th</sup> August".*

The relevant entry in the Governor's Parade book reads:

*"R[request] move to C [wing] – Noted – approved when vacancy arises".*

In his report to the IPS Governor Dowling then recounts his discussion with Assistant Governor Bracken concerning Mr Egan's proposed transfer on Saturday 29<sup>th</sup> July 2006 as follows:

*"At approximately 11.45 a.m. I received a short phone call from A/Governor Bracken who was on duty in Cloverhill – he indicated to me that Mountjoy had been on (D/Governor Barclay) and they were looking to transfer a sentenced prisoner [prisoner B] (due to some local IR issue on him) and they would take Stephen Egan in exchange. I informed him that Stephen Egan should only be allowed to go if he went voluntarily and that he should be asked if he wanted to go and in that event I had no objections to the transfer as we had made this arrangement in the past. I was also conscious of the fact that Stephen Egan was finished his court appearance and was up for sentence on his next court appearance which would leave him in Mountjoy anyway. It would also provide me with valuable space on D2 which is always welcome".*

Governor Dowling had been on annual leave at the time of Stephen Egan's arrival at Cloverhill on 14<sup>th</sup> July, and in his evidence to the Commission he said that he was not aware that Egan had come to Cloverhill from the Central Mental Hospital. Nor was he aware that Egan had previously been the subject of psychiatric attention whilst at Cloverhill in February / March 2006. On that basis it must be concluded that Governor Dowling viewed both Stephen Egan's initial request to be moved off D2 wing and the subsequent proposal to transfer Stephen Egan to Mountjoy as purely management issues, without any psychiatric or medical aspect.

Following Governor Dowling's instructions, [Chief Officer C] (Cloverhill) told [Assistant Chief Officer B] to ask Stephen Egan if he was willing to go to Mountjoy. Mr Egan indicated that he was willing, and [Assistant Chief Officer B] then conveyed him to the reception area to await transfer.

## **Irish Prison Service**

On 29<sup>th</sup> July 2006 [Assistant Principal Officer A], an Assistant Principal Officer in the IPS Operations Directorate, had responsibility for all prison transfer requests, as the officer with whom he normally shared this responsibility was on leave. It being a weekend, [Assistant Principal Officer A] was not in the office but was available on 24-hour call.

[Assistant Principal Officer A] told the Commission that at that time in 2006, he had no access to either the IPS paper files on prisoners or to the computerised PRIS system outside of office hours. In those circumstances, he was almost totally dependent on the information being provided to him by the prisons concerned. [Assistant Principal Officer A] told the Commission that over the years in which he had been doing this job he had developed "*an excellent working relationship*" with the Chief Officers and Governors. He also pointed out that it was "*in nobody's interest to deceive or not provide accurate information because it would soon be discovered*".

[Assistant Principal Officer A] recalls receiving a telephone call from Deputy Governor Barclay (Mountjoy) concerning the proposed transfer of five prisoners to Cloverhill on 29<sup>th</sup> July 2006.

*“He contacted me to say that agreement had been reached, five would go from Mountjoy and one would come back. I asked him to send me on the list – to fax it to me and that I would fax back the decision. Basically that was it”.*

The documentation disclosed to the Commission does not include any transfer request form or similar document from Mountjoy Prison concerning the transfers which took place on 29<sup>th</sup> July 2006. In a written statement Governor Barclay stated that the transfer orders were approved verbally, by telephone, and that he then sent an email to the Operations Directorate General Office containing the necessary details – the prisoners’ names and numbers and the reasons for the transfers. At that time in 2006, [Assistant Principal Officer A] would not have had access to such an email outside of office hours.

[Assistant Principal Officer A] has no recollection of any telephone communication from Cloverhill in relation to the transfer of Stephen Egan. However, the available documentation indicates that a request for approval of the proposed transfer was faxed both to the Operations Directorate General Office and to [Assistant Principal Officer A]’s home fax at 12.55 p.m. on the 29<sup>th</sup> July 2006. The request was not made on the standard transfer order request form, but took the form of a handwritten note which stated:

*“We are requesting a transfer order for the above named, he will be transferring to Mountjoy Prison”.*

No reason was given for the proposed transfer.

According to [Assistant Principal Officer A], the IPS Operations Directorate would generally approve transfers that had been agreed between prisons at Chief Officer or Governor Level,

*“...unless I was aware of a name or for some reason I needed to question it”.*

The Commission questioned [Assistant Principal Officer A] as to his own level of knowledge concerning Stephen Egan at that time. [Assistant Principal Officer A] said:

*“Stephen Egan didn’t mean anything to me. He would have been the same as any other names put up. I was aware of [prisoner B], because... he was a difficult sort of prisoner, I will put it that way”.*

It appears that [Assistant Principal Officer A] was not aware that Stephen Egan had been recently discharged from the Central Mental Hospital:

*“A: We would have details of offences and sentences and when they were due for release and that sort of stuff. In addition we would also have a Garda opinion or a Garda view... The prison generally would have information in relation to whether the prisoner attends school, whether the prisoner has a drink or a drugs addiction problem.*

*Q: Would you have that information?*

*A: No. Not generally you wouldn't. We don't have access to it. We don't have access to the medical records of prisoners.*

...

*Q: Did you have access to the medical or psychiatric status of individuals?*

*A: No, no”.*

In this particular instance, [Assistant Principal Officer A] did not even have access to the computerised PRIS file on Stephen Egan, as it was a weekend and he was not in his office.

In his evidence to the Commission [Assistant Principal Officer A] 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.

[Assistant Principal Officer A]’s apparent lack of information concerning Stephen Egan can be contrasted with his state of knowledge regarding prisoner B. According to [Assistant Principal Officer A]’s recollection, prisoner B had been discussed with him earlier in the week, possibly one or two days before the transfer took place:

*“It had been mentioned to me that [prisoner B] had been committed to Mountjoy and we had to move him on – (a) because of the instruction from the Operations Directorate and (b) ... he had been convicted of an assault on Mountjoy staff”.*

[Assistant Principal Officer A] informed the Commission that in cases where a prisoner is committed by the courts to a prison and there is a standing order that he should not be held there, the normal procedure is that

*“...the prisoner would be brought in, the warrants would be executed and then a transfer would be done straight away back to the prison where he came from”.*

This procedure, referred to as a “court turnaround”, is set out in an IPS Operations Directorate circular of 2<sup>nd</sup> November 2005 which states:

*“When a person is on escort from a prison for a court appearance and, by virtue of a new warrant, has to be lodged in a committal prison following this court appearance, it is the responsibility of the committal prison to request the appropriate transfer order. This should be done by faxing the order request in the normal manner. There is, however, no need in such instances to keep the escort ‘at the gate’ pending transfer approval and it can be assumed that the order will issue subject to the condition that the transfer is taking place, between two closed prisons...”*

This procedure was followed with prisoner B on a previous occasion in March 2006, when he was committed to Mountjoy by the courts. Records show that on that occasion he arrived in Mountjoy at 3.25p.m., was processed in the Reception area, and at 5 p.m. was returned to Cloverhill, where he had been prior to his court appearance.

However, on the occasion of 27<sup>th</sup> July when prisoner B was once again committed to Mountjoy, his return to Cloverhill did not occur with the same immediacy. [Assistant Principal Officer A] told the Commission:

*“My understanding and I can’t recall who I had this discussion with – it was somebody in Mountjoy – they said there were difficulties in Cloverhill. They didn’t particularly want to take him back. I don’t know the reasons for it or anything like that”.*

## **Medical / Psychiatric Aspects of Transfer**

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

At that time in Cloverhill, a consultant psychiatrist visited the prison on Mondays, Wednesdays, and Thursdays. A community mental health nurse attended the prison for a full day on Tuesday and half-days on Wednesday and Friday respectively. No one from the Psychiatry Service attended the prison at weekends. For that reason, the earliest any member of the Psychiatry In-reach Service at Cloverhill would have become aware of the transfer of Stephen Egan to Mountjoy was on Monday 31<sup>st</sup> July 2006.

The Community Psychiatric Nurse attached to the In-reach Service at Cloverhill told the Commission that if he became aware that a prisoner who had been receiving psychiatric attention had been transferred to another prison, he would contact his counterpart in that prison to apprise them of that fact. In the case of Stephen Egan, it would appear that no such contact took place, as the Community Psychiatric Nurse in question remained unaware of the fact that Stephen Egan had been transferred out of Cloverhill until after the death of Gary Douch.



## 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.

Between July 2003 and July 2006 particularly, Stephen Egan was involved in multiple disciplinary incidents in Mountjoy, Midlands, and Cloverhill Prisons. During that period he also spent time in Cork and Limerick prisons. These transfers arose as a direct result of his troublesome behaviour in other prisons. In August 2004 he was discussed by the Disruptive Prisoners and Security Group, which contained the Governors of all the above prisons plus the Governors of Portlaoise and Wheatfield, along with the Director of Operations of the Irish Prison Service. In evidence to the Commission the then Governor of Midlands, John O’Sullivan described the prisoners who were discussed by this Group as:

*“...the people who are really coming to the fore and ‘up in lights’ most of the time, and they were difficult to operate [with]”.*

Stephen Egan’s disruptive behaviour during this period included attacks on prisoners and prison officers, damage to prison property and obstructing staff in the performance of their duties. Some of the incidents in which he was involved, such as his escape from Cloverhill courthouse on 2<sup>nd</sup> July 2005, throwing excrement in the courtroom at Cloverhill on 28<sup>th</sup> July 2005 and his attempted hostage-taking whilst en route to Cloverhill Prison on 27<sup>th</sup> November 2005, would have earned him a notoriety well beyond that of the average prisoner. As Governor O’Sullivan put it to the Commission

*“Stephen Egan was one of many people that would be well known and ‘red-flagged’ throughout all the systems”.*

Taking all of the above into account, the Commission considers it reasonable to conclude that for at least two years prior to his assault on Gary Douch in July 2006 Stephen Egan’s troublesome reputation was well-known throughout the prison system and in particular, to staff and management at Mountjoy, Cloverhill and Midlands Prisons.

- **Stephen Egan’s transfer from Cork Prison to Cloverhill on 27<sup>th</sup> 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.**

From the information disclosed to the Commission, it is clear that the transfer of Stephen Egan from Cork Prison on 27<sup>th</sup> November 2005 took place in breach of official policy which required that a prisoner in his category be transported separately from other prisoners and with a three-man guard.

This resulted in an unprovoked assault on a prison officer which, but for the instinctive reactions of some of her colleagues, might have resulted in serious injury or even death. As it was, the incident had traumatic physical and emotional consequences for the officers involved – consequences which persist to this day in the case of some officers, as their evidence to the Commission made clear.

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

The initial response of senior management at Cork Prison and at the IPS to news of Stephen Egan’s attempted escape and hostage-taking was swift. Deputy Governor

Collins reported to the IPS Director of Operations within one day of the incident, and indicated that written statements from the personnel involved would be taken in due course. This task was completed by February 2006.

However, the documentation disclosed to the Commission does not reveal any evidence of a further review or assessment of the incident by the prison authorities, either at local level or within the IPS. Nor is there any evidence that the matter was discussed by the Disruptive Prisoners and Security Group.

When asked about the response by senior management at Cork Prison to the incident, [Assistant Chief Officer A] (who had been in charge of the escort on 27<sup>th</sup> November 2005) gave evidence to the Commission as follows:

*“Q: So how was it regarded in Cork by management? Was it just another incident or was it regarded as –*

*A: Well, I felt they didn’t take it seriously. It felt like we kind of blew this thing out of proportion, it was only a little incident that took place on the bus. Now, they weren’t there to see what had taken place...*

*I was just called in to see the Governor, told him what happened and then told to make a report about it.*

*Q: Did he say anything to you about it?*

*A: No.*

*Q: Just make a report. Did he ask you for your assessment as to why Stephen Egan had gone like that?*

*A: No”.*

The Commission is also concerned to note that the incident did not prompt any referral of Stephen Egan to the Psychiatric In-reach Service, notwithstanding the wholly unexpected nature of the attack and his subsequent prolonged, bizarre behaviour, which

necessitated his being placed in a special observation cell. This is discussed further in the section of this report which deals with Stephen Egan's medical care and treatment during this period.<sup>61</sup>

In addition to the apparent failure to carry out a comprehensive review and assessment of Stephen Egan's care and management following the attack of 27th November 2005, the evidence given to the Commission by a number of the prison officers involved indicates that there was a failure to appreciate and to address the effect of the incident on prison staff. The most obvious example of this failure is that, notwithstanding the traumatic nature of the incident, the officers involved (with the exception of the female officer who was the principal victim of Mr Egan's assault) were instructed to escort another prisoner back to Cork Prison on the same day.

In terms of further follow-up and debriefing in relation to the incident, [Prison Officer A] told the Commission:

*"Management got us to see a psychologist once. He came down once for one session. He told me he'd be back in three weeks and I don't know whether he can't find Cork or what his problem is so we ended having to pay for our own psychological treatment".*

Finally, the Commission is extremely concerned to note that there has been no official recognition of the courage shown by the prison officers who intervened to restrain Stephen Egan during the assault on 27<sup>th</sup> November 2005. [Assistant Chief Officer A] in his report to the Governor of Cork Prison on 28<sup>th</sup> November 2005 had stated:

*"I would also like to add but only for the prompt intervention of especially Officers [Prison Officer A] and [Prison Officer B] this could have been a way more serious incident and I feel they should be complemented on their action".*

The Commission is similarly of the view that the actions of the above-named officers should have been the subject of official commendation.

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<sup>61</sup> See Medical Treatment of Stephen Egan, 2000 – 2006

- **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.**

The “carousel policy” of moving troublesome prisoners between prisons on a regular basis is considered further in chapter 15 of this report, which concerns the management of violent and disruptive prisoners. In the particular context of Stephen Egan’s management, the Commission considers that the adoption of such a policy towards Mr Egan during 2005 and 2006, whilst it may have made the short-term management of Mr Egan somewhat easier, did not benefit his long-term management within the prison system.

The Commission accepts that in many instances, decisions to move Mr Egan during 2005 – 2006 were made as a direct result of violent and / or aggressive behaviour on his part, and were justifiable from the perspective of short-term prison management. However, one unfortunate result of these frequent transfers was a lack of any coherent oversight regarding his long-term management.

In addition, the number of times Mr Egan was transferred during this period almost certainly contributed to a lack of continuity in record-keeping concerning both his management and perhaps more significantly, his medical care.

## **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.**

As detailed here and in sections 2.3, 2.5 and 2.6 of this report<sup>62</sup>, there are numerous instances in which Stephen Egan's prison medical records for the period under examination by the Commission are inadequate, lacking in necessary information, or otherwise unreliable. The failure to keep full and proper records has hampered the ability of the Commission to review Mr Egan's chronology of treatment, as required by the Terms of Reference.

More importantly, the absence of detailed, reliable record-keeping contributed to a situation in which issues relating to Mr Egan's medical and psychiatric care were identified but not followed up – as evinced by the lack of psychiatric intervention following [Consultant Psychiatrist C]'s report of 14<sup>th</sup> February 2006, for example.

- **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 27<sup>th</sup> November 2005. This was not done.**

The Commission makes no conclusion as to whether the assault carried out by Stephen Egan on 27<sup>th</sup> November 2005 was related to any mental health problems. In September 2006 while under review at the CMH, Stephen Egan himself appeared to claim that his mental health problems began at or around the time of the incident; but this may have been no more than an attempt to avoid responsibility for his actions. It is equally possible that the incident was the result of a pre-meditated escape attempt on his part.

However, given the apparent ferocity of the assault, his continued, violent resistance for the remainder of the journey, and his bizarre behaviour in smearing himself and the holding cell at Cloverhill with excrement, the Commission considers that a psychiatric review of Mr Egan should have been carried out at some point over the next few days while he was in Cloverhill. Even if no mental health issues had been identified prior to

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<sup>62</sup> See p. 242 – 266

the assault, a proper risk assessment and review of the incident should have included input from the Psychiatric Services.

- **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.**

Notwithstanding [Consultant Psychiatrist C]'s recommendation in her report of 14<sup>th</sup> February 2006 that Stephen Egan remain on D2 and be subject to on-going psychiatric review, there is no record of Mr Egan being seen by the Psychiatric In-reach Service from 9<sup>th</sup> February 2006 until 26<sup>th</sup> June 2006 – some 4 months later – when he was seen in Mountjoy Prison following a request from a GP that he be reviewed. The Commission is of the view that this was neither acceptable nor was it good practice in the circumstances.

The Commission concludes therefore that Stephen Egan did not receive the on-going review and treatment to which he was entitled, and which [Consultant Psychiatrist C] had prescribed for him and deemed necessary for him clinically, with a resulting breakdown in his continuity of care.

- **Stephen Egan was moved out of D2 wing, Cloverhill on either 10<sup>th</sup> or 16<sup>th</sup> March 2006 and was transferred to Mountjoy Prison on 16<sup>th</sup> March. These movements took place without the knowledge or approval 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 16<sup>th</sup> March 2006.
- The transfer of Stephen Egan from D2 wing at Cloverhill to Mountjoy on 16<sup>th</sup> March 2006 without medical or psychiatric consultation represents a serious departure from good practice.

The Commission is of the view that what occurred on 16<sup>th</sup> March 2006 amounts to a serious departure from anything approximating to good practice and implies either a wilful disregard or an unacceptable lack of knowledge on the part of prison management at Cloverhill concerning the mental health care of Stephen Egan, the recommendations of the Psychiatric In-reach Service and the management of risk.

## **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.

As is set out earlier in this chapter, the Commission has received diverging opinions from experts as to whether the appropriate diagnosis regarding Stephen Egan's mental health problems in July 2006 was one of mania, paranoid schizophrenia, or schizoaffective disorder. These differing points of view cannot be resolved by the Commission.



However, the Commission sees much force in the comment of Dr Lelliott that “*Mr Egan’s history and symptoms before and during his first admission to CMH were complex and presented a mixed picture*”, and considers that this fact has implications for Mr Egan’s length of stay in the Central Mental Hospital.

The complexity of Mr Egan’s presentation is demonstrated by the fact that consideration was given at various points during his stay in the Central Mental Hospital as to whether Mr Egan was “faking” his symptoms of psychotic behaviour, although the Commission accepts the evidence of Professor Kennedy that such concerns did not form part of the final diagnosis on his discharge from the CMH back to prison on 14<sup>th</sup> July 2006.

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

The records available to the Commission indicate that Mr Egan was not seen by the Psychiatric In-reach Service for a period of five months following his refusal to continue taking his prescribed anti-psychotic medication in February 2006.

In addition to being a departure from good practice, this apparent failure to keep Mr Egan under review means that any diagnosis of Mr Egan’s mental condition as at July 2006 cannot, in the view of the Commission, be treated as definitive.

The evidence provided to the Commission by and on behalf of the Central Mental Hospital and the Psychiatric In-reach Service suggests that Mr Egan’s abnormal behaviour during 2005 and 2006 was regarded as episodic in nature, and that this conclusion influenced the diagnosis arrived at by his treating psychiatrists at the CMH in July 2006. However, the apparent absence of any psychotic symptoms from February to June 2006 cannot be relied upon as evidence of the episodic nature of Mr Egan’s behaviour, given that the Psychiatric In-reach Service had no contact with Mr Egan during that time.

- 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.

In this regard, the Commission refers in particular to the fact that urine toxicology tests carried out on four separate occasions between 4<sup>th</sup> and 18<sup>th</sup> June 2006 found no evidence of drug use by Mr Egan. The Commission agrees with Dr Lelliott, who expressed the view to the Commission that:

*"The record does not provide clear evidence of a strong and consistent relationship between drug use by Mr Egan and his symptoms of mental illness".*

- 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 14<sup>th</sup> July 2006, nine days after admission.

The Commission agrees with the views of Dr Fahy and Dr Lelliott that nine days was an unusually short period within which to treat someone with a diagnosis of mania, particularly in circumstances where the possibility of his symptoms having been drug-induced or faked was being actively considered by his treating psychiatrists during this treatment period.

The assertion that this was an unusually short period for treatment of a patient with a diagnosis of mania is also supported by statistics provided to the Commission by the CMH, which indicate that over a six-year period from 1997 to the end of 2002, only 17% of patients with a similar diagnosis were discharged after nine days or less.

The Commission also agrees with the view expressed by Dr Lelliott that, although Stephen Egan posed a risk of violence towards others which was independent of his mental health, there were some risk factors for violence towards others which were or

may have been related to his mental illness, and warranted a longer period of observation than nine days. These factors as listed by Dr Lelliott were:

- Paranoid delusions about plots against him by individuals with whom he will have contact (other prisoners, psychiatric staff and prison staff)...
- Auditory hallucinations directed at him by others.
- A previous history of at least one act of violent behaviour (setting fire to his cell on 18<sup>th</sup> December 2005) apparently in response to symptoms of mental illness.
- Agitated behaviour when actively considering his delusional beliefs.
- History of poor compliance with medication.

## **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 only or in particular to D2 at Cloverhill Prison.**

The Commission is not aware of any contact between the psychiatrists treating Stephen Egan at the CMH and either Cloverhill or Mountjoy Prison on or prior to the 14<sup>th</sup> July 2006 concerning Mr Egan's prospective discharge. The only relevant conversations which took place prior to the discharge involved a HSE employee from the CMH making telephone call(s) to Mountjoy regarding his discharge and were primarily concerned as far as we can ascertain, with Mr Egan's status as a remand or sentenced prisoner.

This is a matter of particular concern, given that the consultant psychiatrist who oversaw Stephen Egan's treatment at the CMH gave the Commission the impression that she would not have discharged Stephen Egan to Mountjoy Prison. From the information before the Commission it seems clear that in reality, had Governor Salley of Mountjoy

not refused to take him, Stephen Egan would have ended up at Mountjoy rather than Cloverhill.

- The Central Mental Hospital discharged Stephen Egan to Cloverhill Prison in the full knowledge that once discharged back to prison, in the absence of any specific guidance or instruction to the prison authorities regarding accommodation and management, he could be placed in the general prison population or transferred to another prison at any time, without reference to the CMH or to the Psychiatric In-reach Service at Cloverhill.

Even if the CMH had made it clear to both prisons that Stephen Egan was being discharged solely on the understanding that he was going to Cloverhill and that he was not to go to Mountjoy, it remained a possibility that prison management could agree to transfer Stephen Egan to Mountjoy or another prison at any time without the sanction, or even the knowledge of the CMH or the Psychiatric In-reach Service at Cloverhill. The staff of the Central Mental Hospital were aware of this at the time the decision to discharge Stephen Egan was made.

Under s.18 of the Criminal Law (Insanity) Act 2006, a prisoner can only be discharged from the CMH if the Clinical Director forms the opinion that they no longer require in-patient care or treatment. Two possible scenarios arise:

- (i) a prisoner no longer requires psychiatric care or treatment of any kind
- (ii) a prisoner still requires some psychiatric care and treatment, but of a kind which can be administered in a setting outside of the Central Mental Hospital

The evidence of Professor Kennedy to the Commission is that on 14<sup>th</sup> July 2006, Stephen Egan fell into the latter category only insofar as there was a place – D2 Wing at Cloverhill Prison – which had the necessary resources to ensure that Mr Egan would continue to receive medication and would be kept under appropriate review. This implies that if Stephen Egan could only have been discharged to Mountjoy Prison, the absence of

such resources would have meant that Professor Kennedy could not have formed the opinion necessary to discharge him.

- **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 14<sup>th</sup> July 2006.**

The second requirement for a discharge under s.18 of the 2006 Act is that of consultation with the Minister for Justice as to the appropriate prison to which the prisoner should be transferred on discharge. It should also be remembered that all inter-prison transfers require Ministerial sanction before they can take place. That being so, in the case of Stephen Egan it was open to the Clinical Director of the CMH, during his consultation with the Minister or with the Minister's representative, to recommend that Stephen Egan remain at Cloverhill until such time as the Psychiatric In-reach Service were satisfied that there were no medical reasons to block his transfer to another prison. The Commission considers that if such a recommendation had been made, it would have been treated with the utmost seriousness by the Minister and his representatives, and that Stephen Egan would not have ended up in Mountjoy on 29<sup>th</sup> July 2006.

It is clear from the information provided to the Commission by the Department of Justice and the Central Mental Hospital that, insofar as any communication took place between the Central Mental Hospital, the Department of Justice, and / or the Irish Prison Service on 14<sup>th</sup> July 2006, it fell short of the consultation envisaged by section 18 of the 2006 Act.<sup>63</sup> The written direction given by Professor Kennedy does not mention the importance of Stephen Egan's need for on-going care and treatment, or the reasons why Cloverhill Prison was the appropriate destination for Mr Egan, and there is no evidence to suggest that this information was conveyed to Department of Justice or to the Operations Directorate of the Irish Prison Service prior to the transfer taking place.

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<sup>63</sup> See above p. 210.

The Commission notes that the relevant provisions of the Criminal Law (Insanity) Act had only recently come into effect on 1<sup>st</sup> June 2006<sup>64</sup>. Nevertheless, it is a matter of concern that no formal consultation procedures were put in place until the matter was raised by the Commission in May 2010.

In contrast to what took place on 14<sup>th</sup> July 2006, the Commission notes that when Stephen Egan was about to be discharged from the CMH in October 2006 – where he had been treated since the murder of Gary Douch – Professor Kennedy on this occasion took the step of writing to the Director General of the Irish Prison Service. In that letter of 5<sup>th</sup> October 2006 Professor Kennedy offered specific advice concerning Stephen Egan’s future treatment, and also made suggestions as to what prison unit might be an appropriate placement for Mr Egan. The IPS Director of Operations Mr William Connolly, to whom the letter was passed by the IPS Director General, told the Commission that this was the first such letter he had ever received from the Central Mental Hospital. The letter of 5<sup>th</sup> October fulfilled the requirements of s.18 of the 2006 Act in a way that was not done prior to the transfer of 14<sup>th</sup> 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.**

The Commission has been given to understand that transporting prisoners back to prison from the CMH is a function of the prison service and that as a rule, such transfers tend to occur either in the morning or evening, after all court-related movements have taken place.

In this instance, the Commission considers that it would have been preferable to hold Stephen Egan at the CMH until the morning of the 15<sup>th</sup> July 2006 rather than have him transferred after 6.30 p.m. on the 14<sup>th</sup>.

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<sup>64</sup> S.I. No. 273 / 2006.

Transferring Stephen Egan on the evening of 14<sup>th</sup> July 2006 meant that he arrived in Cloverhill at a time when neither the General Practitioners attached to the prison nor the members of the Psychiatric In-reach team were on duty. It also meant that he arrived at a time when medication was being dispensed in the prison, and when the day shift was in the process of handing over responsibilities to the night shift. All of the above contributed to a risk that Stephen Egan might not be dealt with appropriately on his arrival, and that is in fact what transpired. He was not reviewed by any medical personnel on the evening of the 14<sup>th</sup> July 2006, and there are unexplained anomalies in his PRIS record and in the medical record relating to the dispensing of his Olanzapine medication.

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

In part, the attitude of Cloverhill management towards Stephen Egan during this period can be explained by failures of communication in relation to his medical and psychiatric history. This is evidenced by the fact that Governor Dowling, who approved his transfer from Cloverhill to Mountjoy on 29<sup>th</sup> July 2006, was unaware of Stephen Egan's history of psychiatric problems, or that he had recently been in the Central Mental Hospital.

The Discharge Summary prepared by the CMH and sent to the GP at Cloverhill Prison set out Stephen Egan's on-going care requirements (i.e. continued medication, further psychiatric review, and the use of urine screening to discourage illicit drug use). The existence of these requirements was not communicated to the senior management of Cloverhill Prison in July 2006, and therefore was not considered in the subsequent decision of management to transfer Mr Egan to Mountjoy Prison.

- 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.

The Commission accepts the view of Dr Paul Lelliott in this regard – a view which in the Commission’s opinion is supported by a number of factors:

- the brevity of Stephen Egan’s stay at the Central Mental Hospital
  - the appearance of on-going psychotic symptoms when reviewed in Cloverhill by [Consultant Psychiatrist G] on 17<sup>th</sup> July 2006 and the concerns recorded by [Senior Clinical Psychologist A] following his review of Mr Egan on 26<sup>th</sup> July 2006
  - Stephen Egan’s history of poor compliance with medication, including his refusal to take Olanzapine from 17<sup>th</sup> February to 3<sup>rd</sup> March 2006, (which led to the discontinuance of that medication until his admission to the CMH on 5<sup>th</sup> July 2006)
  - Mr Egan’s propensity for unpredictably violent or aggressive behaviour, which although not entirely attributable to psychiatric problems, appears to derive in some instances from what Dr Lelliott describes as *“the presence of a complex mix of psychotic symptoms, substance misuse and personality disorder”*
- **A failure of management and security resulted in a visitor to Cloverhill Prison on 26<sup>th</sup> July 2006, [Senior Clinical Psychologist A], an external psychologist being exposed to a serious risk of injury or harm from Stephen Egan.**

At the time when clinical psychologist [Senior Clinical Psychologist A] came to see Stephen Egan, he was being kept in a single cell on the “security” side of D2 wing – an area of the prison reserved for troublesome or potentially violent prisoners.

The Commission has been informed that as a matter of practice, prisoners on D2 who were to receive professional visits including those for the purposes of medical or psychiatric assessment or treatment were visited either in the D2 interview room or in the surgery of the medical unit on D1 (the wing underneath D2). Yet in this instance,



Stephen Egan was brought down from D2 to an ordinary visiting room, where he was left alone with [Senior Clinical Psychologist A].

Even if one were to discount Mr Egan's history of mental health problems, his record of unpredictable violence against prison staff and prisoners should have meant that visitors to the prison would be allowed to encounter Mr Egan only in a secure environment and in the presence of one or more prison officers. This did not happen in the case of [Senior Clinical Psychologist A].

## **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 29<sup>th</sup> July 2006.**

Stephen Egan had been on D2 wing at Cloverhill since his discharge from the Central Mental Hospital on 14<sup>th</sup> July 2006. Records of the daily Governor's parade at Cloverhill show that Stephen Egan spoke with a Governor on seven different occasions during his two weeks on D2. On two of those occasions (18<sup>th</sup> and 28<sup>th</sup> July) he asked to be moved to one of the ordinary wings in Cloverhill. At no point during these two weeks did Stephen Egan seek a transfer to Mountjoy or to any other prison.

It has been suggested to the Commission that one of the reasons for transferring Stephen Egan was to create a vacancy on D2. While it is obviously desirable to have spaces available on D2 where possible, the Commission has seen no evidence of any specific, immediate need which demanded that a vacancy be created. In any event, such a requirement could have been fulfilled by moving Stephen Egan onto one of the ordinary wings in Cloverhill – a move which had already been approved in principle by Governor Dowling.

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

It is accepted by all relevant medical and management staff that the medical and psychiatric aftercare facilities available to Stephen Egan at Cloverhill were considerably better than anything available at Mountjoy Prison in July 2006.

[Consultant Psychiatrist F], the consultant psychiatrist who supervised Stephen Egan's treatment at the Central Mental Hospital from 5<sup>th</sup> – 14<sup>th</sup> July 2006, stated to the Commission that Mr Egan was discharged on the understanding that he would be going to Cloverhill, which she described as “...*a very well-resourced and structure aftercare location*”.

[Consultant Psychiatrist F]'s view was shared by Professor Harry Kennedy, who told the Commission that he made the final decision to discharge Stephen Egan on 14<sup>th</sup> July on the basis that “*he would have access to appropriate level of aftercare, and that he would continue to received on-going treatment for residual symptoms*”.

Furthermore, [Consultant Psychiatrist F] told the Commission that she would not have discharged Mr Egan back to Mountjoy.

In addition to the medical reasons why Stephen Egan should have remained in Cloverhill, there was also the issue of appropriate cell accommodation. On 14<sup>th</sup> July 2006 both Governor Salley and Governor Lonergan of Mountjoy informed Governor Somers of Cloverhill that Mountjoy could not accommodate Stephen Egan for two reasons: a lack of appropriate facilities (including medical facilities and single-cell accommodation) and the fact that he had “*burned all his bridges*” – meaning, that there was nowhere in the prison where he could be safely accommodated. The concerns of Governor Salley and Governor Lonergan do not seem to have been shared by [Chief Officer B] or Governor Barclay, who negotiated the transfer which took place two weeks later. Nonetheless, those concerns were borne out when subsequently it proved impossible to place Stephen Egan anywhere other than in a holding cell in “B Base” – a totally

inappropriate environment for someone with his medical background and history of violent behaviour.

On the 14<sup>th</sup> July 2006 when Governor Salley and Governor Lonergan correctly refused to accept a transfer of Stephen Egan, Mountjoy prisoner numbers had already reached 514 against its official bed capacity of 470. This meant that 44 prisoners were without an actual bed to sleep on. However when Governor Barclay agreed to accept Mr Egan on the 29<sup>th</sup> July 2006, Mountjoy Prison numbers were even higher at 527.

The Commission acknowledges the pressures on Prison Governors to manage the acute levels of overcrowding in their prisons on a daily basis – particularly in a committal prison like Mountjoy.

The Commission however is troubled by management's susceptibility to accepting transfer deals in order to ease overcrowding which may result, as in this case, in unjustifiable risk.

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

It has been suggested to the Commission that the transfer of Stephen Egan to Mountjoy on 29<sup>th</sup> July 2006 was in exchange for Cloverhill agreeing to take Prisoner B.

In reality, there was no need for any such swap to take place. Prisoner B had been serving a two-year sentence in Cloverhill since 15<sup>th</sup> March 2006. When he left there on the morning of 27<sup>th</sup> July 2006 to attend court it must have been anticipated by the management at Cloverhill that he would be returning to Cloverhill that evening. The Commission notes that when Prisoner B was eventually returned to Cloverhill on 29<sup>th</sup> July 2006, he was placed in the same cell where he had been prior to his court appearance on 27<sup>th</sup> July 2006. This too suggests that Cloverhill management were anticipating his return to the prison. Once it became clear on 28<sup>th</sup> July 2006 that Prisoner B had in fact ended up in Mountjoy, the management at Cloverhill should have agreed to take him back without any conditions or any swap arrangement.

The Commission notes that a similar situation had arisen on 15<sup>th</sup> March 2006 when Prisoner B received his two-year sentence. On that occasion Prisoner B had been on remand in Cloverhill but was committed by the court to Mountjoy Prison. Prison records show that he stayed at Mountjoy for less than 2 hours on that occasion before being returned to Cloverhill.

In the course of a visit to Cloverhill Prison on 20 April 2010, the Commission asked the IPS Director of Operations William Connolly why the swift “court turnaround” procedure which was followed on 15<sup>th</sup> March 2006 had not been repeated on 27<sup>th</sup> July 2006. Mr Connolly told the Commission that on 15<sup>th</sup> March, the IPS had been aware that Prisoner B’s status was going to change from remand to sentenced prisoner, and that a member of the IPS Operations Directorate team had issued a verbal instruction that Prisoner B was to be returned to Cloverhill regardless of any change in status. There appears to be no written record of any such verbal instruction, either in Cloverhill Prison or at IPS Headquarters.

According to Mr Connolly, the situation on 27<sup>th</sup> July 2006 was different in that any sentence Prisoner B was going to receive on that date would be of a minor nature and would be subsumed into his existing two-year sentence. For that reason, that particular committal went “under the radar” of the IPS Operations Directorate and a verbal instruction to return Prisoner B to Cloverhill did not issue. Nonetheless, Mr Connolly told the Commission that in his view, Prisoner B should have been returned to Cloverhill immediately following his committal to Mountjoy on 27<sup>th</sup> July 2006. This same view was expressed by Mr Connolly in a written report submitted to the IPS Director General in November 2006 concerning the death of Gary Douch, in which he stated:

*“It is my view that Cloverhill Prison availed of the opportunity when approached to take [Prisoner B] to transfer one of their ‘difficult’ prisoners... It is also my view that [Prisoner B] should not have been lodged in Mountjoy Prison for any longer than was necessary to process his warrants and that he should have been returned immediately to the prison whence he came, i.e., Cloverhill Prison. It is significant that when he received the two-year sentence earlier in the year he was returned to Cloverhill Prison on the same day”.*

Written statements from Governor Dowling, Assistant Governor Bracken, and [Chief Officer C] – all of whom were based at Cloverhill in 2006 – suggest that the same swap of Stephen Egan for Prisoner B had taken place on more than one occasion previously. The Commission has not found evidence to show that this is the case. It is noted that when Stephen Egan was transferred to Mountjoy on 16<sup>th</sup> March 2006 (one day after Prisoner B was returned to Cloverhill from Mountjoy) it was described to the IPS as “*a swap for security reasons*”. However, there is nothing in the documentation disclosed to the Commission which identifies Prisoner B as the other party in this swap.

In any event, the concept of a swap arrangement where one of the prisoners had only recently been discharged from the CMH under s.18 of the Criminal Law (Insanity) Act 2006 was less acceptable than in an ordinary case of two prisoners with no history of psychiatric problems. Clearly, the idea of a swap involving a prisoner who had recently returned from the CMH should not have been entertained without detailed consideration of that prisoner’s need for on-going care, treatment, and review.

- **The transfer of Stephen Egan on 29<sup>th</sup> 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 if it had been, Cloverhill Prison had the capacity to accept those additional prisoners without having to transfer Stephen Egan.**

According to the evidence given to the Commission by the Chief Officers from Cloverhill and Mountjoy who negotiated the matter, the transfer of Stephen Egan was not connected with the transfer of four prisoners from Mountjoy to Cloverhill on 29<sup>th</sup> July 2006 in order to relieve overcrowding at Mountjoy.

Even if it had been, Cloverhill Prison had the capacity to accept those extra prisoners without moving Stephen Egan. According to figures provided to the Commission by the IPS, on 29<sup>th</sup> July 2006 the number of prisoners in custody in Cloverhill was 402, compared with a bed capacity of 433. By contrast, on 27<sup>th</sup> July 2006 Mountjoy Prison contained 526 prisoners – 81 more than the bed capacity of that prison.

In the IPS Operations Directorate report into the death of Gary Douch, Director of Operations William Connolly stated:

*“At the time, a Governor’s direction was in place whereby Cloverhill Prison were not to take prisoners on transfer if their numbers were over the 400 mark. This Directorate was not aware of this local arrangement until after the death of Gary Douch when I was advised that it was in place by Governor Liam Dowling. I further understand that this direction was implemented on the instruction of Governor Tom Somers without reference to this Directorate. In my view, such a direction was not justifiable, particularly in view of accommodation pressures being experienced in Mountjoy Prison and elsewhere. It was revoked on my instruction once I was made aware of its existence”.*

In a written response to the Commission on this issue, Governor Somers has clarified that he did not issue a formal direction in the matter, but that the policy of trying to keep prisoner numbers to 400 *“...was a consensus position amongst all senior grades.”*

In his evidence to the Commission, Governor Somers explained the reasons for the policy, stating:

*“We are a remand prison and the numbers fluctuate very quickly. They fluctuate; you could get 50 in on an evening. You might get a round-up by the immigration authorities and they might bring in 25 prisoners. I have to accommodate them. I have to accommodate prisoners who are committed by the courts – legally I am required to take them...”*

*We had discussed this issue... probably in the week or ten days before this incident occurred, this death occurred in Mountjoy. And we had discussed it at our morning management meetings and we had said the ball park number for taking transfers from another prison is around 400. If you have 400 in custody try not to take in committals from another prison who are sentenced because we have to retain spaces for the incoming from the District Courts and from the Garda National Immigration Authorities etc. That is where the issue of the 400 arose”.*

Governor Somers also pointed out that additional difficulties were caused by the fact that at any one time during 2006, approximately 25% of the prisoner population at Cloverhill was composed of non-nationals from a variety of ethnic backgrounds, who often could not be mixed with prisoners from different backgrounds to their own, for security reasons.

Finally, Governor Somers told the Commission that the policy of limiting prisoner numbers was subject to any instructions they might receive from the Operations Directorate in relation to taking prisoners on transfer:

*“Operations have the final call, even if I say ‘400 is the ball park figure, we are not taking any sentenced prisoners’ – Operations may come back to me and say, ‘Hold on, Governor, I’m instructing you to take ten prisoners’. And I will say ‘Fine’. That is the natural order of things”.*

The Commission understands the reasons why Governor Somers sought to preserve additional spaces in Cloverhill by means of a quota. However, the Commission agrees with the IPS Director of Operations that in the context of the prison system as a whole, the need to alleviate overcrowding at Mountjoy far outweighed any concerns regarding potential overcrowding at Cloverhill Prison.

- **There were fundamental systemic failures in every aspect of Stephen Egan’s transfer from Cloverhill Prison to Mountjoy on the 29<sup>th</sup> July 2006.**
- **The Governors of both Mountjoy Prison and Cloverhill Prison at the time of Stephen Egan’s transfer on 29<sup>th</sup> July 2006 failed to ensure delivery of acceptable standards of prisoner management, health, and safety.**

Governor Lonergan submitted to the Commission that “...it would be grossly unfair to give the impression that this totally unacceptable situation was exclusively the failure and fault of the management of Mountjoy and that we did it as a matter of choice.”

Governor Salley also objected to this conclusion.

- **The decision to transfer Stephen Egan to Mountjoy on 29<sup>th</sup> 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.**

This is clear from the fact that no GP, nurse officer or member of the Psychiatric In-reach Services at Cloverhill or Mountjoy Prisons was consulted about the proposed transfer. Nor were they informed of the transfer once it had taken place.

Further evidence that Stephen Egan's medical and psychiatric status played no part in the decision to transfer him is contained in the fact that Governor Dowling, who approved the transfer on the Cloverhill side, was unaware at the time of Stephen Egan's psychiatric history, including his recent sojourn at 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.**

Members of the Psychiatric In-reach Service with responsibility for Mountjoy did not attend the prison on weekends. As a result, they were not aware of Stephen Egan's arrival in the prison until after the death of Gary Douch.

- **Mountjoy Prison management should not have agreed to accept Stephen Egan on 29<sup>th</sup> July 2006.**

On 14<sup>th</sup> July 2006, both Governor Salley and Governor Lonergan refused Cloverhill's request that they take Stephen Egan back from the Central Mental Hospital, rightly maintaining that Mountjoy was under pressure from overcrowding and did not have the accommodation or facilities to deal with the psychiatric needs and behavioural risks associated with Mr Egan at that time. The prison numbers in Mountjoy on the 14<sup>th</sup> July were 514.



Two weeks later, when Cloverhill again sought to have Mr Egan transferred to Mountjoy, if anything had changed it was that Mountjoy Prison was more overcrowded; now having 525 prisoners with even less possibility of finding appropriate accommodation for Stephen Egan, either in a cell on his own or on any of the main wings of the prison with other prisoners.

Furthermore, although the management at Mountjoy who accepted the transfer of Stephen Egan on 29<sup>th</sup> July 2006 (albeit it in a context where Cloverhill was agreeing to take a total of 5 of their prisoners) were not made aware of his current on-going psychiatric care needs, they did know that he had recently been in the Central Mental Hospital.

Given that they were so aware (he had, after all, been moved from Mountjoy to the CMH on the 5<sup>th</sup> July), the Commission considers that the management at Mountjoy might reasonably have been expected to have instituted more detailed inquiries as to Stephen Egan's current care needs and as to how they were being addressed in Cloverhill following his discharge from the CMH, before accepting the transfer. Had they done so, it might have become apparent that the accommodation and medical resources in Cloverhill to ensure Stephen Egan's on-going care exceeded anything available in Mountjoy at that time.

In fairness to Mountjoy Governors and management who dealt with the transfer of Stephen Egan on the 29<sup>th</sup> July, it has to be recognised that trust, with regard to information sharing concerning any transfer prisoner, was the basis of all such transfers. Such inquiries as they did make elicited assurances from Cloverhill that Stephen Egan was fine and just needed a break. Mountjoy Governors and management understandably and justifiably felt let down by those assurances, in the aftermath of what happened two days later, although it has to be said that those assurances may well have reflected the state of knowledge of the person who gave those assurances to them, having, as far as we are aware, just returned from holidays himself and unaware that Stephen Egan had been recently a patient at the CMH. It appears from records, that Stephen Egan had been cleared by management in Cloverhill for a return from D2 wing to the general prison population there also.

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

The responsibility for approving all inter-prison transfers lies with the IPS Operations Directorate and in this case with [Assistant Principal Officer A]. It is clear to the Commission that [Assistant Principal Officer A] did not have all necessary information before him at the time of his decision to approve the transfers of Stephen Egan and Prisoner B. In particular he was not aware of the following relevant matters:

- Stephen Egan's psychiatric history, including his recent stay in the Central Mental Hospital
  - Stephen Egan's record of violent, disruptive and aggressive behaviour
  - The reasons why Stephen Egan in particular was being transferred
  - That Stephen Egan was on anti-psychotic medication and was subject to on-going review by the Psychiatry In-reach Service at Cloverhill
  - That Stephen Egan had been kept in a single cell on a high-security wing in Cloverhill prior to the proposed transfer
  - That Governor Salley and Governor Lonergan had refused to accept Stephen Egan into Mountjoy on 14<sup>th</sup> July 2006
  - That Prisoner B had been in Cloverhill immediately prior to being committed by the court to Mountjoy.
- 
- **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, certainly "sweetened" by an arrangement where they offered to relieve Mountjoy of five prisoners that day on condition of Mountjoy accepting Stephen Egan.**

- 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 weekend when 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. The transfer also involved moving him from the safety of a high observation single cell on Cloverhill's D2 wing to Mountjoy, where they must have known he could 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**

#### **Reception and Screening**

On Saturday 29<sup>th</sup> July 2006 Stephen Egan was collected from Cloverhill Prison at 2.05 p.m. by prison officers from Mountjoy. The prison officer in charge of the transfer, [Prison Officer D], stated that she took custody of Egan's general prison file and his medical file (the latter contained in a sealed envelope). Stephen Egan arrived at the gates of Mountjoy Prison at approximately 2.40 p.m. and was escorted to the reception area by the prison officer who had driven the prison van, [Prison Officer C]. Mr Egan was placed in a holding cell at reception to await processing.

On arrival at Mountjoy, [Prison Officer G] brought Mr Egan's general prison file to the General Office, before going to the Keys Office to have Stephen Egan's name added to the Numbers Book – the book which is used to keep track of the entire Mountjoy Prison population. [Prison Officer G] told the Commission that she then went to the prison surgery to hand over the medical file:

*“I handed the medical file to the medical orderly or nurse. Who it was, I cannot remember.”*

The Commission heard evidence from [Medical Orderly A], the medical orderly who interviewed Stephen Egan at the reception area on 29<sup>th</sup> July 2006. He recalled receiving a telephone call from the Reception Officer to say that a prisoner had arrived on transfer from Cloverhill, whereupon he went to the reception area and interviewed Stephen Egan. His recollection is that he did not have possession of the medical file at that time. It is possible that the file had not made its way to the surgery by the time he left; or it may be that the orderly did not bring the file with him when interviewing Egan. Unfortunately, no records were kept in Mountjoy of medical files received.

In his evidence to the Commission, [Medical Orderly A]’s recollection was that he had noted the results of his interview with Stephen Egan on a standard committal form sheet. Stephen Egan himself also told the Commission that he recalled the medical orderly making notes at the interview. However, no committal form or written note arising from this interview has been disclosed to the Commission, and there is no such document on Mr Egan’s medical file. Furthermore, in a written statement prepared on 27<sup>th</sup> September 2006 in response to queries from IPS Director of Prison Health Care Dr Enda Dooley following the death of Gary Douch, [Medical Orderly A] stated:

*“It is not our practice to fill out committal interview forms on inter prison transfers”.*

The Commission invited [Medical Orderly A] to comment on the apparent contradiction between his oral evidence to the Commission and his written statement of 27<sup>th</sup> September 2006. In a written response the medical orderly stated:

*“I refer in particular to my statement to the Governor of Mountjoy Prison dated the 27<sup>th</sup> September 2006. It is likely that this statement was prepared by me in haste. It is not sufficiently detailed.*

*In particular... I should have stated that it was not the practice to fill out committal interview forms on Inter Prison Transfers when the medical file was present. In the case of the transfer of Stephen Egan, the medical file was not present”.*

In his evidence to the Commission [Medical Orderly A] recalled Stephen Egan saying that he was on Olanzapine – which the medical orderly knew to be an anti-psychotic drug used regularly by the psychiatric services – but that he had not been taking it. When asked by the Commission if he had contacted the surgery at Cloverhill to check on this, [Medical Orderly A] replied:

*“I didn’t actually because the prisoner said he wasn’t taking it. He said he hadn’t been taking it. I told him to mention it to the doctor the next day, and he said ‘I don’t want to see the effin’ doctor’”.*



In his statement of 27<sup>th</sup> September 2006 [Medical Orderly A] responded to a query as to whether he had recorded Egan's refusal to see the doctor by asserting that records of such refusals were not kept in Mountjoy at the time. He stated:

*"There are no records for prisoners refusing to see the Medical Officer".*

The statement continued:

*"I did not read the prisoner's medical notes; I am not aware if any other member of staff did read them.*

*I did not place his [Egan's] name on the doctor's list, as he had declined.*

*I am not aware if Stephen Egan was assessed regarding medication, as I do not have access to his medical notes at present".*

However, in his oral evidence to the Commission [Medical Orderly A] stated that he had, in fact, placed Stephen Egan's name on a list to be seen by the prison doctor on the following morning, notwithstanding Mr Egan's statement that he did not wish to see the doctor. When asked subsequently by the Commission to comment on the apparent conflict between this evidence and his written statement of 27<sup>th</sup> September 2006, [Medical Orderly A] responded in writing to the Commission, stating:

*"...I am quite satisfied that my evidence to the Commission is true and correct in every respect".*

There is a clear conflict between [Medical Orderly A]'s account of events as given to the Commission and his statement on the matter in September 2006. Having examined all the information available to it, the Commission considers his statement of 27<sup>th</sup> September 2006 to be a more accurate representation of what occurred. The Commission further believes that the statement of 27<sup>th</sup> September 2006 is indicative of a lax approach to record-keeping and documentation which was not confined to the medical orderly in question, but appears to have been endemic in Mountjoy at that time.

Even if one were to accept that Stephen Egan's name was placed on a list to be seen by the doctor, there was still a clear failure of communication. Both [Doctor E] and [Doctor A], the GPs who attended Mountjoy on Sunday 30<sup>th</sup> July and Monday 31<sup>st</sup> July 2006 respectively, have stated unequivocally to the Commission that Stephen Egan was not brought to their attention as someone who needed to be seen.

A computerised Patient Medical Records System [PMRS] was introduced to Mountjoy Prison towards the end of 2005. However, problems were experienced in relation to its reliability as a source of information, particularly regarding newly arrived prisoners. By June 2006, it seems that use of PMRS at Mountjoy had been effectively suspended. At a meeting of the Mountjoy Prison Healthcare Committee on 16<sup>th</sup> June 2006, the following complaint was recorded:

*“PMRS not in use in Mountjoy, due to problems with PRIS. Frequently new committals not put on PRIS when [they] arrive in prison, and so are not on PMRS for doctor's clinic next morning.”*

An Assistant Governor at the meeting is recorded as stating that the frequent failure to record information regarding new committals on PRIS was due to a lack of training for some of the officers whose job it was to input the information.

In the case of Stephen Egan, the PRIS record shows that he was recorded on 29 July 2006 as having arrived at the prison on that day. However, this fact alone did not ensure that he was seen by a doctor on the following day, as it seems that the GPs working at the prison were not using the computer record to monitor new committals, owing to its perceived unreliability.

## **Management of Stephen Egan in “B Base”**

### **Assessment at Reception**

Whilst Stephen Egan was in the reception area on 29<sup>th</sup> July 2006 he was seen by [Chief Officer B], who was the senior officer on duty on that day. [Chief Officer B] told the Commission that he had wanted to assess Mr Egan's demeanour for himself:

*“... I wanted to see what his reactions were, how he was dealing with people. His words to me when I went down to greet him, if you like, and welcome him back to Mountjoy were, I said ‘Well Stephen, how are you keeping?’ He said, ‘Well, [Chief Officer B], I am glad to be back’, he says, ‘I am cured’. That is what he said to me...”*

[Chief Officer B] had dealt with Stephen Egan during his previous stay in Mountjoy, up to the time Mr Egan was transferred to the Central Mental Hospital. He told the Commission that in his view, Mr Egan’s demeanour and behaviour on 29<sup>th</sup> July 2006, showed a marked improvement compared with his condition prior to his stay at the CMH:

*“I had seen him before he went out [to the CMH] and he was all over the place. Now, again, I am not qualified as a psychiatrist, but I do rely on my own life experiences, if you like, and to me he appeared to be okay”.*

Notwithstanding this apparent improvement in Mr Egan’s behaviour, finding appropriate accommodation for him in Mountjoy remained problematic.

The duty Governor for Mountjoy prison over that weekend was Deputy Governor Barclay. He told the Commission that he also spoke with Stephen Egan soon after his arrival in Mountjoy on Saturday afternoon:

*“I had spoken to Stephen when he arrived actually and he told me that he was looking to double up with a prisoner called [name given]. I knew I couldn’t house him on the D Division, but I had options on the A Division, the B Division, the C Division and indeed the medical unit, and I was beginning to explore those possibilities of having him moved to one of those areas”.*

Deputy Governor Barclay asked [Chief Officer B], who was in charge of A and B Divisions on that weekend, to explore the matter further.

In an undated written statement, submitted to the Governor of Mountjoy as part of the internal investigation into Gary Douch’s death in 2006, [Chief Officer B] stated:

*“I spoke to prisoner Egan with regard to his status and I informed him that he could not go upstairs [to the main prison wings] until I could assess the situation and make sure*

*there was no threat against him as he had been involved in a number of fights with other prisoners on both sides of the prison. I then spoke to staff and prisoners and the information I received was that while some of the prisoners he was fighting with were prepared to shake hands there was a large number of prisoners going to get him. I then left instruction for prisoner Egan to be placed in the Base until I received word that there were no more threats against him. He was placed in holding cell number 2 and I spoke to him later that evening...”*

In evidence to the Commission [Chief Officer B] confirmed this account, saying:

*“Stephen Egan had made a lot of enemies in Mountjoy... he was fighting with people on both sides of the main prison as such. So the only place I would have had to hold him at the time was the holding cell [in ‘B Base’] and I would have known that when he was coming back... I would have hoped to get him out of the holding cell within a couple of days, but it doesn’t always work out that way”.*

## **Placement in “B Base”**

Stephen Egan was placed in Holding Cell 2, B Base at 3.35 p.m. on Saturday 29<sup>th</sup> July 2006. At that time he was the only prisoner in that cell. This remained the case until 6.05 p.m. when he was joined by another prisoner. The two men were kept in the holding cell overnight.

At 4.10 p.m. on Sunday 30<sup>th</sup> July a third prisoner, who was on protection having been attacked on the D wing, was also placed in the cell. These three prisoners remained in the holding cell during Sunday night. No issues were reported during this period.

## **Governors’ Meeting, 31<sup>st</sup> July**

On the morning of Monday 31<sup>st</sup> July, Governor Salley assumed overall responsibility for the prison in the absence of Governor Lonergan, who was on annual leave. The standard procedure at that time was that all Governors on duty would meet together for a short period on Monday morning, during which time the duty Governor for the previous weekend would provide an

update on the numbers in the prison – both prisoners and available staff. The meeting was also an opportunity for the duty Governor to inform his colleagues of any significant issue or event from the weekend of which they might have been unaware. This meeting – which might be 5 or 10 minutes in duration – was then followed by a larger meeting which would include the various heads of function at the prison.

The morning Governors’ meeting was informal in nature and minutes were not kept. However, in a chronological account of events which was prepared by Deputy Governor Barclay following the death of Gary Douch, and which was subsequently included by Governor Salley in his operational report to the IPS Director General dated 23 August 2006, Deputy Governor Barclay states:

*“9:00am I briefed Governor Salley at the Governor’s 9am meeting regarding the weekend by way [of] transfers, committals and hospitals.”*

In a written submission to the Commission dated 4<sup>th</sup> May 2012, Deputy Governor Barclay gave further evidence in this regard, stating:

*“On the morning of the 31<sup>st</sup> July, at the 9am management meeting with Governor Salley who was chairing the meeting, I briefed Governor Salley with regard to weekend events including the high numbers and the transfer of prisoners both into Mountjoy and out of Mountjoy. I pointed out to Governor Salley that Stephen Egan had a return spring for Cloverhill if required...”*

This account is strongly contested by Governor Salley, who gave clear and consistent evidence to the Commission that he was unaware of Stephen Egan’s presence in Mountjoy until after the fatal assault on Gary Douch was discovered on the morning of 1<sup>st</sup> August 2006. Evidence obtained from the other Governors who attended the meeting was inconclusive. Deputy Governor Barclay’s diary for the period includes an entry, “*Brief Re. S. Egan*” for the date in question, but this in itself is not proof that the briefing did in fact take place.

The Commission devoted considerable time and effort to establishing an accurate chronology of these events and the state of knowledge of each of the key individuals concerned - including holding multiple oral hearings, right up to the 16<sup>th</sup> December 2013. The Commission had also

sought documentary evidence and written submissions - in an attempt to resolve the issue of whether Mr Egan was mentioned or not at the Governor's meeting on the morning of 31<sup>st</sup> July 2006. In the Commission's view, the available evidence does not allow a definitive conclusion on the matter. The significance, or otherwise, of this is considered below in the section entitled 'Possible Return to Cloverhill Prison'.

## **Governor's Parade, 31<sup>st</sup> July**

Every weekday morning a Governor's parade would take place in the B Base, at which prisoners could raise issues or make requests of the prison management. On the morning of 31<sup>st</sup> July 2006, the parade was taken on Governor Salley's behalf by [Assistant Chief Officer D], who was the officer in charge of the Base area on that morning. [Assistant Chief Officer D] told the Commission that it was not unusual for him to begin the parade without a Governor present:

*"The Governors were fairly pushed for time. They would have a management meeting in the morning. If I was to leave the parade for the Governor to come down he mightn't come down until 10:00 or 10:30 and that throws out... the whole procedure within the Base. I used to start the parade with any Governor's consent because they had good confidence in me and they had no difficulty with me taking the parade for them."*

The procedure as outlined by [Assistant Chief Officer D] was that from 8 am onwards, as the prisoners' cells were being unlocked and they were getting breakfast, any requests from the prisoners to see the Governor or any of the agencies within the prison (such as medical or welfare) would be noted by prison officers and their names would be entered in the Governor's Parade Book. At around 9 am the Governor (or whoever was taking the parade on their behalf), would sit in the class office in the B Base area and the noted prisoners would be brought into the office, one at a time to make their requests. The person taking the parade would note their request in a column headed 'Application', beside the prisoner's name. Any decision taken in relation to the request was noted in a column headed 'Decision'.

The last name entered in the Governor's Parade Book for the 31<sup>st</sup> July 2006 was that of Stephen Egan. In the 'Application' column was written, *"Go upstairs."* It is clear from the context and from evidence given to the Commission by the author of the note [Assistant Chief Officer D]

that this entry recorded a request from Stephen Egan to be moved from the B Base to a cell on one of the main wings of the prison.

In the column headed ‘Decision’, [Assistant Chief Officer D] wrote his own name. He told the Commission that this was a reminder to himself to explore Mr Egan’s request with his superiors, as he did not have the authority to move Mr Egan onto one of the main landings without first consulting a Governor or the relevant Chief Officer:

*“I would have explained to him that you are going nowhere today. I will raise the matter with the Governor, I will come back to you, and see what the Governor says.”*

[Assistant Chief Officer D] does not remember who he approached in relation to Stephen Egan’s request, but other documentation disclosed to the Commission indicates that he raised the matter with Deputy Governor Barclay during a visit to the Base by the latter at around 2.30 pm.

Governor Salley told the Commission that on the morning of the 31<sup>st</sup> July 2006 he arrived in the Base area at around 10 am, by which time [Assistant Chief Officer D] had finished dealing with the requests noted in the Governor’s Parade Book. [Assistant Chief Officer D] confirmed this, stating:

*“Every entry put in that day I have adjudicated on it, so therefore, the Governor did not come down to me until after the parade had ended.”*

According to [Assistant Chief Officer D], a Governor who had not taken the Parade himself would not necessarily be expected to review the Parade Book in detail:

*“Q: Would you expect the Governor to go through these entries in detail with you?”*

*A: Well he would not go through it in detail, he would glance over them... If there was anything of specific importance I would point it out to him.”*

[Assistant Chief Officer D] signed and dated the Governor’s Parade Book at the bottom of the page, just underneath the final entry concerning Stephen Egan. Also directly underneath the Stephen Egan entry is a note, signed and dated by Governor Salley, which reads:

*“Inspected all cells found a number of issues / windows, call systems and painting of cells.”*

The Commission has been given to understand that it was the practice of Governors to “put their head in the door” of each cell in the B Base following conclusion of the Governor’s Parade. Although Governor Salley’s note states, *“Inspected all cells...”*, Governor Salley told the Commission that it was not his practice to visit the holding cells when carrying out such an inspection, and for that reason he did not encounter Stephen Egan at that time. This evidence is contested by [Assistant Chief Officer D], who told the Commission that he would insist on any Governor including the holding cells as part of the inspection process:

*“Q: So in your view the holding cells would be part of the general check?”*

*A: Of course they would, yes. In fact I would insist... I would make sure, to cover myself, that he knew who was in the cell.*

...

*Q: The fact that there were only three of them in there at the time – would that factor into your thinking at all in terms of making sure that the Governor saw them?*

*A: They were part of the population of the Base and as such there is no reason to overlook them.”*

As previously stated, Governor Salley has told the Commission that he was unaware of Stephen Egan’s presence in the B Base on 31<sup>st</sup> July 2006. If [Assistant Chief Officer D]’s evidence is correct, then Governor Salley should ordinarily have become aware of Stephen Egan during his visit to the Base on that morning. If, on the other hand, Governor Salley’s evidence is correct, then the Commission considers that he himself is partly responsible for his lack of knowledge, insofar as he did not take the Governor’s Parade that morning, he did not observe Stephen Egan’s name when writing his own note in the Governor’s Parade Book, and he did not include the holding cells in his inspection of the B Base area.

Governor Salley told the Commission that he was in the B Base that morning from approximately 10 am until 11.30 am – a period of 1 ½ hours. If one was to accept his evidence



that he was not alerted to Stephen Egan's presence in the Base by any member of staff during that period, the most obvious explanation for such an apparent failure would be that none of the staff considered Stephen Egan's presence in the Base at that time to be in any way problematic. The alternative interpretation would involve a conspiracy of silence on the part of all the other prison staff to conceal Egan's presence in the prison from Governor Salley – which in the Commission's view, is simply not credible.

The significance or otherwise of Governor Salley's state of knowledge is considered below in the section entitled, 'Possible Return to Cloverhill Prison'.

## **Disciplinary hearings in B Base, 31<sup>st</sup> July**

On the afternoon of Monday 31<sup>st</sup> July Deputy Governor Barclay went to the B Base in order to deal with any disciplinary reports against prisoners. While there he was asked by the Assistant Chief Officer supervising the Base if he would speak with Stephen Egan. Deputy Governor Barclay told the Commission:

*“I spoke to Stephen. He went through the same story again, that he could be housed with [a named prisoner]”*

He continued:

*“[Chief Officer D], a three-bar Chief at the time, was with me in the Base. We tasked [Chief Officer B] to go and speak to the various parties on the A and B wings to ascertain the exact cause, could he go up or could he not go up? [Chief Officer B] came back later that evening and said there was no way – that the word on the divisions was if he came up, he would be done. So we left him there to explore the possibility of the next day of placing him in the medical unit”.*

Three more prisoners were placed in Holding Cell 2 between 3.30 and 4.30 p.m. on Monday 31<sup>st</sup> July. At 6.45 p.m. Gary Douch became the seventh prisoner to be placed in the cell. A further seven prisoners were added between then and 8.30 p.m., at which point seven were moved.

## Medical Treatment

In 2006 there were two GPs who between them attended Mountjoy on a daily basis from Monday to Friday. Weekend cover was rostered between four doctors – the two Mountjoy GPs plus the doctors attached to St Patrick’s Institution and the Dóchas female prison. The doctor on weekend duty was on call from 5 p.m. on Friday until 8 a.m. on Monday. He or she would also visit each of the three institutions in turn on Saturday morning and again on Sunday morning.

The GP who attended Mountjoy over the weekend of 30 / 31<sup>st</sup> July 2006 was the doctor attached to St Patrick’s Institution, [Doctor E]. [Doctor E] knew Stephen Egan from his time spent at St Patrick’s, and had met him on other occasions when on duty at Mountjoy:

*“Stephen would be a regular in one of the special observation cells... So you would be aware of him... as well as the committals, the other people we have to see on a daily basis are people in special observation cells... Stephen would have been there frequently”.*

[Doctor E] visited Mountjoy on Saturday morning, before Stephen Egan had arrived there from Cloverhill. Accordingly, his first chance to see Mr Egan would have been during his visit on Sunday 31<sup>st</sup> July.

The normal procedure at such visits was that the medical orderly on duty would hand the doctor a list of prisoners to be seen. The medical files for those prisoners would be placed in a filing trolley for easy access, should the doctor need to refer to them. [Doctor E] is adamant that he was not informed by anyone at Mountjoy of Stephen Egan’s presence in the prison on Sunday 31<sup>st</sup> July 2006. Stephen Egan’s name was not on any list shown to him of prisoners to be seen that day; nor did he see Mr Egan’s medical file in the trolley. He told the Commission:

*“He [Stephen Egan] had a large file... I would have written in his file from time to time because I would have seen him over the years. [It] would have been an obvious file...”*

The medical orderly who had interviewed Stephen Egan at reception on Saturday 29<sup>th</sup> July 2006 was not on duty on Sunday 30<sup>th</sup> July. The Commission has been unable to confirm whether the

orderly who accompanied [Doctor E] on his Sunday round was aware of Mr Egan's presence in the "B Base" at that time.

Following the death of Gary Douch, an investigation into the medical aspects of Stephen Egan's care was conducted by Dr Enda Dooley, the Director of Prison Health Care for the Irish Prison Service. In a report dated 11<sup>th</sup> January 2007 Dr Dooley concluded:

*"Following on [Stephen Egan's] transfer to Mountjoy there was a failure to –*

- Assess his needs in line with the stated recommendations in the IPS Healthcare Standards*
- Document the nature of the interaction that occurred, his alleged refusal to engage medically or accept medication*
- Arising from a) and b) to ensure that irrespective of his claimed refusal he be brought to the direct attention of the Prison Doctor and*
- To ensure that his prescribed treatment was maintained. There is no record available which would confirm that this occurred".*

Dr Dooley's report went on to state:

*"While the apparent failures might be attributed to individual failure I believe that, if recommendation for remedial action is required this should focus on the review of the management systems in place.*

*The core issue highlighted by these events is the lack of both direct healthcare management in Mountjoy Prison and the associated lack of involvement of prison management in overseeing aspects of healthcare provision. This contributed to a lack of accountability, supervision, and oversight in relation to day to day healthcare practice... Various expediciencies have developed over time which would not conform with best practice in the healthcare area with the ultimate result that efforts to improve standards and accountability using the documented Standards have proven consistently difficult to implement.*

*Secondly, the apparent lack of documentation outlining the health care intervention in Mountjoy is contrary to all recommended health procedure and presents a huge risk to the organisation. From a healthcare perspective I am at a loss to explain this avoidance of documentation. I am aware, however, that contrary to healthcare practice which dictates that you record all interventions the prison system has developed a culture of avoidance of accountability in this area. This may, to some extent, explain this present situation but certainly does not excuse it”.*

## **Possible Return to Cloverhill Prison**

The Commission has been told that all inter-prison transfers took place on a “return spring” basis – that is to say, with the understanding that the transferred prisoner could be returned in the event of his failing to settle at the prison to which he had been transferred. [Chief Officer B] described this policy to the Commission as follows:

*“It is a general agreement between Chiefs throughout the country that if you take a prisoner and he gives you problems that the sending prison would take him back. We call it a ‘return spring’ – that if he causes any problems he goes back to the institution he came from”.*

When asked how frequently this policy might be invoked by Mountjoy, [Chief Officer B] stated:

*“It does happen on occasion – not that often... Obviously you will get the odd individual who you would have to pick up the phone and say ‘Listen, this fella is causing problems for me, you will have to take him back’, and depending if they still had the individual that you sent, they would probably swap him back for him, or they will give you another name to look up”.*

From the information available to the Commission, it seems that the possibility of invoking the return spring policy in relation to Stephen Egan was not considered by the management at Mountjoy Prison at any time between 29<sup>th</sup> and 31<sup>st</sup> July 2006.

With the benefit of hindsight it is easy to suggest that Mountjoy should have insisted on Cloverhill taking Mr Egan back at some stage over that weekend. However, the decision not to do so must be evaluated in light of the information available to the relevant Governors and prison staff at the time. There are a number of factors which the Commission considers are of particular importance in this regard, which are set out below.

## **Relevant factors**

- The duty Governor from 29<sup>th</sup> July 2006 was Deputy Governor Barclay, assisted by [Chief Officer B]. Both men had negotiated the transfer deal which had resulted in Stephen Egan being sent to Mountjoy. They did so on the basis of a relationship of trust with their counterparts in Cloverhill. Deputy Governor Barclay told the Commission he was assured that Stephen Egan had not given any problems since his return from the CMH, and this evidence has not been contested.
- Governor Barclay was dealing with severe overcrowding in Mountjoy on the 29<sup>th</sup> 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 29<sup>th</sup> July.
- Deputy Governor Barclay did not know that Governors Salley and Lonergan had refused to take Stephen Egan when he was discharged from the CMH on 14<sup>th</sup> July 2006.
- Deputy Governor Barclay and [Chief Officer B] had both dealt with Stephen Egan on numerous occasions. They were aware of his potential for violence and disruption, but believed, based on past experience, that he could be managed at Mountjoy Prison if an appropriate cell could be found for him.
- Deputy Governor Barclay and [Chief Officer B] both took the opportunity to meet Stephen Egan on his arrival Mountjoy in order to assess his attitude and demeanour. Both observed a considerable improvement, compared with his behaviour in June 2006, prior to his transfer to the Central Mental Hospital.

- Stephen Egan showed no signs of troubling or disruptive behaviour during 29-30<sup>th</sup> July. Although he had asked to be housed in a cell on one of the main wings in the prison, he did not object to being kept in the B Base over the weekend, pending the evaluation of his request. This good behaviour continued on Monday 31<sup>st</sup> July according to [Assistant Chief Officer D], who was in charge of the B Base area from 8am to 8pm on that day:

*“He didn’t present any problems to me that day. He took part in the routine of what happened to the other chaps in that cell on that day... He did not stick out to me that day for any particular reason.”*

- When Stephen Egan arrived at Mountjoy, Deputy Governor Barclay believed that it would be possible to find a suitable placement for him on one of the main wings in the prison. This option was not finally ruled out until the afternoon or possibly early evening of 31<sup>st</sup> July 2006, following further enquiries by [Chief Officer B] (on Deputy Governor Barclay’s instruction). Even at this stage, there remained a possibility of accommodating Mr Egan on the Medical Unit – a possibility which at that stage could not be explored until the next day. Accordingly, if Gary Douch had not been attacked and killed on the night of 31<sup>st</sup> July 2006, it is possible that Stephen Egan might have been moved out of Holding Cell 2 on the following day.
- Throughout the period 29-31<sup>st</sup> July 2006, the Governors and prison officers responsible for Stephen Egan’s management remained unaware that he had not been seen by a doctor and was not being given his prescribed anti-psychotic medication.

## **Conflict of evidence**

Governor Salley assumed overall control of Mountjoy Prison from Deputy Governor Barclay on the morning of 31<sup>st</sup> July 2006. As was made clear earlier in this report,<sup>65</sup> the Commission has received conflicting evidence concerning Governor Salley’s state of knowledge regarding Stephen Egan. Governor Salley is clear in his recollection that he did not know Stephen Egan

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<sup>65</sup> See the section above entitled ‘Management of Stephen Egan in “B Base”’.

was in Mountjoy on 31<sup>st</sup> July. Deputy Governor Barclay is equally clear in his recollection that he informed Governor Salley of Stephen Egan's presence at the Governors' meeting on that morning.

In considering this matter, the Commission must also consider the other opportunities which Governor Salley had to discover Stephen Egan's presence in the prison, including his review of the Governor's Parade Book and his inspection of cells in the B Base. It has to be conceded that no one could expect Governors could personally be aware of every single prisoner in the prison on a given day (over 500 prisoners in Mountjoy on the day in question).

Despite the best efforts of the Commission, it has not proved possible to resolve the conflict of evidence regarding Governor Salley's state of knowledge on 31<sup>st</sup> July 2006. Even if it were possible to do so, the Commission considers that this would not significantly alter its conclusions in relation to its Terms of Reference, for the following reasons:

- Both Governor Salley and Deputy Governor Barclay are highly regarded, dedicated, competent individuals who were given the near-impossible task of managing a grossly overcrowded prison with insufficient resources.
- Leaving aside the issue of whether Governor Salley knew or ought to have known that Stephen Egan was in Mountjoy on 31<sup>st</sup> 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:
  - i) that he had been transferred to Mountjoy without the knowledge or consent of the Psychiatric In-reach Service at Cloverhill;
  - ii) that he was not seen by a doctor or by any member of the Psychiatric In-Reach Service in Mountjoy over the period 29-31<sup>st</sup> July 2006; and
  - iii) that he was not receiving his prescribed anti-psychotic medication.
- Governor Salley has told the Commission that, if he had been aware that Stephen Egan was in the B Base Holding Cell 2 on the morning of 31<sup>st</sup> July 2006, he would have

immediately tried to move him, either to a single occupancy cell or out of the prison altogether. In support of this, Governor Salley referred to the occasion on 14<sup>th</sup> July 2006 (the day of Mr Egan's discharge from the CMH) when he refused a request, not once but twice, from Cloverhill to take Mr Egan. The Commission fully accepts that Governor Salley did not consider Mountjoy in 2006 to be an appropriate place for Stephen Egan, and understands his feeling that, had circumstances been different, he might have been able to prevent the tragedy which occurred. However, his evidence in this regard, though undoubtedly genuinely felt, can only at this remove be considered hypothetical in nature. It cannot be said for certain that he would have sought to move Mr Egan immediately, or that it would have proved possible to do so before lockdown on the evening of 31<sup>st</sup> July 2006. To compare hypothetical responses and consequences with the decisions actually taken by Deputy Governor Barclay and the other prison officers who managed Stephen Egan on that day would, in the Commission's view, be unhelpful and potentially unfair.

- The Commission acknowledges the toll the tragic death of Gary Douch at the hands of Stephen Egan has had on both these Governors, both of whom carry heavy burdens of regret for things they might – had their information and knowledge been different – have done differently. They share a deep sadness for the family of Gary Douch, and believe that his death was preventable. They also share a belief that in the ordinary course of events that the following day Stephen Egan would have been moved elsewhere had the cascade of perverse events not placed Gary Douch's life at the mercy of this mentally ill and violent young man on the night of the 31<sup>st</sup> July 2006.

It was the case that within a short period of Egan's arrival on 29<sup>th</sup> July, both Deputy Governor Colm Barclay and [Chief Officer B] were aware that he could not be housed in any of the main wings of the prison. By the morning of 31<sup>st</sup> July 2006 this situation had not changed. Nonetheless, rather than seek to return him to Cloverhill, on the notional and it has to be said, rarely used "return spring" option, it was decided to continue to keep Mr Egan in Holding Cell 2 overnight, with a view to seeing on the following day whether he could be placed in the area of Mountjoy known as the Medical Unit. However, the question of whether a suitable place could have been found for Mr Egan in that unit was rendered moot by the killing of Gary Douch on the night of the 31<sup>st</sup> July.



As indicated elsewhere in this report, the management of Cloverhill Prison had initially sought to move Stephen Egan to Mountjoy on 14<sup>th</sup> July 2006, even before he arrived there from the Central Mental Hospital. That request was refused by Governor Salley of Mountjoy on the basis that Mountjoy did not have appropriate medical facilities or accommodation for him. Governor Salley was not on duty when Stephen Egan arrived in Mountjoy on Saturday 29<sup>th</sup> July 2006, but he was on duty on Monday 31<sup>st</sup> July. In relation to the issue of whether Stephen Egan should have been returned to Cloverhill, Governor Salley told the Commission:

*“Stephen Egan was never going to get back up on the landings in Mountjoy. He was never going to be able to mix back in Mountjoy. Chief Kelly’s report... indicates that. I think [that] became apparent on Saturday, certainly Sunday that he was in the Base to stay. At that time he should have been transferred back, yes”.*

Governor Salley told the Commission that he was not aware of any discussions taking place on 31<sup>st</sup> July concerning a possible return of Stephen Egan to Cloverhill Prison.

- The Commission concludes having investigated the matter thoroughly, that it would be extremely unfair to hold either of these Governors to blame for the tragic death of Gary Douch. Gary Douch’s death was caused by system wide failures.

## 3.2 Death of Gary Douch, 1 August 2006

### Request for Protection

On Monday, 31<sup>st</sup> July 2006, Gary Douch was sharing cell 17 on C1 Wing, Mountjoy Prison with three other prisoners. In their statements to investigating Gardaí, all three prisoners said that Gary Douch expressed a desire to be moved from C Wing. One of his cellmates stated:

*“Gary was afraid he was going to be striped, that means cut on the face. He wouldn’t say who was going to do it. He didn’t say any name. He just made the gesture with his hand up to his face that he was going to be striped. I don’t know what it was about, he never told me anyway. He wanted to go to ‘A’ Wing or ‘B’ Wing. He didn’t want to go on protection... I thought he was very nervous. He was a hyper person anyway. When the officer was opening the door at 5.30 p.m. I heard Gary saying to them that he was having a problem with someone upstairs. He said that it was somebody on C3 but he didn’t say a name. He said that he wanted to go to ‘A’ Wing or ‘B’ Wing and the officers said that they would move him to the holding cell”.*

Another cellmate stated:

*“On Monday, 31<sup>st</sup> July 2006, we all had tea in the cell from 4.30 p.m. until 5.30 p.m. During the tea [Gary] was hyper and saying he wanted to get off the landing. He thought he was going to get a stripe. I don’t know off who, he just wanted to get off the landing... He didn’t want to go on protection but he wanted to get off the landing”.*

The third prisoner who was sharing cell 17 had been in the cell for two weeks. He claimed not to have known Gary Douch prior to this. He stated:

*“I had tea in the cell at 4.30pm. Gary was hyper but he was always like that. He was afraid he was going to get a stripe. We were saying to him he was only paranoid. I know Gary didn’t want to be in a four man cell. He wanted to get off the landing and go to A*

*or B Wing. He said he didn't want to go on protection. He never mentioned a name of anyone who was going to give him a stripe. I don't know who told him this".*

The cells on C1 landing were unlocked after the tea break, at 5.20p.m. Two of the prisoners left the cell for recreation. Gary Douch spoke to [Prison Officer E]. In a statement made to investigating Gardaí in August 2006 (a copy of which has been disclosed to the Commission) [Prison Officer E] stated:

*"Gary told me that he was afraid on the landing and that he wanted to be put on protection. Gary was afraid he was going to be striped, meaning slashed with a knife on the face. I asked him who he was afraid of but he said he couldn't say. He told me it was somebody on the landing. He wouldn't give a name or even say what it was all about. He said he had heard this over the tea break from his cell mates... He was agitated and seemed anxious to be moved off the landing".*

[Prison Officer E] locked Gary Douch into the cell. She then found and returned with the Assistant Chief Officer (ACO), [Assistant Chief Officer E]. In his statement to investigating Gardaí [Assistant Chief Officer E] described what happened next as follows:

*"I went into the cell. Gary was at the door. He started saying to me 'I have to get out of here'. He was anxious to transfer to the 'Base' as he called it. I knew this to mean 'B Base'. Gary told me that he was 'going to be done on C1'. Those were his exact words. I asked him who was going to do him. He replied, 'someone'. I asked Gary was he afraid of someone in his cell and he replied 'No, someone on the landing'. He wouldn't give me a name of anyone or a reason why he was frightened".*

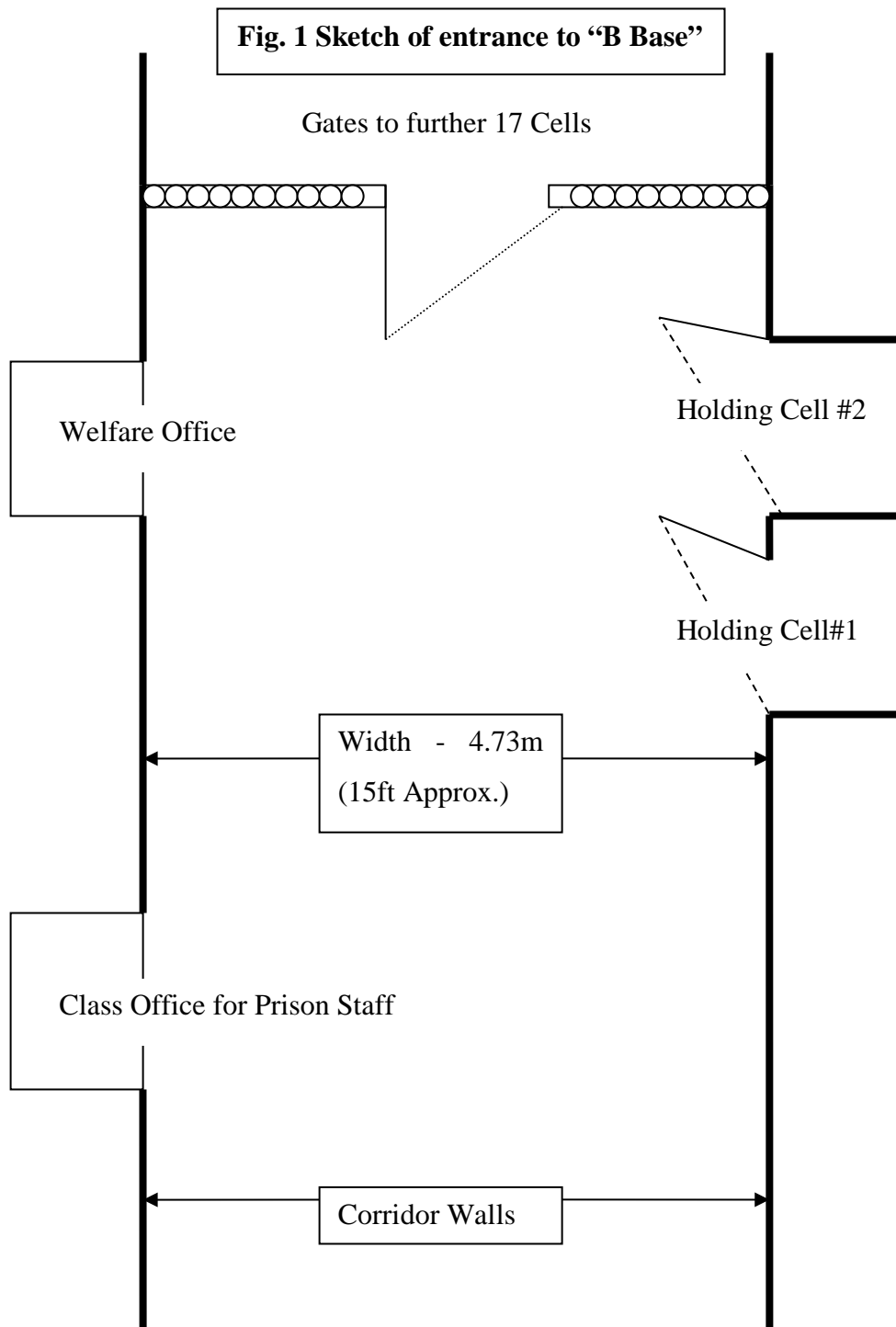
[Assistant Chief Officer E] then informed his superior, [Chief Officer D], of his conversation with Gary Douch. [Chief Officer D] told Gardaí:

*"I told [Assistant Chief Officer E] to arrange to have Gary Douch moved to 'B Base'. This would be a normal enough occurrence where prisoners look to be moved around... Once I gave him the instruction I knew it would be done. I had no further dealings with anyone in relation to this incident".*

## **Transfer to “B Base”**

The area known as “B Base” is in the basement of the main prison building at Mountjoy. In 2006 it contained a number of single cells which were used to house prisoners on protection. At the entrance to the Base area were two holding cells, which were intended to be used as a temporary holding area for prisoners awaiting placement on one of the main wings in the prison. Such prisoners might include new arrivals at the prison, or prisoners such as Gary Douch who needed to be moved from one wing of the prison to another for protection purposes.

The following sketch, taken from Mr Mellett’s report shows the location of Holding Cell 2 within the B Base area, as it was on 31<sup>st</sup> July 2006.



Gary Douch was escorted to “B Base” by [Prison Officer F], a prison officer who had started working in Mountjoy Prison in June 2006. [Prison Officer F] stated:

*“Gary Douch came from the cell with me. He seemed to know where he was going. Gary didn’t speak to me at all... It’s not a long distance to walk and he never spoke to me”.*

One of the prisoners in cell 17, who was present when [Prison Officer F] came to escort Gary Douch to “B Base”, told Gardaí:

*“When Gary left the cell he was fully convinced he was going to ‘A’ or ‘B’ Wing and that he was going to the holding cell for one night. The screw just said we will bring him down to the holding cell and then sort it out for him”.*

The officer who received Gary Douch into the basement area was [Prison Officer G]. He stated to Gardaí:

*“At about half past six or towards seven o’clock, prisoner Gary Douch was accompanied to the basement area with another Officer. I didn’t know the Officer’s name. I knew the prisoner Gary Douch; I’d have come across him before. The normal thing is when a prisoner comes down to the basement he’s placed in a holding cell... [Assistant Chief Officer E] had earlier informed us that Gary Douch was on protection. When Douch came down to the basement he said ‘I don’t want to go on protection’. He was told that he had to go in once he requested it. He had to go in until he [was] signed off it by the Governor”.*

The statement continued:

*“Both holding cells at the time had protection in it. There was six in one and there was four or five in the other. I went to put him in holding cell no.2, I think. I opened the door, stood at the door. Gary Douch could clearly see who was in the cell. At that he walked in and closed the door. Normally if there is a problem the prisoner bangs on the door or hits the red call light but this didn’t happen. The next thing I had to do with the cell was when it opened for the prisoners to get their tea, milk or water... That would have been at about ten past, twenty past seven. That was the last dealings I had with them”.*

[Prison Officer G] was questioned by the Commission concerning Gary Douch's statement that he didn't want to go on protection. [Prison Officer G] told the Commission that this statement

was made just as Gary entered the general area of “B Base”. [Prison Officer G] said the statement was not made to anyone in particular, and that he interpreted it as *"a bit of bravado... in case any of the ones inside or the other protection [prisoners] heard him"*. [Prison Officer G] told the Commission that *"there would be a stigma attached to going on protection"*.

[Prison Officer G]'s view is supported by the fact that Gary Douch entered voluntarily into Holding Cell 2 without any further protest. Nor did he make any complaint when the prisoners in Holding Cell 2 were let out to get their tea at around 7.20 p.m.

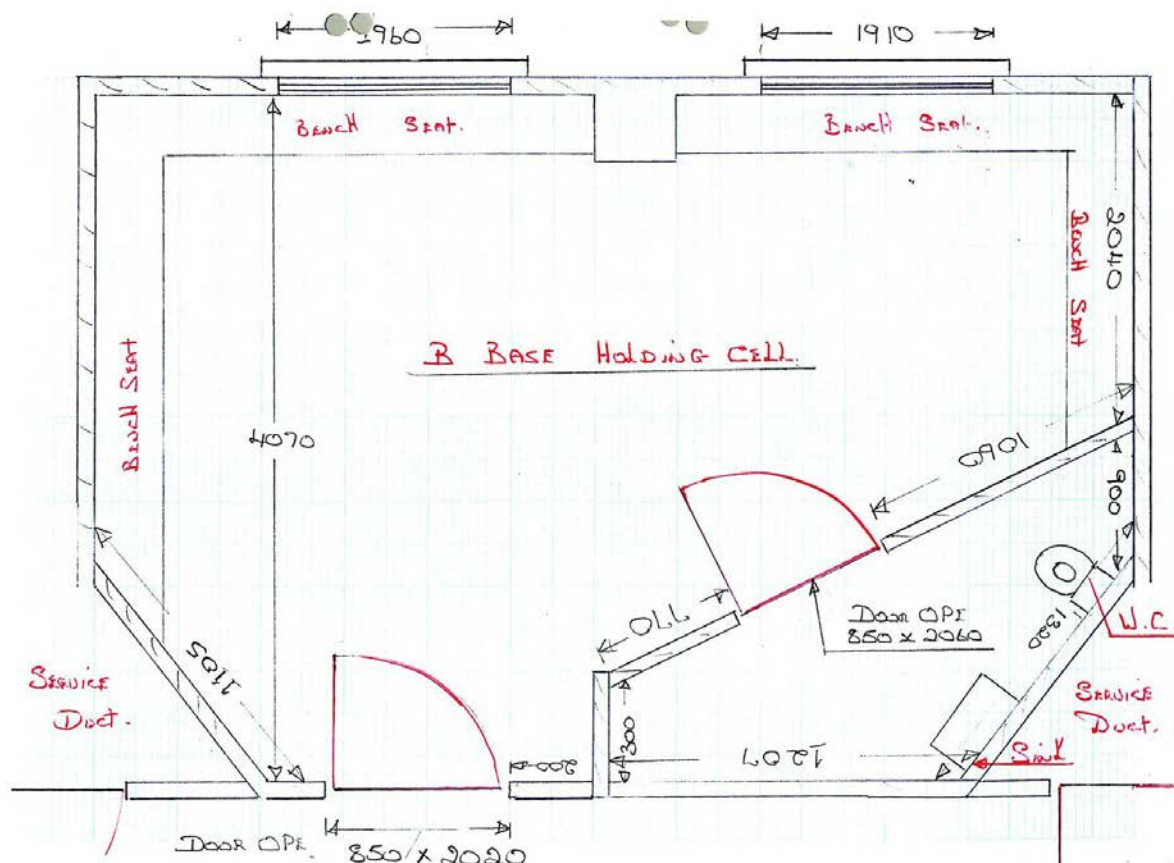
The holding cells in “B Base” were never intended to house prisoners on a long-term basis. The number and identity of those housed in the holding cells changed from day to day, and often from one hour to the next. For that reason, it is unlikely that Gary Douch would have known who was in Holding Cells 1 or 2 at the time he made his request to be moved from C Wing. However, it seems from [Prison Officer G]'s evidence that Mr Douch had the opportunity to see who was in Holding Cell 2 when the door was opened, before he entered the cell. [Prison Officer G] told the Commission that Gary Douch did not specifically object to being placed with any of the prisoners in Holding Cell 2. Had he done so, [Prison Officer G] says he would then have called the ACO down to deal with the matter.

From the information available to it, the Commission is satisfied that whilst Gary Douch may have expressed a general unwillingness to go on protection, he did not make any specific objections to being placed in Holding Cell 2 or to being placed with any of the prisoners in the cell at that time, including Stephen Egan.

## **Holding Cell 2, “B Base”**

The cell in which Gary Douch was placed on 31<sup>st</sup> July 2006 was located on the right hand side of the “B Base” area. It was approximately 15 feet across, 13 ½ feet deep and 9 feet high. Daylight entered the cell through two glass brick “windows”. A fixed wooden bench, approximately two feet from the concrete floor ran along the inside walls of the cell. One corner of the cell contained a toilet and wash hand basin, separated from the rest of the cell by a concrete wall

containing a steel door which opened outwards. The entrance door to the cell itself was also steel, and contained a viewing hole. The cell, which contained no beds, was intended for use as a place to hold prisoners for a minimal period of time before they were placed into dedicated sleeping cells.



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Unfortunately it has not been possible for the Commission to see the cell as it was in July 2006, as in the aftermath of Gary Douch's death, both holding cells in "B Base" were first closed down and subsequently demolished. The area occupied by the holding cells was then converted into three rooms – a tiled shower room, a special observation room (with a clear glass door), and a smaller holding cell. For that reason, the Commission in this section of its report relies heavily on the Report and investigation of Mr Michael Mellett, Senior Civil Servant who attended Mountjoy prison and visited the Base area within a matter of hours following the death of Gary Douch.

<sup>66</sup> Sketch taken from documents provided by Mellett Inquiry to the Commission.



## Conditions in Holding Cell 2

Mr Mellett pointed out in his report that Holding Cell 2 at that time was comprised of two ordinary cells, combined by removing the dividing wall, blocking up one of the doors and installing in-cell sanitation. There were two glass windows, covered with grilles. When Mr Mellett visited the cell on 1<sup>st</sup> August 2006, he found that most of the glass in the windows had been broken; it is generally accepted that it was broken over time by prisoners in order to allow some fresh air into the cell. The windows allowed some daylight into the holding cell but even so the level of day-light in the B Base area and Holding Cell 2 in particular was less than in other wings of the prison. Mr Mellett found that there was adequate artificial lighting in Holding Cell 2.

Mr Mellett noted in his report that the maximum temperature at Dublin Airport on 31 July 2006, as supplied by the Meteorological Service, was 19.4 degrees centigrade and the minimum was 13.1 degrees centigrade. The temperature in Holding Cell 2 could be expected to have been significantly higher than those outside readings considering that at times during that day there were up to 14 prisoners accommodated there, although the number was reduced to 7 by that evening. It is important to note also that while these holding cells are not intended to be used to hold even individual prisoners for long periods it is clear that some of the prisoners in Holding Cell 2, including Stephen Egan, had been there for up to three days prior to Mr Egan's attack on Gary Douch.

The only opportunity to clean Holding Cell 2 was during the one hour the prisoners were allowed out for exercise. However, Mr Mellett reported that even this opportunity did not necessarily arise every day due to the constant arrival of new prisoners. It was customary for a work party of prisoners to perform the cleaning function.

Mr Mellett visited Holding Cell 2 approximately eight hours after the body of Mr Douch had been discovered. His comments here about conditions relate solely to what he saw personally in Holding Cell 2 on that visit. The cell was then a preserved crime scene. Mr Mellett said that the conditions in the cell were dreadful. The windows were broken. The floor and walls were dirty. The toilet was filthy. There were faeces on the floor amid the duvets – although this can be

attributed to Stephen Egan, who deliberately smeared faeces on the body of Gary Douch following his assault. The duvets were soiled. The cell was infested with flies.

Although as a rule prisoners were supplied with clean sheets and a pillow case on arrival, Mr Mellett found little evidence to suggest that the duvets and/or mattresses which they used as bedding in 2006 received anything approaching proper cleaning. At that time the usual practice whenever the Holding Cells contained overnight prisoners was for the prisoners to place their duvets and mattresses in bins located on the landing when the cells were opened in the morning. Mr Mellett found that this bedding often remained there unwashed until required for further use, sometimes by other prisoners.

On 31<sup>st</sup> July 2006, it appears that not all of the prisoners in Holding Cell 2 had been supplied with mattresses for the night, although they were all given a duvet. The cell was consistently described as being very hot and inadequately ventilated. These were the conditions in which Gary Douch and Stephen Egan, amongst others, found themselves. As Mr Mellett observed in his report:

*“Clearly there were far too many prisoners in those holding cells during the day and, indeed, on the night of the 31 July. Holding so many prisoners in those cells was considered by staff to be unavoidable at the time because of pressure on accommodation. Holding cells are effectively waiting rooms and are meant to hold prisoners pending their allocation to regular accommodation elsewhere in the prison or dispersal to other prisons and then only for relatively short periods, certainly not for several days. Holding such a large number of prisoners in the appalling conditions described above cannot be justified on any grounds.”*

## **Prisoners in Holding Cell 2**

Gary Douch arrived in Holding Cell 2 at approximately 6.45p.m. There were five other prisoners in the cell at that time. 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 Commission was told by one of the prison officers on duty in the “B Base” on 31<sup>st</sup> July 2006 that the prisoners taken out of Holding Cell 2 were those who were not on protection:

*Q: In terms of the movement of prisoners from say Cell 2, how do you pick?*

*A: It was on the Numbers Book who was on protection and who wasn't.*

*Q: Right.*

*A: I was told there was X amount in that cell that had to be taken out, they weren't on protection. So the mix wouldn't be desirable. So we had to take them out then.*

*Q: That is basically what you are told, that anyone on protection...*

*A: Yeah.*

*Q: To be separated.*

*A: Well actually the lads that weren't on protection we took out”.*

The prisoners who were brought to the reception area remained there, under supervision, for the night. The Commission has been told that there were building works going on in the reception area at the time, so that the lack of proper sleeping facilities in this area was compounded by dirt and dust from the construction work. Conditions in the area at that time were described by the prison officer who supervised these prisoners on the night of 31<sup>st</sup> July as “*terrible – really bad*”.

The remaining inmates of Holding Cell 2 were issued with bedding, and the cells were then locked.

None of the seven prisoners who were moved to the reception area recalled any problems arising between any prisoners during the hours they were in Holding Cell 2. The only suggestion of possible discontent is found in a Garda memo of a conversation with one prisoner, which states:

*“He described the atmosphere as ‘good’ and there was no problems. In fact the only problem 2 or 3 of the lads had was that they couldn’t get any ‘gear’ as they were in the base. He did not name these lads”.*

The Commission has spoken to some of the prisoners who were in Holding Cell 2 and they confirmed that the atmosphere in the cell had been good over the course of the night.

In his report to the Minister, Mr Mellett gave the following profile of the prisoners who were kept in Holding Cell 2 overnight:

*“The prisoners in Holding Cell 2 had been convicted of various offences including Assault, Burglary, Theft, Armed Robbery and Manslaughter. Several of those prisoners had been in the prison for some time and some of them had been in prison on at least one previous occasion. Some of them had a history of drug abuse. They varied in age. The youngest was just 18 years old. He was admitted to Holding Cell 2 at 8.45pm, having returned from the Mater Hospital. Mr Douch was 21 years old. Stephen Egan was a 22 year old who had psychiatric problems and a history of extreme violence. The other prisoners were around the same age or slightly older.”*

As stated earlier in the Commission’s report, each of the prisoners kept in Holding Cell 2 overnight had been given protection status, for a variety of reasons. The Commission has learned that each prisoner had many problems and personal difficulties of his own. Very few of them had met any of the others in the cell beforehand. Some had serious substance abuse problems; others had ill health, prior mental health problems and others were recovering from physical injuries.

## **Summary of what transpired in Holding Cell 2 ‘B Base’, on 31st July/1st August 2006**

The following account of what took place in Holding Cell 2 on the night Gary Douch was killed is based on information obtained from a variety of sources, including documents disclosed to the Commission by the Irish Prison Service, An Garda Síochána, the National Forensic Mental Health Service, independent consultant psychiatrist Professor Tom Fahy and Mr Michael Mellett, as well as interviews conducted with relevant persons and other information obtained by the Commission in the course of its inquiries.

From all accounts relations were good amongst the prisoners in Holding Cell 2, certainly during the earlier part of the evening of 31<sup>st</sup> July and early morning of 1 August. Some of the prisoners stated that Mr Douch and Stephen Egan were talking at one point about “*old times*”. While relations between them appeared good, Mr Douch seemed to be wary of Stephen Egan, repeatedly asking “*if things were ok*” between them.

As previously stated, there were seven prisoners in the holding cell at the time the attack occurred. Some of them had arrived that day, while others had been there for a number of days. There were 6 prisoners in Holding Cell 1. In the course of his inquiries Mr Michael Mellett talked to almost all of the prisoners who had been in Holding Cells 1 and 2 that night. They told him that there had been regular verbal communication between the two cells via the broken windows. The levels of detail supplied by the prisoners in relation to what they knew or were prepared to say about the attack varied. For example, one prisoner refused to say anything at all while another stated he was under the influence of illicit drugs and consequently knew nothing of what had occurred until unlock later that morning.

Nevertheless, a considerable amount of information was gathered from those who spoke frankly to Mr Mellett. The Commission agrees with Mr Mellett that the circumstances of an inquiry into an event of such seriousness in a prison, necessitates extreme caution in the assessment and evaluation of the information collected. It was helpful that once it became apparent on the morning of 1st August that a serious attack had occurred, each of the prisoners was isolated by

the prison authorities and some were even moved to other prisons. This procedure greatly diminished the opportunity to concoct or coordinate a single version of events. While some of the accounts vary, the Commission shares Mr Mellett's belief that there is sufficient consistency running through them to allow a reasonably accurate picture of how the events unfolded in the cell that night to emerge.

All of the prisoners stated that the mood in the cell up to the time of the attack had been good. Tea and milk was supplied by the prison staff and prisoners were sharing what they had by way of cigarettes and possibly illicit drugs and alcohol. A number of prisoners, including Mr Douch, were playing cards and there was, early on in the night, lively conversation amongst themselves and with the inmates in the cell next to them. Stephen Egan was lying on his mattress apparently listening to a personal stereo with earphones and keeping largely to himself.

A number of the prisoners made reference to unusual behaviour on the part of Stephen Egan as the evening wore on. One of the prisoners who knew him previously, stated: "*he wasn't the person I used to know*". The Commission heard evidence to suggest that Mr Egan appeared to be talking to himself mainly but also aloud occasionally about rapes of a female and "beasts" and kept calling out the names of various individuals who had gained some degree of notoriety within the prison system in the past. None of his utterances related to anything that was being discussed by the rest of the prisoners in the cell at the time and seemed incongruous. Stephen Egan said subsequently that while he was in Holding Cell 2 that night he was constantly "*hearing voices*" in his head.

All of the prisoners were vague on what time the lights were turned out in the cell. As we have seen, the evidence from the prison officers on duty was that a night light was put on in place of the main light at about 10.15 p.m.

Mr Mellett in his report stated:

*"Some of the prisoners described the sleeping arrangements in the Holding Cell 2. Mr Douch, they said, was sleeping on a bench which runs around three sides of the cell while Prisoner A [Stephen Egan] lay on a mattress on the floor. There was another prisoner between Mr Douch and Prisoner A. It appears that in the early hours of the*

*morning, as it was getting bright, this prisoner was awoken suddenly when stood on by Prisoner A as he approached Mr Douch.*

What followed was Mr Douch receiving a savage beating. He was punched and kicked in the head and upper body by Stephen Egan.

In his own account of the attack Stephen Egan himself described the ferocity of the assault which took place. He also alleged that a second prisoner was also involved in the attack although no other evidence supports that contention. One prisoner stated that as far as he could determine, Mr Douch was unconscious within minutes of the start of the attack.

In ordinary circumstances, one might expect that a violent and frenzied attack such as that carried out by Stephen Egan on Gary Douch would have resulted in enough noise to attract the attention of the prison officers on duty in B Base. However, from the evidence available to the Commission it has not been possible to establish with certainty that the assault was audible to anyone outside of Holding Cell 2 itself. This issue is discussed in more detail in the subsection which deals with supervision of the B Base area.

What can be said is that there were understandable reasons why the other prisoners who were in Holding Cell 2 did not attempt to raise the alarm when the assault took place. For these other five men, strangers to each other, closeted together in an overcrowded cell, either asleep or trying to sleep, it is hard to imagine the level of confusion, shock and outright terror which the suddenness and ferocity of Mr Egan's assault must have caused.

The prisoners who were prepared to speak to Mr Mellett and / or the Commission claimed they were terrified of what the consequences might be for them if they alerted the staff to what was happening at that time. None of them dared to physically intervene although several remonstrated verbally with Stephen Egan and no one imagined that the assault would end in the death of Gary Douch. They believed they ran the very real risk of being attacked themselves by Stephen Egan if they raised the alarm or tried to intervene. They were also fully aware that it could take some time for staff to come and rescue them if they were to raise the alarm and then be attacked by Stephen Egan as a result. Prisoners knew that the door could not be opened from outside at night until the Assistant Chief Officer in charge of the entire prison could be found and the master lock to the B Base cells opened. The prisoners also knew that one or two officers

would not be able to open a cell with 7 prisoners in it without assembling about 10 officers to assist them – particularly in circumstances where a violent incident was taking place.

The evidence from all sources (including from Stephen Egan himself) strongly points to the fact that Stephen Egan was in an extremely psychotic state at the time of this unprovoked, unexpected assault which came suddenly out of the blue, when the prisoners were sleeping and in near darkness. The accounts provided to the Commission describe Stephen Egan as being fuelled with rage and violent intent as he assaulted Gary Douch, without any provocation whatsoever, exhibiting throughout the attack some of his prior irrational preoccupations, such as falsely accusing Gary Douch of being a “beast” and of being responsible for some unspecified rapes. In shock, and woken suddenly from sleep, the prisoners in the cell instinctively shared a real fear that Stephen Egan was completely unstoppable in this state and that they lacked the ability to restrain him or overpower him even if they had been able to respond quickly and in unison.

The accounts provided to the Commission also echo strongly with descriptions of Stephen Egan’s behaviour on the transport from Cork Prison to Cloverhill on the 27<sup>th</sup> November 2005 when he violently assaulted a Prison Officer without any prior warning by suddenly putting his rigid bar handcuffs around her throat. On that occasion it took every ounce of strength, professional control and restraint training from a number of prison officers on a bus containing no less than nine officers - as well as an immediate instinctive heroic response by [Prison Officer A] and by [Prison Officer B] who came immediately to his aid – followed by the trojan efforts of all the other trained officers to restrain Mr Egan. And even then some of the officers sustained significant injuries.

Accounts of how long Mr Egan’s assault on Gary Douch lasted vary, but the evidence before the Commission suggests that it lasted at least 10-15 minutes and possibly longer. After the attack, Stephen Egan apparently went to the toilet area to wash himself, having obtained a plastic bag which he subsequently defecated in. While he was doing this some of the prisoners say that they went to Gary Douch’s aid removing bedding from his face and placing a pillow under his head to aid his breathing. There is also evidence to suggest that the prisoners attempted to alert the officers on duty by trying to pour liquid (tea and milk) and squirting toothpaste under the door of the cell into the landing, but to no avail. Neither of the prison officers on duty noticed such



material but one officer did say that even if they had, it would not be in any way unusual to see liquids, such as tea or coffee, seep out from under the cell doors, having leaked from containers or refuse sacks provided in the cells. When he came out of the bathroom Stephen Egan smeared the face and ears of Gary Douch with his own faeces.

## **Supervision of “B Base”**

The following account of how the “B Base” area was managed in July 2006 relies principally on information provided to the Commission by prison officers and senior management who were working in Mountjoy Prison at the relevant time.

The “B Base” area, including the holding cells, was supervised at night by two prison officers. The officers took it in turns to patrol the area, 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. In the context of proving that there were regular and proper inspections of the cells and their occupants, Mr Mellett observed that the system served little purpose as all that was proven was that the system was activated at a particular time. It did not prove that the officer actually looked into each and every cell. Furthermore, as the electronic “pens” with which the officers make the recordings are not personalised there was no way of identifying which officer activated the system at any given time. In July / August 2006 there was no facility for CCTV supervision of the B Base area: if there were it could have been useful in verifying whether or not real inspections of the cells were carried out.

In between rounds the officers were based in a room near the entrance to the Base area, on the opposite side to the holding cells. The distance from the officers’ room to Holding Cell 2 was approximately 20 feet.

Once the cells are locked up for the night at 8 p.m., the prison officers on duty in the “B Base” cannot open those cells. The keys to the cells are kept by an Assistant Chief Officer (ACO), who has overall responsibility for the prison once the Governors and Chief Officers have gone home.

[Assistant Chief Officer C], who was on duty in Mountjoy Prison on the night of 31<sup>st</sup> July 2006, told the Commission:

*“You come in on a situation like that on nights you are totally in charge. You are the Governor; you are in charge of everything. You make all the decisions. Nobody moves a cell. Nobody does anything without the Assistant Chief Officer giving the go ahead”.*

The two prison officers in charge of Holding Cell 2 on the night of Monday 31<sup>st</sup> July 2006 were [Prison Officer I] and [Prison Officer H]. Statements were taken from both men by Gardaí on 1<sup>st</sup> August 2006. Both officers have also given evidence to the Commission.

According to [Prison Officer I], they gave tea and cereal to the occupants of Holding Cell 2 at around 9.45 p.m. At about 10.15 p.m. the prisoners in the cell requested that the “blue lights” be switched on:

*“This means that we can see them from outside the cell but they can still sleep”.*

In relation to the periodic supervision of the cell during the night, [Prison Officer I] states:

*“Approximately every half hour we would have gone around all of the cells under our supervision to check the prisoners. This included holding cell 1 and 2”.*

However, [Prison Officer H] states that he checked holding cell 2 “about every 15 to 20 minutes”. He explains that this was because prisoners in the holding cells were deemed “special observation” or “special obs” prisoners:

*“In relation to prisoners on special obs, the prisoners are checked every 15 to 20 minutes because of their status. Special obs would be committal prisoners, prisoners who have been transferred and a lot of prisoners down in the basement are on protection, so we have to check them at regular intervals... The prisoners in holding cell number two were all on protection”.*

Records obtained from the electronic recording system in the Base indicate that the area was checked approximately every 30 minutes from midnight on 31<sup>st</sup> July 2006. The last of these checks took place at 6.05 a.m. on the following morning. At 6.30 a.m. the master lock was

removed from all cells in the B Base area. The door to Holding Cell 2 was opened by the officers at around 6.50 a.m.

An IPS internal investigation report into the death of Gary Douch, submitted to the Tánaiste in March 2007, confirmed that checks should have been carried out on the prisoners in B Base every 15 minutes:

*“Prisoners located in B Base are designated as special observation prisoners and the standing order in Mountjoy is that such prisoners should be checked every 15 minutes.*

*The Prison Electronic Recording System indicated that the B Base was checked on average every 30 minutes from midnight to 6.05 a.m. on 1 August 2006.*

*It is clear that the checks of the cells in the B Base were not carried out in line with set procedures.*

*Our investigation has concluded that checks of the cells in B Base were not carried out in line with the above instruction.”*

As stated earlier, [Prison Officer H] told the Commission that Holding Cell 2 was checked every 15 to 20 minutes because it contained protection prisoners. Although it is possible that a separate check was carried out on Holding Cell 2 in between the half-hourly patrols of the entire Base area, this cannot be proven. As the holding cells were very close to the area where the officers were based in between patrols, it would certainly have been easy for an officer to carry out a quick check of the holding cells in between the carrying out of patrols. In the absence of CCTV footage or any other form of supervision, the Commission has only the evidence of the officers themselves that such checks were carried out.

Checking prisoners simply meant looking through the viewing hatch in the door of the cell to see if everything was okay. The level of visibility was limited, particularly at night. In the case of Holding Cell 2 on the night in question, visibility was undoubtedly made worse by the presence of so many prisoners and their respective belongings on the floor and on the bench in the cell. This resulted in a very limited means of supervision, as [Prison Officer I] described to the Commission:

*“A: ... Because of the fellas being there all the time the glass has been scored and scratched, to the point really it is like looking at something on a foggy day. If someone were to ask me in a bright light what colour someone’s eyes were, I wouldn’t be able to tell with the quality of glass that was in the door. But just to see the body shapes and the people in the cell, you will be able to count guidelines. If someone was to ask you what type of runners was one of the prisoners wearing, you wouldn’t have a hope of identifying them from looking outside the door into the cell, in a bright light, blue light, or dark light. You wouldn’t have a chance. The vision was very unclear.*

*Q: In terms of the vision of the full extent of the cell, when you look in the door of Holding Cell 2, could you see every corner of the cell?*

*A: Well you could see every corner. I would say to the far right would be difficult enough. It was often the case in the other cells, which have a similar layout within the Base, the toilet door that is available opens outward. What prisoners tend to do, whether by accident or whether they do it on purpose, they leave the door open, and throughout that night in fact, as is still the case, you would often end up waking prisoners up, putting on the bright light and asking them to close the toilet door so that you could see into the right hand corner where the beds were. It is a similar shape as the holding cell, and over to the far right may not be as easy to see...*

*Q: From your experience in terms of being required to look into the cells, was that a satisfactory way of being able to supervise what was going on in the cells?*

*A: Had there been just two prisoners in the cell it is a satisfactory way. You see if the glass is clear you can rest assured you can look in and you will even see, you don’t need to wake the lad who is asleep or whatever, you just need to see him breathing...*

*But with that cell, with seven prisoners in it, no it wasn’t a satisfactory level of viewing for the cell and the amount of prisoners that are in it”.*

According to both officers, the atmosphere in Holding Cell 2 appeared to be good throughout the night. [Prison Officer H] states:

*“In holding cell number two there was laughing and joking coming out of the cell at different periods during the night. All of the prisoners seemed to be in good form and there was nothing out of the ordinary that happened. I certainly didn’t hear any arguing or shouting going on in the cell. The last time I checked the cell was at 6.30 a.m. on the 1<sup>st</sup> of August 2006. All of the prisoners appeared to be asleep in the cell and there wasn’t any noise coming from it”.*

[Prison Officer I] supports this description of events, stating:

*“A couple of times throughout the night I had to tell the prisoners in holding cell 2 to keep the noise down. They were awake all night. I didn’t hear any argument as such but they were noisy... There was also unified laughing coming from holding cell 2 throughout the night, right up until half six in the morning. At half six I did a check on holding cell 2. The 7 prisoners were either lying or sitting down but everything appeared normal”.*

In relation to Gary Douch he states:

*“...when I checked the prisoners at 6.30 a.m. I could see Gary Douch lying down. Between the blue lighting and the observation glass on the cell door it is difficult to be accurate of someone’s physical condition”.*

In his second statement to Gardaí, dated 9<sup>th</sup> August 2006, [Prison Officer I] recalled two occasions during the night in which he had communication with prisoners in holding cell 2:

*“...I recollect at around 1.45 a.m. on the 1.8.2006 the prisoner [sic] in holding cell 2 requested milk. I told them it wasn’t possible and that I’d given them all the milk that was available before lock-up earlier that evening. I can’t remember who exactly asked me for the milk.*

*Just after 4 a.m. I remember the prisoner who I think to be Gary Douch requesting the toilet light to be turned on. I did so immediately but the light mustn’t have come on. He shouted out to turn on the light and after flicking at the switches it eventually came on. He thanked me and I heard a prisoner saying from inside the cell door ‘he thinks we are*

*winding him up'. When prisoners call us or ask us to do things on nights they often do it so as to disturb the officer from other tasks or duties that he may be carrying out. In this case it was as if to say that the toilet light had been on all the time. I'm not 100% sure that it was Douch asking for the light to be turned on".*

The light switches for Holding Cell 2 were adjacent to the cell door on the outside of the cell. It is not clear whether [Prison Officer I] looked into the cell at this time. Even he did so; visibility into the cell was so poor that it would have been almost impossible to identify with certainty which prisoner was speaking.

[Prison Officer I] also gave further details concerning his observation of the prisoners in holding cell 2 at 6.30 a.m.:

*"When I checked the prisoners at 6.30 a.m. Gary Douch was lying down with his head nearest the door and his feet pointing away from the door. I could see his head, it just appeared to me that he was sleeping. He was lying on his left hand side. He was lying on a mattress. He may have had a pillow or a folded up duvet under the head..."*

The prison officers on duty in the B Base reported to [Assistant Chief Officer C], who was the senior officer in charge of the entire prison for the duration of the night shift and as such, bore ultimate responsibility for the supervision of all staff on duty in the various wings of the prison that night. Having interviewed [Assistant Chief Officer C] about the events of 31<sup>st</sup> July / 1<sup>st</sup> August 2006 Mr Mellett stated in his report:

*"The ACO in question was frank and honest enough to admit that he did not visit the B Base at any stage during the night. He suggested that there was no need to visit these staff due to their level of experience and competence."*

Although it is true that [Assistant Chief Officer C] did not visit the B Base once the cells were locked for the night, it should be noted that he had visited the area shortly after coming on duty at 8 p.m. In fact it was [Assistant Chief Officer C] who made the decision to remove 7 of the 14 prisoners who were then in Holding Cell 2 and place them in the Reception area. He told the Commission that he was alerted to the chronic overcrowding in Holding Cell 2 when he reviewed the Numbers Book for the entire prison at the outset of his shift. He went down to see

the situation for himself, discussed the matter with the two officers on duty and decided that 7 prisoners should be moved to the Reception area.

In order to facilitate this, [Assistant Chief Officer C] had to ask a prison officer who was going off duty to work an additional 12-hour shift. Without that prison officer's co-operation, there would have been no-one available to supervise the prisoners in the Reception area overnight – every other officer in the prison was occupied with existing duties.

When asked by the Commission about the absence of spot checks and inspections of the officers in B Base, [Assistant Chief Officer C] indicated that in his view it was not possible for one ACO, in charge of the entire prison, to conduct meaningful spot checks on the prison officers to ensure that they were carrying out their duties:

*“...you would have to stand there and watch that they check them every 15 minutes, and you would do nothing all night – you would never check them properly... It is not practical.”*

[Assistant Chief Officer C] also pointed out that he would have had to carry out similar checks of the officers working in C Wing and in any other area of the prison containing protection or special observation prisoners. In that regard, it should be remembered also that as the ACO in charge of the prison overnight, he would have needed to remain available to a potential call for assistance from any section of the prison. Finally, [Assistant Chief Officer C] reiterated that the two officers on duty in the Base area that night were “*very good, experienced officers*” on whom he felt he could rely to perform their duties honestly.

Regardless of the experience and competence of the staff in the B Base on the night of 31<sup>st</sup> July 2006, the Commission shares the view put forward by Mr Mellett in his report that as a reason for not inspecting them, it is unsustainable. It is an inherent part of the ACO's supervisory role that he actually inspects the officers at their various locations. The Commission is inclined to agree with Mr Mellett that this needs to be made clear to the staff and that some record of inspections by the ACO on his rounds, should be kept. In light of this need for inspections, the Commission also considers that it is unsafe to leave the entire prison in the charge of one ACO at night.

The holding cells in the B Base area were fitted with a button which activated a red light outside and inside the cell door. Once activated, the light could only be switched off from outside by the staff. Mr Mellett reported:

*“This device is used by prisoners to signal to staff that they need attention. In general, the device is used for all manner of requests and consequently its use as an alarm is greatly compromised. Prisoners have stated that it can take up to forty minutes or more to get a response. This is disputed by staff who say they would normally respond within a matter of a few minutes. This I believe to be the case in the most favourable circumstances. On late night visits to Mountjoy I saw several cells with their red lights activated and officers were in the process of responding to them. However, a substantial period of time could elapse if a large number of prisoners were seeking assistance at the same time. This time factor also influenced the decision of the prisoners not to use this call system to alert the staff to what was happening in Holding Cell 2. If a prisoner had operated it all the other prisoners would have known he had done so, possibly provoking a fresh attack on him from Prisoner A [Stephen Egan]. Prisoners say, and some staff admit, that the most effective way at present for a prisoner to attract urgent attention is by shouting for assistance or banging on the door.”*

The exact time when the assault on Gary Douch took place cannot be established, but it appears to have happened in the early hours of the morning, most probably sometime between 5 a.m. and 6.30 a.m. There is some evidence to suggest that a prison officer did look into Holding Cell 2 either shortly after the assault had taken place, or possibly during a temporary lull in Stephen Egan’s attack on Mr Douch. It was assumed by some of the prisoners that the prison officer must have come to the cell as a result of hearing the noise of the attack in progress, but this may not be the case. In their evidence to the Commission the prison officers themselves made no mention of hearing any such noise.

From what the Commission has learned about this fatal attack, both from the accounts given and from the autopsy, there is a possibility that Mr Douch, having been caught unawares when the attack commenced and having very little chance to defend himself, was rendered unconscious quickly. Given the fact that there were mattresses and bedding on the cell floor and benches which may have absorbed sounds combined with the reluctance of prisoners to openly seek



assistance, this could possibly offer some explanation as to how the assault could have gone unnoticed by the prison officers who were on duty in the B Base area.

The data obtained from the electronic clock in the B Base indicates that the last recorded patrol of the Base area concluded at 6.05 a.m. However, [Prison Officer I] told the Commission that he “*did a check on Holding Cell 2*” at 6.30 a.m., when he saw Gary Douch lying on the floor, apparently asleep.

As stated earlier, the master lock for all the cells in the B Base was removed at 6.30 a.m. and the prison officers on duty began the process of opening Holding Cell 1 and emptying the cell of bedding. They did not open Holding Cell 2 until around 6.50 a.m. It is possible that [Prison Officer I] may indeed have looked into Holding Cell 2 briefly before proceeding to open Holding Cell 1. His account of having done so is supported to some extent by Stephen Egan himself, who recalled that a prison officer turned on the main light and looked into the cell at some point after the assault had taken place, when Gary Douch was lying on the floor of the cell.

## Discovery of the Assault

At 6.30 a.m. on the morning of 1<sup>st</sup> August 2006, the master lock was removed from the cells, allowing the prison officers in the “B Base” to unlock the individual cells. Officers Fitzpatrick and McAree went to Holding Cell 1 and removed the bed linen and mattresses. They finished this task at about 6.50 a.m. [Prison Officer I] then opened the door of Holding Cell 2, instructing the prisoners to remove their bedding from the cell:

*“Prisoner Stephen Egan was first out but had no bedding... I told him to return to the cell and remove his bedding. In the meantime the other prisoners had exited the cell. Egan returned as instructed and removed what was I think a duvet... He placed the duvet in the storage bin. Egan then walked away down the landing and isolated himself from the other prisoners. The other prisoners, with the exception [of] Douch, remained in our vicinity. They also hadn’t removed their bedding. They quietly informed us that they were not going back into the cell. Gesturing with their heads they indicated that Egan was the*

*reason they wouldn't re-enter the cell... I then asked them where was Gary Douch. Again they quietly told me that he was still in the cell. [Prison Officer H] and I discovered Gary Douch under a pile of duvets with a sheet over his face. We immediately told [Prison Officer J] to get the nurse and the A.C.O... We removed the duvets from Gary Douch with our feet. Gary Douch's cheeks were swollen, he had black eyes and around his neck was purple. He looked as though he wasn't breathing, neither of us checked for a pulse. There was no sign of life in him".*

The Nurse Officer on duty arrived shortly afterwards. He checked Gary Douch for vital signs but found none. 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.

## **Post Mortem**

A post mortem examination on the body of Gary Douch was carried out by Professor Marie Cassidy on 1<sup>st</sup> August 2006, with further examinations on 2<sup>nd</sup> and 9<sup>th</sup> 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".*

The report went on to state:

*"Despite the multiplicity of injuries, there were very few injuries which could be regarded as typical 'defence-type' injuries nor was there evidence of injuries to suggest*

*he had been restrained. The lack of such injuries raises the possibility that he was caught unaware initially, e.g. if he had been sleeping.”..*

There was no evidence of a sexual assault.

Under the heading ‘Toxicology’ the report stated:

*“Samples of blood and urine were retained for toxicological analysis. There was a **moderate level of alcohol in the blood 187mg%**. The urine contained no alcohol, but **amitriptyline and morphine were identified**. Further quantitative analyses confirmed the presence of opiates in the blood (Morphine and Codeine) but **no drugs were present in the blood**”.*

In her conclusions Professor Cassidy interpreted these findings as follows:

*“Toxicological analyses identified alcohol but not in his urine. This suggests he had drunk a considerable quantity of alcohol shortly before his death, and that he died rapidly before the alcohol could be metabolised. Drugs were found in his urine indicating recent use of a ‘Morphine’ based drug and Amitriptyline, an antidepressant, however these were not identified in the blood. If he had drunk a large quantity of alcohol fairly rapidly this could have affected his actions and reactions, including his ability to defend himself”.*

Professor Cassidy has informed the Commission that under normal circumstances, one would expect alcohol traces to be detected in urine within an hour of consumption. This suggests that Gary Douch consumed a significant quantity of alcohol within one hour of the assault which caused his death.

The Commission has not been able to establish how and when Gary Douch came into possession of this quantity of alcohol. It is possible that it was in the Holding Cell before he arrived, or he may have brought it to the cell himself. None of the other prisoners in Holding Cell 2 were tested for alcohol or drug consumption.



### 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 29<sup>th</sup> July 2006. There were evident deficits in management, decision-making, record-keeping and communication in this regard.**

At this remove it is not possible to establish with certainty whether the medical orderly who interviewed Stephen Egan on arrival documented the results of that interview. What can be said is that none of the information gleaned by the medical orderly during this interview is on Stephen Egan's medical file as disclosed to the Commission. Nor was any of this information conveyed to the General Practitioners who were on duty at Mountjoy from 29<sup>th</sup> to 31<sup>st</sup> July 2006. In fact, the GPs remained completely unaware of Stephen Egan's presence in the prison until after the death of Gary Douch.

The Commission considers that the above failures occurred in the context of a system-wide failure to appreciate the importance of documenting information, in particular medical information, and what IPS Director of Prison Health Care Dr Dooley described as “...*a culture of avoidance of accountability in this area*”.

- **The decision to keep Stephen Egan in a holding cell in B Base from 29-31<sup>st</sup> 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.**

Owing to the fact that Stephen Egan was not seen by a doctor at Mountjoy, and that the Psychiatric In-reach Service were as yet unaware that he had been moved from Cloverhill to Mountjoy, the Governors and prison officers responsible for his management had no way of knowing that he was supposed to be under ongoing review by the Psychiatric In-reach Services, and that he was supposed to be taking anti-psychotic medication, which he

was not now receiving. Had the persons responsible for his management at Mountjoy been aware of these facts, they may very well have made different decisions concerning his management.

## **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.**

When Gary Douch asked to be moved from C1 wing, prison officers at Mountjoy responded quickly and appropriately. The practice at that time was for protection prisoners to be placed temporarily in "B Base", while awaiting re-location to another wing of the prison. This removed the prisoner from the area in which he felt threatened, allowing staff time to establish firstly, what alternative placements were available and secondly, whether the prisoner in question would be safe in his new placement.

Ideally, each prisoner requiring protection would be kept by themselves in a single cell in "B Base" pending relocation. However, problems with overcrowding in the prison and with the increasing numbers of prisoners requesting protection meant that by 2006 the single cells in the Base were being occupied on a semi-permanent basis by protection prisoners who could not be placed elsewhere in the prison.<sup>67</sup> When Gary Douch arrived in "B Base" on 31<sup>st</sup> July 2006 the only place available for him was in a holding cell, along with other protection and non-protection prisoners. Staff in Mountjoy were well aware of the unsuitable nature of the holding cell as accommodation for anyone, let alone prisoners on protection. But in the circumstances which confronted them on 31<sup>st</sup> July 2006, they felt they had no other choice.

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<sup>67</sup> For further discussion of overcrowding in the prison and its effects, see Part 5.

- The conditions in which the 7 ‘protection’ prisoners were kept in Holding Cell 2 B Base on the 31<sup>st</sup> July/1<sup>st</sup> August 2006 were appalling and unacceptable.
- The conditions in which the prisoners in Holding Cell 1 B Base and particularly in the Reception area on the 31<sup>st</sup> July/1<sup>st</sup> 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.

The duties and obligations which the State owes to those prisoners in its care are set out in section 1.2 of this report. These duties and obligations form the basis for the *Standards for the Inspection of Prisons* which were published by the current Inspector of Prisons in his July 2010 Report.

Though the Inspector of Prisons published his standards in 2010, they are based on national and international standards which were in place prior to the death of Gary Douch in 2006.<sup>68</sup>

The Inspector identified three general headings for the State’s obligations to prisoners – (a) accommodation, (b) services and regimes and (c) prisoner safety. He stated:

*“All prisons must satisfy the three criteria – appropriate accommodation, adequate services and regimes and prisoner safety. If a prison fails to meet one or a number of these conditions it is overcrowded”.*

The conditions in Holding Cell 2 on the night of 31<sup>st</sup> July / 1<sup>st</sup> August 2006 constituted a blatant and inexcusable breach of the State’s obligations under all three criteria.

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<sup>68</sup> See, for example, the European Prison Rules 1987, rules 14–19. Further information as to the relevant, internationally acceptable standards can be found in the pre–2006 reports of the European Committee for the Prevention of Torture (CPT).

Purely in terms of physical space, the cell was chronically overcrowded. In 1992, 14 years before the death of Gary Douch, the European Committee for the Prevention of Torture (CPT) set seven square metres as an appropriate guideline standard for a single occupancy cell.<sup>69</sup> This guideline was subsequently adopted by the European Court of Human Rights in the case of *Kalashnikov – v – Russia*.<sup>70</sup> Building on these guidelines, the Inspector of Prisons has since made the following recommendation:

*“In certain circumstances cells of a smaller size could be deemed appropriate in the short term. However, cells of 6m<sup>2</sup> should never be used for accommodation purposes and cells of less than 9 m<sup>2</sup> should never be used to accommodate more than one prisoner”.*

Notwithstanding this on 31<sup>st</sup> July 2006 Holding Cell 2, a cell measuring approximately 5m x 4m, was used to accommodate up to 14 prisoners during the day, and seven prisoners overnight.

Holding Cell 2 was also manifestly inadequate in terms of the conditions in which the prisoners were kept and the services available to them. Rule 18.1 of the European Prison Rules (2006) states:

*“The accommodation provided for prisoners, and in particular all sleeping accommodation, shall respect human dignity and, as far as possible, privacy, and meet the requirements of health and hygiene, due regard being paid to climatic conditions and especially to floor space, cubic content of air, lighting, heating and ventilation”.*

Holding Cell 2 contained no proper sleeping facilities, inadequate ventilation and was clearly an unhealthy and unhygienic environment in which to keep seven prisoners overnight. As one prison officer who worked in Mountjoy told the Commission:

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<sup>69</sup> CPT 2<sup>nd</sup> General Report (April 1992).

<sup>70</sup> ECtHR judgment of 15<sup>th</sup> October 2002 (Application No. 47095/99).



*“The cell would receive a lot of traffic of different prisoners, and it shows. If someone was to be blunt about it, you wouldn’t put a dog in it”.*

Finally, the use of Holding Cell 2 to keep Gary Douch and six other prisoners overnight in 2006 gave rise to unacceptable security risks for both prisoners and staff, as set out below.

- **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.**

Firstly, putting seven prisoners in such a crowded and completely unsuitable environment, where they were locked down overnight was likely to create or exacerbate tensions between them, with unpredictable consequences. In that regard the Commission notes that the decision as to which prisoners were to remain overnight in Holding Cell 2 was not made on the basis of any individualised risk assessment concerning their suitability to be part of such a group, but was made simply on the basis of their classification as “protection” prisoners. The later removal of non-protection prisoners to another equally unsuitable location did little to ameliorate the potentially toxic mix left in Holding Cell 2.

Secondly, the facilities for supervising those prisoners in Holding Cell 2 were inadequate. The viewing hatch into the cell might have been sufficient if one or two prisoners were being kept there, but it did not allow for the proper supervision of seven prisoners.

Thirdly, there was no effective means for the prisoners in Holding Cell 2 to alert prison officers to an assault of the kind which took place on Gary Douch on 31<sup>st</sup> July 2006, in circumstances where the other prisoners in the cell were understandably afraid that pressing the alarm button or banging on the door might lead to themselves being assaulted in similar fashion.

Finally, the prospect of prison officers successfully intervening in any incident in Holding Cell 2 was hampered by the fact that (i) their ability to perceive what was happening in the cell was limited; (ii) the cell could not be opened without first obtaining the key from the Assistant Chief Officer, whose office was not in the “B Base”; and (iii) the number of prisoners in the cell outnumbered the number of prison officers on duty in the Base area at night.

- **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.**

Stephen Egan was well known to staff at all levels in Mountjoy Prison as a prisoner who had exhibited behavioural problems and who had demonstrated a propensity for serious violent and aggressive behaviour towards staff and other prisoners on many occasions. Many of these incidents had resulted in disciplinary reports which were contained on his prison file and on the computerised prison records system (PRIS).

Mr Egan also had a known history of mental health problems resulting in psychiatric interventions, details of which were contained in his prison medical file.

Issues arising from the management and treatment of Stephen Egan in the prison system are addressed in detail in subsequent chapters of this report. For now, it is sufficient to note that it was not appropriate to leave someone with Stephen Egan’s history in a crowded cell overnight with six other prisoners, and that this was, or should have been self-evident to those responsible for his management and care.

- **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 5-14<sup>th</sup> July 2006, (ii) [Senior Clinical Psychologist A], Psychologist during his interview with Stephen Egan at Cloverhill prison on 27<sup>th</sup> 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 31<sup>st</sup> July/1<sup>st</sup> August that he had displayed previously when unwell.

- 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 31<sup>st</sup> July/1<sup>st</sup> 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 Prison 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.

The Commission heard evidence that an ingrained resistance to the implementation of new policy and best practice was tolerated if not fostered at Mountjoy Prison, leading to unsafe working practices for both prisoners and staff.



**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. He was visited at 2.15 p.m. by a psychologist attached to the prison, and then by Mr Michael Mellett on behalf of the Minister for Justice. He was also reviewed by [Consultant Psychiatrist D], which interview was cut short by the arrival of arresting Gardaí. At 3.45 p.m. Stephen Egan was arrested and taken into Garda custody. He was returned to the special observation room at 23.25 p.m.

On the following day Stephen Egan was transferred to Cloverhill Prison, where he was placed in a special observation cell. He was reviewed by doctors at Cloverhill, who certified that he was suffering from a mental disorder for which he could not be afforded appropriate care or treatment within Cloverhill Prison. On that basis, Governor Dowling directed in writing on 3<sup>rd</sup> August 2006 (pursuant to s.15 of the Criminal Law (Insanity) Act 2006) that Stephen Egan be transferred to the Central Mental Hospital for treatment.

### **Stephen Egan at Central Mental Hospital, August – October 2006**

#### **Assessment and Treatment**

In terms of risk, Stephen Egan was assessed on arrival at the CMH as follows:

*“Stephen presents an extreme risk of violence towards staff and patients. He will be nursed in seclusion in the long term. A minimum of four staff will deal with Stephen during all interactions in order to minimise risks of serious assaults”.*

Mr Egan's mental state was assessed in seclusion at 6.30 p.m. by [Consultant Psychiatrist B], the consultant psychiatrist on duty. [Consultant Psychiatrist B] noted:

*"Presents a convincing display of psychotic symptoms.*

*There is some concern of impression management although this seems unlikely".*

The reference to "impression management" relates to the possibility that Mr Egan might have been deliberately affecting psychotic behaviour, rather than displaying genuine symptoms – a possibility that was considered unlikely by [Consultant Psychiatrist B] on this occasion.

Stephen Egan was recommenced on Olanzapine 20mg nocte, and was reviewed on a daily basis. A second antipsychotic medication, Amisulpride, was added to his medications on 6<sup>th</sup> August 2006.

A weekly nursing evaluation dated 13<sup>th</sup> August 2006 noted that Mr Egan "*remains a high risk of extreme violence*" but that no incidents had taken place since admission. It was noted that he was complying with medication, and that he "*does not think he has a mental illness*". Between 14<sup>th</sup> and 25<sup>th</sup> August Stephen Egan continued to report psychotic symptoms. He continued to be compliant with medication.

On 21<sup>st</sup> August 2006 Stephen Egan was seen by a psychologist for the purpose of beginning a process of assessment. According to documentation disclosed to the Commission by the CMH, this psychological work included personality assessment, assessment of symptom validity and risk assessment.<sup>71</sup> Further sessions took place on 22<sup>nd</sup> and 24<sup>th</sup> August, and Mr Egan was noted as being co-operative during these sessions.

On 25<sup>th</sup> August a case conference concerning Stephen Egan was held at the CMH, for which [Consultant Psychiatrist C] prepared a presentation. The presentation incorporated known details of Mr Egan's personal history, drug use, prison misconduct records, and psychiatric history to date. Notes of the presentation have been disclosed to the Commission by the CMH. Under the heading 'Discussion: Placement Issues' the notes state:

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<sup>71</sup> See CMH file B p.429.



*“Mr Egan is likely to require a minimum period of several months of continuous observation in CMH before final conclusions about diagnostic and placement issues can be fully clarified”.*

Regarding his being kept in seclusion, the notes state:

*“It was agreed that association at the present time would put patients and staff at significant risk...”*

*It was agreed to plan for his safe transfer out of seclusion as soon as safely possible”.*

Egan’s short-term and medium-term management were discussed again at a meeting on 28<sup>th</sup> August 2006. On 29<sup>th</sup> August he was seen again by a psychologist, who noted that the risk of violence remained high. On 30<sup>th</sup> August he was seen by Professor Harry Kennedy, who noted:

*“We will need to assess the practicalities of re-integrating him into the patient group for assessment... My assessment at present is that Mr Egan is at very high risk of violence to others, he is at very high risk of attempting to abscond”.*

Stephen Egan continued to be kept in seclusion at the CMH throughout the month of September 2006.

In a weekly nursing evaluation dated 3<sup>rd</sup> September 2006 it was reported:

*“Continues to be compliant with medication... Each evening, mon-frid, Stephen has 1 hour with a psychologist for psychological assessment, he is compliant with this. During these sessions and during seclusion reviews he voices delusional thoughts and beliefs, auditory hallucinations, and thought insertion. However, with care staff he does not voice these thoughts, or show any thought disorder, preoccupation, or any signs or symptoms of mental illness. No incidents since admission”.*

His progress during the month of September 2006 was summarised as follows in a report prepared for a case conference on 4<sup>th</sup> October 2006:

*“There was no marked change in Stephen Egan’s presentation.*

*He was noted to be intermittently demanding, for example, eager for movement out of seclusion and occasionally threatening dirty protests if his demands were not granted. When reviewed by [Consultant Psychiatrist D] on the 4<sup>th</sup> September he reported his belief about the sex beasts that he was happy that it was not bothering him any longer as the medications were working.*

*Over the next couple of days when reviewed Mr Egan continued to report subjective improvement in his mental state according to him he felt that his head was clearer now. He remained compliant with medication and availed of time in the single airing court. Psychological assessment... also continued during this period.*

*When reviewed by [Consultant Psychiatrist B] on the 10<sup>th</sup> September he reported that he had not heard voices for a couple of days he also denied feeling the 'signal' or being concerned about 'beasts'...*

*When reviewed by [Consultant Psychiatrist C] on the 23<sup>rd</sup> September on direct questioning about the issue of 'beasts' he said he had talked enough about it but that his beliefs had not changed and has decided not to think about it. He continued to express his frustration at the lack of association with other patients...*

*Over the next week Stephen remained in seclusion. There were no new management issues... His appetite and sleep pattern over the period of admission has remained stable. He is fully compliant with medication..."*

A weekly nursing evaluation dated 24<sup>th</sup> September 2006 noted:

*"Stephen can be very demanding at times and continues to pose a very high risk of assault or hostage taking and staff need to be on high alert at all times".*

A mental state examination was carried out on 3<sup>rd</sup> October 2006, the results of which were reported as follows:

*"He appeared relaxed; his rapport was good and was appropriate at interview. His speech was normal in rate and volume. He described his mood as good objectively he appeared euthymic. He denied any psychotic symptoms and his insight was reasonable".*

At 12.30 p.m. on 4<sup>th</sup> October 2006 Stephen Egan was reviewed in seclusion. The psychiatric case notes record his mood as “*euthymic*”, and his affect as “*calm & relaxed*”. Under the heading ‘thoughts’ it was noted:

*“Continues to describe belief that 2 named prisoners in MJP [Mountjoy Prison] are involved in sexual exploitation of women & children... States he believes 2... Gardaí raped a girl in a field in 2002”.*

At 5.55 p.m. on the same day the Clinical Director Professor Kennedy conducted a detailed interview with Stephen Egan. Present also during this interview were consultant psychiatrists [Consultant Psychiatrist A] and [Consultant Psychiatrist B], together with other CMH staff. A wide range of matters were discussed, including Stephen Egan’s sleep patterns, appetite, current mental state and fitness to stand trial, Asked if he still believed people could read his mind, Mr Egan responded:

*“We have discussed that, I don’t want to again”.*

Questioned as to whether he still heard voices, Mr Egan replied:

*“Not really, not anymore – maybe before I came here, yeah”.*

With regard to Mr Egan’s mental state, Professor Kennedy noted:

*“Does not think of himself as being ill now. Believes he was ‘ill’ i.e. tired and worn out. Is settled on medication. ‘Keeps me relaxed’”.*

Stephen Egan is noted as saying that he was willing to continue taking his medication.

Professor Kennedy noted his conclusions as follows:

*“- Has not had any sustained periods of abnormal mental state.*

*– No longer in need of treatment in hospital”.*

Also on 4<sup>th</sup> October 2006 Stephen Egan was reviewed by [Consultant Psychiatrist A] for the purpose of preparing a pre-sentence psychiatric report in relation to a recent conviction for

robbery. The robbery had taken place in June 2005, following Mr Egan's release from Midlands Prison. The report was based on a single interview carried out by [Consultant Psychiatrist A] on that date, together with the clinical notes held at the CMH and the Book of Evidence in relation to the robbery charge. [Consultant Psychiatrist A]'s report summarised Stephen Egan's personal, medical, and forensic history to date, before concluding:

*"Mr Egan was not suffering from a mental illness at the time of my interview nor was there any evidence which would indicate that he was suffering from a mental illness at the material time.*

*His main diagnosis is one of psychopathic personality disorder.*

*His psychopathic personality disorder is complicated by his on-going history of illicit drug abuse including opiates...*

*Mr Egan has been advised that continued use of drugs will result in deterioration in both his physical and mental health. However, this is something that only he himself can achieve..."*

Arising from the reviews of Mr Egan carried out on 4<sup>th</sup> October a multi-disciplinary case conference was held to review his progress and current situation at the CMH. Concerning his progress during September 2006 a note of the conference stated:

*"There was no marked change in Mr Egan's presentation.*

*He was noted to be intermittently demanding for example eager for movement out of seclusion and occasionally threatening dirty protests if his demands were not granted..."*

He was noted as being fully compliant with his medication. His appetite and sleep pattern over the period of admission were noted as having remained stable.

The note of the case conference which was disclosed to the Commission does not record the conclusions reached at the case conference in relation to Stephen Egan's on-going treatment. However, it is apparent from other documentation disclosed by the CMH that a decision was

taken to return him to prison. An evening report from Unit B (where Mr Egan was being held) dated 4<sup>th</sup> October 2010 stated:

*“Remains in seclusion... Settled in presentation, no evidence of psychosis. Case conference today, to be returned to prison over the next few days but not informed due to risk he poses.”*

## **Mental Health (Criminal Law) Review Board**

Sections 10 and 11 of the Criminal Law (Insanity) Act 2006 provide for the establishment of an independent Mental Health (Criminal Law) Review Board (hereinafter referred to as “the Review Board”) to review the detention of prisoners in designated centres such as the Central Mental Hospital. By order of the Minister for Justice, the Review Board was established on 27<sup>th</sup> September 2006 – it was not in existence when Stephen Egan first came to the CMH in July 2006. Nor did it have any interaction with Stephen Egan during his second stay at the CMH from August – October 2006.

The Review Board is an independent, statutory body responsible for reviewing the detention of patients at the Central Mental Hospital (currently the only designated centre defined by the Act) who have been referred there arising from a decision by the courts that they are unfit to be tried or where they have been found not guilty of an offence by reason of insanity. The Board is also responsible for reviewing the detention in the Central Mental Hospital of prisoners, including military prisoners, suffering from mental disorders that have been transferred from prison and military personnel referred from the relevant Defence Acts.

Section 17 of the Criminal Law (Insanity) Act 2006 provides a number of mechanisms which allow the Board to carry out such a review.

Firstly, in the case of a prisoner transferred involuntarily to the CMH – either by a court following a verdict of not guilty by reason of insanity, or by a prison Governor following certification by appropriate medical officers under s.15 (2) of the 2006 Act – the Minister for

Justice may direct the Board to review the detention of that prisoner where satisfied “...*that it is in the interests of justice to do so*”.<sup>72</sup>

The Board can also conduct a review on its own initiative of the detention of a prisoner pursuant to s.15 of the 2006 Act<sup>73</sup>, and in any event is obliged to ensure that every such detention “...*is reviewed at intervals of such length not being more than 6 months as it considers appropriate...*”<sup>74</sup>

Finally, a prisoner detained at the CMH has a right pursuant to section 17(3) to request the Board to conduct a review, and s.17(3) requires the Board to honour such a request “... *unless satisfied that the review is, in all the circumstances of the case, not necessary...*”

If, following a review of a detained prisoner, the Board is satisfied that further detention is not required, the Board, following consultation with the Minister for Justice, must order the prisoner to be transferred back to the prison from which he/she had been referred or to “*such other prison as the Minister considers appropriate in all the circumstances of the case*”.<sup>75</sup> This mirrors the requirement for consultation with the Minister imposed by s.18 of the 2006 Act in the context of a decision by the Clinical Director of a designated centre to discharge a prisoner.

Under s.17 of the Act, the Review Board can conduct a review of a prisoner detained at the CMH if directed to do so by the Minister for Justice, or if requested to do so by the prisoner themselves. The Review Board may also review a detention on its own initiative. In any event, s.17(2) requires the Review Board to ensure that the detention of a prisoner at the CMH is reviewed “*at intervals of such length not being more than 6 months as it considers appropriate*”.

The documentation disclosed to the Commission by the CMH includes a letter dated 5<sup>th</sup> October 2006 from the Clinical Director Professor Kennedy to Mr Patrick Wylie, Chief Executive Officer of the Review Board which states:

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<sup>72</sup> Criminal Law (Insanity) Act 2006, s.17(1).)

<sup>73</sup> Criminal Law (Insanity) Act 2006, s.17(4).)

<sup>74</sup> Criminal Law (Insanity) Act 2006, s.17(2)

<sup>75</sup> Criminal Law (Insanity) Act 2006, s.17 subsections (3) and (4)

*“I am writing to inform you that the above named [Stephen Egan] is detained here under the above Act and is now awaiting a hearing before the Mental Health Review Board”. (This must be a reference to the expected six-monthly review due to be done by the Board under s.17 (2). The procedure for giving such notice needs to be commented upon so that any necessary recommendations or guidelines can be proposed for making sure the system works as well as it can be expected to)*

Mr Wylie responded by letter dated 11<sup>th</sup> October 2006, in which he informed Professor Kennedy that the Review Board was in the course of finalising its procedures under the Act, and would then get in touch with a view to making arrangements to review Mr Egan’s case. On 19<sup>th</sup> October 2006 Professor Kennedy wrote to Mr Wylie informing him that Stephen Egan had been discharged from the CMH on 6<sup>th</sup> October 2006.

## **Discharge to Midlands Prison**

On 5<sup>th</sup> October 2006 the Clinical Director of the Central Mental Hospital Professor Kennedy, wrote to the Director General of the Irish Prison Service Mr Brian Purcell informing him of a decision to direct Stephen Egan’s transfer back to prison. The letter stated:

*“Mr Egan was admitted from Mountjoy Prison however I believe we are in agreement that it would not be appropriate for him to return to Mountjoy Prison.*

*A discharge summary listing any requirements concerning future mental health care and treatment will be forwarded today. However in order to assist you in reaching your decision regarding his most appropriate placement the following advice should be noted:*

*Even when completely well, Stephen Egan is likely to represent a serious danger to others.*

*This danger is considerably worsened by access to any intoxicants and measures should be taken to minimise his opportunity for access to intoxicants.*

*It would not be appropriate to place Mr Egan in a setting where high risk individuals are mixed with mentally ill or vulnerable prisoners or other special groups”.*

The letter continued:

*“My advice is that Stephen Egan... should be accommodated in the special unit which remains unstaffed and unopened adjacent to Portlaoise and the Midlands Prison. The appropriate model of operational management would be similar to the Close Supervision Centre at Woodhill in Milton Keynes...*

*I understand that as an interim measure you may be able to accommodate Mr Egan in the special unit in the Midlands Prison, while you bring the new unit on stream”.*

As stated earlier in this report,<sup>76</sup> s.18 of the Criminal Law (Insanity) Act 2006 requires the Clinical Director of the CMH to consult with the Minister for Justice as to the return of a prisoner to an appropriate prison after his / her discharge from the CMH. In the view of the Commission, Professor Kennedy’s letter of 5<sup>th</sup> October 2006 is a good example of the CMH providing the Minister’s representatives with the kind of information and advice which the Minister might expected to receive in order to more effectively discharge his role of consultation under s.18.

This contrasts starkly with the apparent lack of consultation and information sharing prior to Stephen Egan’s previous discharge from the CMH on 14<sup>th</sup> July 2006, as discussed elsewhere in this report.<sup>77</sup>

Stephen Egan was transferred to Midlands Prison on 6<sup>th</sup> October 2006. The 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.

The discharge summary for Stephen Egan is dated 6<sup>th</sup> October 2006.

Under the heading ‘Treatment and Investigations’, it stated:

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<sup>76</sup> See above p. 94

<sup>77</sup> See above p. 210



*“Detailed psychological assessments suggest some impairment of higher executive functioning. Psychological investigations underline a severe dissocial personality with markedly elevated psychopathy cores on the PCL-R. Psychological investigations also contain evidence of feigned symptoms”.*

Under the heading ‘Risk Management’ the discharge summary stated:

*“Mr Egan must be regarded as representing an extremely high risk for unpredictable violence. In light of his abnormal personality, this risk, although it may be attenuated by antipsychotic treatment, will nevertheless remain extremely high. Factors which may increase risk include use of any intoxicant or disinhibiting substance, including prescribed potentially disinhibiting substances...”*

*Risks relate to any form of violence, and have to date included fire setting, hostage taking, alleged homicide, alleged incitement to homicide, alleged incitement to sexual assault.*

*Management:*

*Risk should be managed with appropriate security precautions.*

*Treatment:*

*Mr Egan is regarded as refractory to psychological therapeutic intervention”.*

The summary continued:

*“Mr Egan has presented an account of various psychotic like symptoms in an unusual phenomenological context. He has described what appear to be auditory hallucinations, delusions, and passivity phenomena without an attendant abnormal affect. His account of symptoms has sometimes been associated with increased tempo in speech and apparent flight of ideas, but this has been brief and restricted to formal medical review. Nursing staff repeatedly observe normal interactions before and after reviews by doctors. There remains an index of suspicion about the veracity of his complaints. A formal diagnosis of psychosis has not been made”.*

Notwithstanding the absence of a formal diagnosis of psychosis, and the suspicions held by staff at the CMH concerning the truthfulness of his complaints, Stephen Egan was discharged with a prescription for both Olanzapine (20mg) and another antipsychotic medication, Amisulpride (400mg twice daily). Under the heading ‘Recommendations and Follow-up’ the discharge summary stated:

*“Psychiatric in reach services should provide follow up because Olanzapine may be useful in mood stabilisation.*

*Amisulpride may be phased out”.*

Under the heading, ‘Final Diagnosis’, the discharge summary recorded a diagnosis of “*dissocial personality*”. This is defined in the *International Classification of Diseases* (ICD – 10) published by the World Health Organisation (WHO) as:

*“Personality disorder characterised by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by adverse experience, including punishment. There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence; there is a tendency to blame others or to offer plausible rationalizations for the behaviour bringing the patient into conflict with society”.*

Dissocial personality disorder is one of a group of specific personality disorders which are defined by the WHO as follows:

*“These are severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood”.*

The Commission notes that the diagnosis of dissocial personality disorder is one with which Dr Lelliott, the expert consultant psychiatrist chosen to assist the Commission in its inquiries,

agrees. However, Dr Lelliott went on to express the view that Stephen Egan was also suffering from a mental illness, stating in his report to the Commission:

*“The information contained in the medical record up to 30th November 2007 suggests that Mr Egan has both a dissocial personality disorder and a severe psychotic illness. In my opinion, the most likely diagnosis for the latter is paranoid schizophrenia”.*

Similarly, forensic psychiatrist Dr Fahy, who interviewed Stephen Egan in 2008 and reviewed his medical records, was of the opinion that Stephen Egan was suffering from both a personality disorder and a mental illness with psychotic features.<sup>78</sup>

## Management of Stephen Egan, October 2006 to date

### Cell Placement

Stephen Egan arrived at Midlands Prison on 6<sup>th</sup> October 2006. Documentation disclosed to the Commission indicates that he 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. On occasions where he had to appear in court, he was transferred briefly to Cloverhill Prison on the day in question and returned to Midlands immediately following his court appearance. In November 2008 he was transferred to Wheatfield for one day to facilitate pre-arranged visits, but did not stay there overnight.

When Stephen Egan arrived at Midlands on 6<sup>th</sup> October 2006, he was met by the then Governor, John O’Sullivan. Governor O’Sullivan told the Commission:

*“On the day he arrived, he arrived about 6pm in the evening. I waited back for him. He knew I was the Governor there and I spoke with him the next day and the following days. He was a very disturbed man and he was anxious to talk and I was more anxious to let*

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<sup>78</sup> See above p. 181

*him settle down. And I told him that he should settle down first before he got into any dialogue. And I advised him not to talk to anybody in prison.*

*He was going to be isolated; he would have no other direct communication or association with other prisoners. It took him a while to settle down but he was a lot easier to deal with than my experience with him in the previous June”.*

## **Administration of Medication**

As stated previously, a discharge summary and a copy of Stephen Egan’s prescription sheet from the CMH were faxed to the medical staff at Midlands Prison on Friday, 6<sup>th</sup> October 2006. However, the Drug Administration Record on Stephen Egan’s prison medical file indicates that he was not administered any medication until Monday 9<sup>th</sup> October 2006.

Stephen Egan was taking three types of medication at the time of his discharge from the Central Mental Hospital – two with antipsychotic effect (Olanzapine and Amisulpride) and one anti-fungal treatment for a toenail infection. As was the practice, the Drug Administration Record at Midlands does not identify the medication administered by name but uses an alphabetical code – “A”, “B”, etc. The key to this code, outlining which medication corresponds to which letter, is normally found on a prescription sheet drawn up by a GP at Midlands Prison. Stephen Egan’s prison medical file as disclosed to the Commission does not contain such a prescription sheet. Without it, it is not possible to know which medication was administered and when.

The Drug Administration Record indicates that Stephen Egan accepted medication on 9<sup>th</sup> and 10<sup>th</sup> October 2006 but declined at least one of his medications on the evening of 11<sup>th</sup> October. A comment beside the entry for that date reads:

*“Advised he will need to see Dr [illegible]”*

A medical continuation sheet on Mr Egan’s medical file indicates that he was seen by a member of the medical staff at Midlands on 12<sup>th</sup> October 2006. It was noted that he “*refuses to take psychotropics*” – that is to say, his antipsychotic medication.

Contrary to what one would expect, the Drug Administration Record does not contain entries for every day. There are entries for 12<sup>th</sup>, 13<sup>th</sup>, 16<sup>th</sup>, 17<sup>th</sup> and 20<sup>th</sup> October 2006. On each of those dates, Mr Egan refused to take medication. The record indicates that one medication was taken on 23<sup>rd</sup>, 24<sup>th</sup>, 26<sup>th</sup>, 27<sup>th</sup> and 28<sup>th</sup> October. Again, without the relevant prescription sheet, it is not possible to say whether this was an antipsychotic medication, or whether it was the treatment prescribed for his toenail infection. In any event, Mr Egan is recorded as declining all medication on 5<sup>th</sup> November and again on 9<sup>th</sup> November 2006, the date of the last entry on the relevant Drug Administration sheet.

## Psychiatric Review

As referred to above, the discharge summary sent to Midlands Prison from the CMH recommended that the Psychiatric In-reach Services provide further follow-up on Stephen Egan at Midlands, particularly in relation to monitoring the appropriate levels of antipsychotic medication.

A note from Stephen Egan's prison medical file records that he was reviewed at Midlands by [Consultant Psychiatrist B] on 10<sup>th</sup> October 2006. The note states:

*"Reviewed Midlands Prison.*

*No complaints.*

*No evidence of psychosis*

*Polite & courteous...*

*Pleased to gradually come off Amisulpride".*

A subsequent note on a medical continuation sheet from the prison medical file indicates that Mr Egan was seen again by a member of the Psychiatric Services at Midlands on 24<sup>th</sup> October 2006. The note indicates that Mr Egan "*appears euthymic*", that he denied thoughts of aggression or harm towards others and that he denied any bizarre beliefs. The fact that he was not taking his prescribed medication was also noted, although it is not clear whether this refers to his anti-

psychotic medication or other medication. Further problems arise from the fact that the note is difficult to read in parts: for example, there is a reference to pressured speech, but it is not clear whether Stephen Egan is being described as having pressured speech or not.

The Commission has seen no record of any further follow-up by the Psychiatric In reach Services between 25<sup>th</sup> October and 9<sup>th</sup> January 2007, when concerns expressed by prison officers about Mr Egan's behaviour prompted a review by [Consultant Psychiatrist B]

In a letter of 9<sup>th</sup> January 2007 to the GP at Midlands Prison [Consultant Psychiatrist B] reported his conclusions as follows:

*“Mr Egan's thought content remains replete with violent and grandiose themes... Concern remains about the extent to which symptoms may be exaggerated for secondary gain or represent over-rehearsed fantasy with excited affect in the context of a psychopathic personality. In any event, in recent weeks accounts describe increasing affective instability, violent preoccupation and aggressive posturing. I think it prudent to recommend that he recommence Olanzapine 15mg nocte”.*

On 10<sup>th</sup> January 2007 Professor Harry Kennedy, Clinical Director of the Central Mental Hospital wrote a memo to the CMH Hospital Manager and the CMH Director of Nursing in which he stated:

*“I have been informed by [Consultant Psychiatrist B] that Stephen Egan appears to have become psychotic again while in a special isolation unit in the Midlands Prison. [Consultant Psychiatrist B] is trying to persuade him [to] accept antipsychotic medication where he is. However it may be necessary to admit him again. Clearly we will have to make special arrangements and we need to meet and discuss this”.*

Stephen Egan's prison medical file does not contain either a prescription sheet or a Drug Administration Record in relation to the recommencement of Olanzapine in January 2007. The next date for which the administration of medication is recorded on the file is 22<sup>nd</sup> February 2007.

[Consultant Psychiatrist B] reviewed Stephen Egan in Midlands again on 16<sup>th</sup> January 2007. He was informed that Stephen Egan was refusing to take the anti-psychotic medication prescribed for him, and that he continued to display unusual behaviour. [Consultant Psychiatrist B] reported:

*“I am inclined to regard Mr Egan as presenting with symptoms of a relapse of a schizoaffective paranoid psychosis. He is on the waiting list for admission to the Central Mental Hospital”.*

Amongst the documents disclosed to the Commission by the CMH is a document dated 19<sup>th</sup> January 2007 and headed “Re: Patient Stephen Egan“. The document appears to be a list of proposed arrangements regarding the management of Stephen Egan in the event of his being re-admitted to the CMH. It refers, amongst other matters, to his proposed location in the hospital, to the number of staff required to manage him, and to the carrying out of daily risk assessments by the charge nurse.

On 22<sup>nd</sup> January 2007 Stephen Egan was seen by [Doctor F] at Midlands Prison, who recorded his impressions as follows:

*“Manic, pressure of speech, flight of ideas, appears to be deluded as well. Denies hallucinations, does not want to take medications...”*

He was seen again on 29<sup>th</sup> January by the Community Psychiatric Nurse attached to the Midlands, [Community Psychiatric Nurse A], who reported improvements in his condition in an email to [Consultant Psychiatrist B], stating:

*“The most significant difference since you saw him is that he is now agreeable to taking medication.”*

[Consultant Psychiatrist B] saw Stephen Egan on the following day, 30<sup>th</sup> January 2007. He reported:

*“Mr Egan told me that he was content to take medication... Prison officers told me that there had been a modest improvement in the last couple of days however they comment that he continues to demonstrate bizarre ideation”.*

[Consultant Psychiatrist B] increased the prescribed amount of Olanzapine from 15 to 20mg nocte.

In the absence of the relevant Drug Administration Record, it is not possible to confirm whether Mr Egan was in fact taking his medication at this time.

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. On 15<sup>th</sup> February Governor O'Sullivan wrote to the GP at Midlands, [Doctor F] expressing his concern over Stephen Egan's condition, stating:

*"As you are aware the above named prisoner is currently accommodated in the Special Protection Area of C1 landing. He is serving a sentence of 4 years... Other serious charges are pending in this man's case which may not be disposed of for some time yet. Due to the seriousness of the pending offences Stephen will remain in this area for the foreseeable future.*

*Over the past number of months I have had occasion to meet with Stephen and noticed a remarkable change in his demeanour. It would appear that he is encountering difficulty coping with his current situation and seems very agitated".*

The letter concluded:

*"In my opinion this man presents himself as a danger to himself and others. In his current state of mind he is capable of doing anything, he appears unbalanced and in urgent need of urgent medical support. Your assistance in this matter would be appreciated".*

[Doctor F] responded by letter dated 19<sup>th</sup> February, stating that he had examined Stephen Egan on 16<sup>th</sup> February along with the Community Psychiatric Nurse attached to the Midlands, [Community Psychiatric Nurse A]. He stated:

*"I found him very unwell, his mental status has deteriorated certainly over the last number of weeks. He remains a danger to himself as well as to the staff around him. I have expressed my concerns to the CPN [Community Psychiatric Nurse A] that*



*considering the current deteriorating mental health and the past history / incident in Mountjoy Prison of this gentleman, he needs an urgent inpatient assessment and treatment.*

*[Community Psychiatric Nurse A] has promised to speak to [Consultant Psychiatrist B] or Dr Harry Kennedy regarding psychiatric intervention”.*

Also on 19<sup>th</sup> February, [Community Psychiatric Nurse A] emailed [Consultant Psychiatrist B] with her assessment of Mr Egan’s condition, stating:

*“There was little change in his presentation from the last time I saw him two weeks ago, his personal hygiene was better and he was more kempt. His conversation remains bizarre and persistent in its themes of violence that clearly energises him... He is still on the Olanzapine Velotab 20mgs at night, and staff are happy that he is complying with taking it. He says himself that while he is not keen to take it he will carry on with the prescription.”*

On the same day, Governor O’Sullivan spoke to the IPS Director of Health Care, Dr Enda Dooley, seeking to enlist his help in securing a place at the CMH for Stephen Egan. A handwritten note by Governor O’Sullivan on Stephen Egan’s file records:

*“Discussed with [Doctor F] today. Discussed with Dr Dooley today. This man (S Egan) has problems that need to be addressed without delay”.*

Governor O’Sullivan reiterated his concerns in an email to Dr Dooley on the same day in which he stated:

*“This prisoner is behaving in a rather bizarre manner to say the least. Over the last number of weeks I made a point of meeting with him regularly. As Stephen is well known to me I am in a good position to judge his current state of mind. I am very concerned and am of the view that this man should be transferred for further assessment to the Central Mental Hospital.*

*In the month of January he was interviewed by personnel from the Central Mental Hospital on the following dates...*

*I would appreciate your assistance in securing a place in the Central Mental Hospital for this man”.*

On 20<sup>th</sup> February Governor O’Sullivan met with [Doctor F] and with [Doctor G], a member of the Psychiatric In reach team attending Midlands Prison. [Doctor G] wrote to [Consultant Psychiatrist B] on 21<sup>st</sup> February stating:

*“Mr Egan has been in the punishment block due to his high risk of violence towards staff and inmates. Mr O’Sullivan expressed concern about Mr Egan’s situation and he is requesting further clarification regarding his transfer to the Central Mental Hospital”.*

A Drug Administration Record on Stephen Egan’s medical file indicates that from 22<sup>nd</sup> 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.

[Consultant Psychiatrist B] reviewed Stephen Egan at Midlands on 28<sup>th</sup> February 2007. He found him *“much calmer in his demeanour”*. He wrote:

*“Prison staff reported that in the last week he appears to be calmer in his demeanour although they did express some concern that he hasn’t been attending the gym this week.*

*Mr Egan told me that he has been taking his medication regularly and said that they had a sedating affect...*

*I have made no changes in his treatment”.*

The next recorded psychiatric intervention with Stephen Egan is on 15<sup>th</sup> May 2007, when he was reviewed by [Consultant Psychiatrist B]. [Consultant Psychiatrist B] reported:

*“He remains relatively stable although under questioning will continue to elaborate delusional beliefs...*

*I have made no changes in Mr Egan’s management”.*

[Consultant Psychiatrist B] reviewed Mr Egan again on 17<sup>th</sup> September 2007, noting that he appeared “*much improved*”. [Consultant Psychiatrist B] made no change to his treatment, leaving him on Olanzapine 20mg.

In November 2007 a pre-sentence psychiatric report was prepared by [Consultant Psychiatrist H] of the CMH. Stephen Egan was due to be sentenced in December 2007 in relation to assaults committed during his attempted escape from a prison van on 27<sup>th</sup> November 2005. [Consultant Psychiatrist H] interviewed Stephen Egan on 7<sup>th</sup> November 2007. She also had access to the book of evidence and to Stephen Egan’s prison medical notes, although she stated that “*full chronological contents [were] not available at [the] time of my assessment*”.

[Consultant Psychiatrist H] recounted Stephen Egan’s personal, forensic, medical, and psychiatric history. Regarding the psychiatric interventions since his discharge from the Central Mental Hospital in October 2006, she stated:

*“Earlier this year prison staff reported deterioration in his mental state with reports of increased affective instability, violent preoccupation and aggressive posturing. On formal psychiatric assessment the following diagnoses were considered – a psychotic episode, exaggeration of symptoms for secondary gain or the verbal and behavioural expression of violent fantasies with excited affect in someone with a psychopathic personality. He was recommenced on antipsychotic medication having previously stopped medication himself. Over the following weeks his mental state improved”.*

Under the heading ‘Opinion and Recommendations’ [Consultant Psychiatrist H] concluded:

*“Mr Egan was not suffering from a mental illness at the time of my interview nor was there any evidence which would indicate that he was suffering from mental illness at the material time.*

*Mr Egan’s main diagnosis is one of Severe Dissocial Personality Disorder with strong psychopathic personality traits. He also has a long history of polysubstance misuse and has continued to abuse illegal drugs in a custodial setting”.*

In relation to Stephen Egan's mental state when his attempted escape was carried out in November 2005, [Consultant Psychiatrist H] concluded:

*"Mr Egan was not found to be suffering from a mental disorder when assessed by the forensic psychiatry services in Mountjoy Prison in the period immediately following the index offence.*

*In my opinion Mr Egan's index offence was not related in any way to mental illness and was secondary to his underlying personality disorder. His behaviour was motivated by a calculated and opportunistic attempt to escape from custody.*

*However, more recently there is some evidence to suggest that Mr Egan may have developed a psychotic illness the onset of which post dated the index offence. However, there remains some diagnostic doubt as to the nature, severity and validity of any such mental disorder".*

Regarding Stephen Egan's future management in the prison service [Consultant Psychiatrist H] stated:

*"Mr Egan continues to represent a very high risk for future serious and unpredictable violent behaviour. Based on his history of previous violence the nature of any future violence is likely to be of a serious and life threatening nature. Appropriate relational and physical security measures will need to be taken by the prison authorities to manage this risk. Factors which may increase his risk of violence include the use of illegal drugs or certain prescribed disinhibiting substances such as benzodiazepine medication.*

*While in a custody setting Mr Egan will continue to be reviewed as required by the In-reach Forensic Psychiatry Services. He does not require inpatient treatment. I have re-enforced to him the importance of remaining abstinent from illegal drugs and alcohol".*

As of January 2009 a further psychiatric review of Stephen Egan indicated that he "...reports on-going auditory hallucinations but appears to be able to dismiss these". He did not appear thought disordered or display any abnormal affect at review. He was noted as still being on Olanzapine 20 mgs daily.

On 1<sup>st</sup> September 2009 Mr Egan was reviewed by [Consultant Psychiatrist B], who noted:

*“He continues to take Olanzapine which he finds beneficial. From a psychiatric perspective he reports control of his symptoms for several months and he remains training in the gym...”*

*He described a rapid deterioration in his mental state upon moving from Cloverhill Prison to Mountjoy Prison 48-72 hours before the death of Gary Douch. At that time he said he was in his own words ‘messed up in my thinking’. Beyond describing a range of psychotic symptoms he also reported that he had a history with Mr Douch. He said that Mr Douch referred to his brother James Egan who had been shot within the past year. Nevertheless the history he gave is consistent with a rapid deterioration in mental state after having stopped Olanzapine. A similar pattern emerged in the Midlands Prison. Now that Mr Egan is taking Olanzapine regularly his mental state has shown a sustained improvement.”*



## 4.2 Conclusions

- **There was an appropriate level of consultation between the Central Mental Hospital (CMH) and the Irish Prison Service prior to Stephan Egan's discharge on 6<sup>th</sup> October 2006.**

On 5<sup>th</sup> October 2006 the Clinical Director of the CMH, Professor Kennedy wrote to the Director General of the Irish Prison Service concerning the anticipated return of Stephen Egan to the prison system from the CMH. The letter contained advice as to an appropriate placement for Mr Egan within the prison system, and effectively fulfilled the requirement under s.18 of the Criminal Law (Insanity) Act 2006 for the Clinical Director of the CMH to consult with the Minister prior to directing Mr Egan's return to prison.

- **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 was discharged from the CMH with a prescription for two forms of anti-psychotic medication (Olanzapine and Amisulpride) and a recommendation from the Clinical Director of the CMH that the Psychiatric In reach Services provide follow up, particularly with regard to the on-going use of Olanzapine and the advisability of phasing out Amisulpride. Mr Egan was reviewed on 10<sup>th</sup> October, and again on 24<sup>th</sup> October 2006. By the time of the latter review the Psychiatric In reach Service was made aware that Mr Egan had stopped taking his anti-psychotic medication.

There appears to have been no further follow-up by the Psychiatric In reach Service until 9<sup>th</sup> January 2007, when a review was carried out in response to concerns expressed by the prison officers regarding Mr Egan's behaviour, and he was recommenced on Olanzapine.

In the view of the Commission, the level of on-going psychiatric review between October 2006 and January 2007 was inadequate in the light of Stephen Egan's medical history, the fact that he was refusing to take his prescribed anti-psychotic medication and his history as a person who presented a serious risk of unprovoked violence towards others.

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

As detailed in this chapter, there are significant gaps in the medical records concerning the administration of prescribed drugs to Stephen Egan in 2006 and 2007. The prescription sheet for October 2006 is missing, and the drug administration record for that month was not filled in on a daily basis as it should have been. Both the prescription sheet and the drug administration record for January / February 2007, when Stephen Egan was recommenced on Olanzapine, are missing from his medical file.

The failure to keep such records properly is totally unacceptable, particularly in the case of Mr Egan, a high-risk prisoner with a history of mental health problems and a demonstrated propensity for sudden and unprovoked attacks on prisoners and prison staff.



**Part Five**  
**Review of Policy Issues**



## 5.1 Prisoner Safety – Policies, Practices and Procedures

In addition to carrying out an investigation into specific matters arising from the death of Gary Douch, including the treatment and management of Stephen Egan, the Commission's terms of reference also require it to carry out the following tasks:

*“...a review of policies, practices and procedures regarding the safety of prisoners in custody whether in prison, a place of detention, the Central Mental Hospital or other institution and in particular:*

- *a review of protocols for those prisoners with specific behavioural problems or vulnerabilities (psychiatric, violent or disruptive or those in need of additional protection)*
- *a review of their application in this case*
- *a review of any changes which have taken place since the 1<sup>st</sup> August 2006*
- *the making of recommendations on what cost effective policies and / or legislative measures could be adopted in the future for the management and treatment of such prisoners together with an estimate of the approximate implementation costs 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”*

Taken by themselves, the above paragraphs would seem to task the Commission with undertaking a root-and-branch review of all aspects of prisoner safety in every prison and related

institution in the State, both as they were in July 2006 and as they are now. Given the limited resources under which the Commission operates, a review of that magnitude would be far beyond the scope of this Commission.

The Commission considers that the above paragraphs must be interpreted in the light of the preceding paragraphs of the terms of reference, and particularly bearing in mind that this Commission was created in the first instance to investigate matters arising from the death of Gary Douch in Mountjoy Prison. The Commission is strengthened in this view by the fact paragraph 2 requires the Commission to review the application of such policies, practices and procedures in the specific case of Gary Douch's death.

On that basis, the Commission will address only those aspects of prisoner safety which relate to, or arise from, the circumstances which resulted in Gary Douch being killed. These aspects can be summarised as follows:

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

In terms of prisoners "*with specific behavioural problems*", it is important to distinguish between (i) vulnerable prisoners – that is to say, those at risk of being harmed – and (ii) violent or disruptive prisoners who pose a threat others. These are two distinct categories, requiring different treatment and approaches.

The category of vulnerable prisoners can be further divided into prisoners at risk of self-harm, and those at risk of being harmed by others. Again, these are distinct groups requiring different management approaches, although it is possible to have prisoners who fit into both categories.

From a management point of view it is clear that, notwithstanding his psychiatric problems, Stephen Egan was not categorised as a “vulnerable” prisoner by those who managed him within the prison system, but rather as a violent or disruptive prisoner.

In normal circumstances one might expect “*a review of protocols for those prisoners with specific behavioural problems or vulnerabilities*” to include a review of protocols for dealing with prisoners at risk of self-harm or suicide. However, the issue of self-harm does not arise in relation to Gary Douch or Stephen Egan, and accordingly it is not a matter which the Commission proposes to review in this report, except insofar as the treatment of such prisoners may provide useful points of comparison or contrast with the treatment of prisoners who are a threat to others, or who are placed on protection for reasons unrelated to self-harm.

Finally, in addition to reviewing policies, practices and procedures in the abovementioned areas, it is necessary to review the mechanisms in place to ensure their implementation. A system which does not encourage compliance with, or monitor adherence to standards of practice runs the very serious risk that such elementary standards remain little more than aspirational.

## 5.2 Overcrowding

Overcrowding is undoubtedly one of the key contributing factors to the circumstances which resulted 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 31<sup>st</sup> 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. Some 25 years ago, the Whitaker Committee of Inquiry into the Penal System reported that:

*“Existing prison accommodation is not only of poor standard generally but also insufficient for the numbers now in custody. Overcrowding has increasingly forced the abandonment of the one prisoner to a cell principle, led to the diversion of specialist institutions... from the roles conceived for them, and encroached on space and facilities needed for education and recreation. Even with fewer prisoners, many of the prisons could provide neither the living conditions nor the range of services which should be available”.*

Following a visit to Irish prisons in 1993 the European Committee for the Prevention of Torture (CPT) recommended that

*“...a very high priority be given to measures designed to reduce overcrowding”.*

The CPT also recommended that

*“...due consideration be given to introducing an enforceable ceiling on the inmate population of each prison”.*

Five years later in 1998, the CPT reported that the effort made by the State to improve living conditions for prisoners

*“...continues to be undermined by overcrowding, which would appear to be an endemic feature of the Irish prison system”.*

The CPT report noted plans on the part of the Government to provide an additional 2,000 prison places by 2002, but warned that new prison places alone would probably not solve the overcrowding issue:

“While noting the ambitious scale of the action planned by the Irish authorities, the CPT considers it unlikely that providing additional accommodation will alone provide a lasting solution to the problem of overcrowding. Indeed, a number of European States have embarked on extensive programmes of prison building, only to find their prison populations rising in tandem with the increased capacity acquired by their prison estates.

By contrast, in those countries which enjoy relatively un-crowded prison systems, the existence of policies to limit and/or modulate the number of persons being sent to prison has tended to be an important element in maintaining the prison population at a manageable level”.

The CPT next visited Ireland in October 2006. In its ensuing report, the CPT made it clear that overcrowding remained a critical issue, particularly with regard to Mountjoy Prison. The report stated:

*“More generally, overcrowding continues to exert pressure upon the limited and dilapidated conditions in the prison. Specific reference should be made to the basement of B Block where, despite the recent renovation, the conditions in the cells were poor, with broken window panes, stained and peeling walls, dirty floors and broken light bulbs in the sanitary annexes. There were also complaints about mice and cockroaches”.*

In the first Interim Report of this Commission of Investigation, which was submitted to the Minister for Justice in December 2007, the Commission considered it necessary to make the following observations concerning the problem of overcrowding:

*“Regarding the issue of overcrowding in prisons, the Commission is motivated to make observations at this time by a sense of overwhelming urgency. To say that the current level of overcrowding in Irish prisons is unacceptable and must be remedied is not*

*controversial. Nor is it new: it has been said in reports by prison officers, prison governors, prison visiting committees, prison chaplains, the Inspector of Prisons, and various bodies concerned with human rights, including the European Committee for the Prevention of Torture. Some of these reports date as far back as 1993.*

*The overcrowding problem is particularly acute in Mountjoy Prison, and has been for many years. There is no doubt that it was a significant factor in the circumstances which led to Gary Douch losing his life. The Commission believes that if his status as a 'protection prisoner' had afforded Gary Douch a single cell, the tragic events of the night of 31<sup>st</sup> July 2005 would not have occurred.*

*The Commission believes that immediate practical steps need to be taken to alleviate the overcrowding in Mountjoy Prison. The Commission is aware that the original plan was for Mountjoy Prison to be taken out of service once the proposed prison complex at Thornton Hall is built and made operational. This is expected to occur sometime in 2010. This does not in any way alter the State's obligations to improve the current conditions in Mountjoy Prison. The Commission is concerned that the inevitable concentration of attention and resources on the planning and construction of Thornton Hall could divert the State away from fulfilling its obligations to uphold the basic human rights of prisoners currently in Mountjoy Prison. It must be highlighted that any contention that a lack of resources has led to the current difficulties with regard to overcrowding will not excuse the State from its obligations under the Constitution and the European Convention on Human Rights to uphold the basic human rights of those prisoners in its charge".*

Since the publication of the Commission's Interim Report in 2007, the planned construction of a new prison at Thornton Hall has incurred further delays, and the development may not now take place, or may be scaled down to the extent that it will not be possible to close Mountjoy Prison even after a new prison is built at Thornton Hall.

The CPT visited Ireland again from 25 January to 5 February 2010. The subsequent report, together with the response of the Irish Government, was published on 10 February 2011. In relation to overcrowding the CPT report observes:



*“In the three and a half years since the CPT’s last periodic visit to Ireland the prison population has expanded considerably, rising from some 3,150 in October 2006 to over 4,000 by the end of January 2010. At the same time, the Irish Prison Service has struggled to provide sufficient capacity to accommodate the increasing prison population. The official operational capacity of some 4,100 belies the very real overcrowding that exists in a number of prison establishments, such as Cork and Mountjoy Prisons and the female unit at Limerick Prison, where many inmates have to sleep on mattresses on the floor due to insufficient beds and a lack of space. As was the case in 2006, the de facto overcrowding, combined with the conditions in certain of the old and dilapidated prisons, raises real concerns as to the safe and humane treatment of prisoners”.*

Both before and after the death of Gary Douch, overcrowding has been and continues to be a major problem in the Irish prison system. The Commission sees little prospect of this being reversed without a major commitment from Government and from those stakeholders who are engaged in all aspects of the prison system.

## **Effects of Overcrowding**

In his annual report for 2008 (published in May 2009) the Inspector of Prisons made it clear that overcrowding remained a major issue in the Irish prison system. The Inspector’s report went on to list the many deleterious effects which overcrowding has on the prison system, stating as follows:

*“When prisons are overcrowded there is an air of tension throughout such prisons.*

*Existing facilities for prisons (in some cases totally inadequate) are geared to cater for a population which is based on the design capacity of such prisons.*

*When prisons are overcrowded the existing facilities (even if adequate to cater for the design capacity) are not sufficient to deal with such increase in population.*

*The facilities that I speak of include: -*

- *School facilities*
- *Workshop facilities*
- *General work facilities*
- *Recreational facilities*
- *Catering facilities*
- *Laundry facilities*
- *Medical facilities*
- *Rehabilitation facilities*
- *Showering and personal hygiene facilities*
- *Visiting facilities*
- *Searching facilities.*

*Overcrowding puts extreme pressure on management and all officers working in such prisons.*

*When prisons are overcrowded certain posts are 'stripped' of their officers to provide cover in more sensitive and important areas. This is done for security reasons. It amounts in nearly all cases to facilities for prisoners being withdrawn.*

*Overcrowding can lead to inter-prisoner violence..."*

In evidence to the Commission given in December 2009 the Governor of Mountjoy Prison, Mr John Lonergan offered similar observations to those of the Inspector of Prisons concerning overcrowding. He told the Commission:

*“We do know ourselves from monitoring – and we have monitored numbers over the years – that when your numbers go up there is always a significant increase in violent activities simply because again the ratio of staff to prisoner, the knowledge prison staff have of prisoners and all that sort of thing, the attention people are able to get, how often they can see the dentist, how often they can see the psychologist... We have an excellent psychological service in Mountjoy... but even with three full-time psychologists we still have huge waiting lists, sometimes up to three weeks”.*

To the abovementioned factors, the Commission would add the fact that overcrowding severely inhibits the capacity of the IPS and the Governor of a prison to manage risk, both in relation to staff and to prisoners. As [Senior Clinical Psychologist B], a senior clinical psychologist working at Mountjoy, put it in his evidence to the Commission:

*“The bottom line is that overcrowding compromises good risk management. It is as simple as that. If you have multiple cell occupancy you cannot be sure, you simply cannot be sure, that people in the cell are not a risk to one another”.*

The pressure which overcrowding exerts on prison staff can affect prison life in different ways. In addition to the personal toll taken by stress on prison officers, persistent overcrowding can lead to a decline in general standards of practice and procedure. A sense of hopelessness can start to pervade the prison system, as staff are forced to accept and become inured to conditions which any reasonable person would decry as completely unacceptable. The inevitable effect is a general lowering of prison standards. This can manifest itself in obvious ways, such as a decline in standards of cleanliness, and also in more subtle ways, such as in a less responsible approach to documentation and record-keeping.

One illustration of how persistent overcrowding can lead, over time, to a *de facto* acceptance of the unacceptable arose during Governor Lonergan’s evidence to the Commission in December 2009. The Commission sought Governor Lonergan’s view on the merits of having a rule to the effect that a prison cell cannot be used unless it is certified as fit for use by the governor of the prison. Governor Lonergan accepted the merit of the proposal in principle, but indicated that it was not possible to implement such a rule under the conditions then in place:

*“...I could not go around Mountjoy and certify 50% of the cells as being suitable for housing for two people – I would have to say no. We haven’t integrated sanitation first of all so that means fellows have to go to the toilet on pots. I couldn’t certify that is acceptable from a humanitarian perspective. I couldn’t go down to the basement and go into a cell where there is five people or six people sometimes and say I certify that this cell is suitable. I would have to say I certify this cell is unsuitable”.*

A related problem arises insofar as overcrowding can render prison staff unable to adhere to certain Prison Rules, Governor’s Orders, or Directions from the IPS. This conflict between what staff are being asked to do and what the available resources in fact allow them to do tends to undermine authority and respect for rules within the prison system. An example of this can be seen in relation to the management of prisoners who request protection. On 2<sup>nd</sup> August 2006, the Minister for Justice directed the IPS to implement an interim recommendation of Mr Michael Mellett to the effect that any prisoner asking for protection must be placed in a single occupancy cell for at least 24 hours. The impact of this directive was described by Governor Lonergan in his evidence to the Commission as follows:

*“Someone comes in and says he needs protection. You are looking for – as the directive says, you need to put him in a single cell. There is not a single cell to be found in Mountjoy.*

*You are running around, so that pads [i.e. special observation cells] are being used as single cells to comply with the directive, but undermining my directive that says you should never put a person in a padded cell unless he is certified or unless he is ill or is there on the basis that the doctor has recommended [it].*

*One directive is being implemented while another directive is being undermined. You can see where all that sort of stuff eventually undermines people in terms of what is a priority”.*

## Single Cell Occupancy

The on-going problem of overcrowding in the Irish prison system has resulted in a *de facto* abandonment of the principle that in general, cells should not hold more than one prisoner – a principle which has been espoused in Irish penal policy for some decades. The 1947 Rules for the Government of Prisons provided, in rule 4, that:

*“Each prisoner shall occupy a cell by himself by day and by night (except as otherwise directed). If, for medical reasons or in other special circumstances, it is necessary that prisoners be associated, not fewer than three prisoners may be located in one room, in which each shall be supplied with a separate bed”.*

The Report of the Whitaker Committee of Inquiry into the Penal System (1985) also advocated a commitment to single cell occupancy, stating:

*“Basic living conditions for a prisoner should correspond broadly to those available to persons with an average disposable income. Thus, prisoners should be expected to have... normally (and always where prisoners so desire) private sleeping accommodation in single cells, with beds and bedding of normal quality”.*<sup>79</sup>

A similar approach was taken in the 1987 European Prison Rules, rule 14 of which stated:

*“1. Prisoners shall normally be lodged during the night in individual cells except in cases where it is considered that there are advantages in sharing accommodation with other prisoners.*

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<sup>79</sup> Report of the Committee of Inquiry into the Penal System (July 1985), para. 7.4.

2. *Where accommodation is shared it shall be occupied by prisoners suitable to associate with others in those conditions...*”

In 1994 the Department of Justice published a five-year plan for the prison service entitled *The Management of Offenders*. Appended to the plan was a set of draft Prison Rules. The draft Rules explicitly acknowledged the influence of the European Prison Rules, stating:

*“Prisons shall be operated, as far as practicable, in accordance with the principles of the European Prison Rules (Strasbourg 1987) as adopted by the Committee of Ministers of the Council of Europe on 12 February, 1987, and the principles of any international instrument for the promotion of human rights to which the State is a party”.*<sup>80</sup>

The draft Rules maintained an express commitment to single cell occupancy, albeit with certain reservations, stating:

*“(a) A prisoner shall, as far as practicable, be given a cell for sole occupation. Cells shall not be used to accommodate prisoners unless certified by the Minister as being suitable from the point of view of size, lighting, ventilation, heating and fittings for such use, and as having a means of communication with prison staff. Where there are specific medical or psychosocial reasons to justify such a course, prisoners may be accommodated more than one to a cell.*

*(b) Where the Governor of a prison is of the opinion that accommodation in a prison is insufficient to enable each prisoner to occupy a cell by himself / herself, the Governor may give a direction enabling, for so long as the said accommodation continues to be insufficient, two or more prisoners to occupy a cell and such direction may, in relation to the prison concerned, apply to prisoners generally or prisoners of a particular class or description. Where a direction under this Rule is, for the time being, in force and in the opinion of the Governor the insufficiency of accommodation which caused the direction to be made no longer exists, he shall revoke the direction. Where prisoners are*

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<sup>80</sup> The Management of Offenders (1994) Draft Prison Rules, Part II, rule 1.

*accommodated more than one to a cell, care shall be taken that each prisoner has a separate bed, bedding and utensils”.*<sup>81</sup>

Notwithstanding the publication of these draft Prison Rules in 1994, it was 2007 before the 1947 Prison Rules were substantially overhauled.

In December 1995, the Irish Government published a report submitted to it by European Committee for the Prevention of Torture (CPT) which, amongst other things, was critical of the level of overcrowding in the Irish prisons visited by the Committee. The CPT recommended that *“a very high priority be given to measures designed to reduce overcrowding”*.<sup>82</sup> In its published response to the CPT report, the Government responded to criticism on the issue of overcrowding by renewing a commitment to single cell occupancy, stating:

*“Single cell occupancy (except, of course, in recognised dormitory set-ups) is one of the objectives of official policy. Wheatfield Place of Detention was designed around single cell occupancy... Furthermore, any new prisons will be designed for single cell occupancy”.*<sup>83</sup>

However, the next new prison to be designed and built – Cloverhill Prison, which opened in June 1999 – contained 120 triple cells, five double cells and only 60 single cells.

In 2001, the Irish Prison Service (IPS) published a Strategy Statement which promised that the next phase of prison building would provide a further 466 prisoner places by the end of 2003. It was suggested that the new places would

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<sup>81</sup> The Management of Offenders (1994) Draft Prison Rules, Part IV, rule 1.

<sup>82</sup> Report of the European Committee for the Prevention of Torture (publ. 13/12/1995), para. 98

<sup>83</sup> Government response to CPT Report, 13 December 1995.

*“...eliminate pockets of overcrowding and facilitate movement towards a model of predominantly single-cell accommodation for prisoners”.*

In February 2006, a revised version of the European Prison Rules was published. Rule 18 expanded on the previous rule regarding sleeping accommodation for prisoners, stating *inter alia* that:

*“18.1 The accommodation provided for prisoners, and in particular all sleeping accommodation, shall respect human dignity and, as far as possible, privacy...*

*...*

*18.5 Prisoners shall normally be accommodated during the night in individual cells except where it is preferable for them to share sleeping accommodation.*

*18.6 Accommodation shall only be shared if it is suitable for this purpose and shall be occupied by prisoners suitable to associate with each other.*

*18.7 As far as possible, prisoners shall be given a choice before being required to share sleeping accommodation”.*

The goal of “a pre-dominantly single-cell model” was still being held up in the IPS draft Strategy Statement for 2006 – 2008.<sup>84</sup> However the new Prison Rules issued by the Minister for Justice [S.I. No.252 of 2007] make no mention of single cell occupancy. Rather, rule 18(2) (a) states:

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<sup>84</sup> IPS draft Strategy Statement 2006–2008 (unpublished), quoted in the Irish Prison Service Capital Expenditure Review (Nov 2006).



*“The Minister may specify the maximum number of persons who may, in normal circumstances, be accommodated in cells or rooms belonging to such class as may be so specified”.*

In its Interim Report, submitted to the Minister in December 2007, the Commission observed that

*“Based on its research to date, the Commission is inclined towards the view that the provision of single cells for prisoners’ best meets the legal and human rights obligations of the State”.*

The Inspector of Prisons, in his annual report for 2008 (submitted to the Minister in May 2009) accepted that some doubling up of prisoners in single cells could not be avoided, given the resources available in the current prison system. However, he was adamant that the practice should be kept within certain limits, stating:

*“I accept that in certain cases because of the numbers in Irish Prisons and because of the limited accommodation in such prisons that doubling up of prisoners in cells is inevitable. I accept that, in this context, a distinction must be drawn between some of the accommodation cells in Mountjoy, Cork and Limerick prisons and those in newer prisons such as Wheatfield and the Midlands. The former were constructed in the 19<sup>th</sup> century, are small with little light and ventilation and no in-cell sanitation. Whereas the latter are larger, have adequate light and ventilation and are equipped with in-cell sanitation. Doubling up of prisoners in cells should only be accepted as a temporary measure (which should be kept under constant review) and should, except in exceptional circumstances, never happen with the following classes of prisoners: -*

- *prisoners on 23 hour lock up*
- *prisoners who are kept in their cells longer than normal*
- *prisoners serving life sentences*

- *prisoners serving long sentences*
- *male or female prisoners who because of their type of prison accommodation do not enjoy the [same] norms of privacy as other prisoners*
- *prisoners who, because of their mental, medical or physical conditions, could not be deemed suitable for such multiple cell occupancy”<sup>85</sup>*

It is clear from the Inspector’s 2008 report that these proposed limitations were being exceeded as a matter of routine throughout the prison system in 2008 and in the early part of 2009. This was particularly the case in Mountjoy.

As of 16<sup>th</sup> February 2009 the Inspector assessed the design capacity of the cells in use at Mountjoy as being 489 prisoners. The stated bed capacity as of that date was 573, achieved by doubling the capacity of 84 single cells through installing bunk beds. The Inspector went on to state in his 2008 report that

*“When the population of Mountjoy Prison exceeds 573 the overflow numbers are accommodated on mattresses on the floor in cells already occupied, in cells not meant for that purpose or in holding cells in the reception area.*

*Since 1<sup>st</sup> January 2008 Mountjoy Prison has consistently operated far beyond its design bed capacity and also beyond its stated bed capacity”.*<sup>86</sup>

Mountjoy is not the only prison to have struggled with overcrowding. A report of the Inspector of Prisons entitled *“The Irish Prison Population – an examination of duties and obligations owed to prisoners”*, dated 29 July 2010 found that Castlerea, Cloverhill, Cork, Wheatfield, Limerick prisons, and the Dóchas Centre were all operating with prisoner populations in excess

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<sup>85</sup> Inspector of Prisons, Annual Report 2008, para. 7.4.

<sup>86</sup> Ibid., para. 7.14, 7.15.

of their stated bed capacity. A report of the Thornton Hall Project Review Group (commissioned by the Minister for Justice in April 2011) observed that at that time the:

*“Available statistics... show that the number of persons committed to prison has increased steeply in recent years... Such forecasts as are available indicate further increases, reaching levels far in excess of the capacity within the prison estate and which cannot but cause concern to all concerned with criminal justice policy, penal policy and prison planning”.*<sup>87</sup>

However efforts to reduce the prison population are proving effective. The following table, taken from the most recent Annual Report published by the IPS, shows the daily average number of prisoners per institution during 2012:

<b>Institution</b>	<b>Bed Capacity</b>	<b>In Custody</b>
Arbour Hill	148	146
Castlerea	351	361
Cloverhill	431	429
Cork	252	259
Limerick (male)	263	261
Limerick (female)	34	28
Loughan House	149	104
Midlands	638	616
Mountjoy (male)	589	603
Mountjoy (female)	105	124
Portlaoise	316	278
Shelton Abbey	113	102
St Patrick's	217	204
Training Unit	127	116
Wheatfield	687	687

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<sup>87</sup> Report of the Thornton Hall Project Review Group (July 2011), p.4.

It is important to remember however that the above figures constitute a daily average; they do not reflect the fact that on a given day, certain prisons could face considerably worse overcrowding as the prison population fluctuates.

## Overcrowding In Mountjoy Prison

The problem of excessive prisoner numbers has been particularly acute at Mountjoy for many years now. The reasons for this include its status as a committal prison, the rising number of prisoners on methadone maintenance who cannot be transferred anywhere else, as well as the archaic design and dilapidated condition of the prison itself.

In December 2003 – 2 ½ years before the death of Gary Douch – the Prison Officers' Association (POA) submitted a report to the Governor of Mountjoy Prison which highlighted concerns about overcrowding and related matters at the prison. The report stated:

*“The number of inmates currently in custody in Mountjoy Prison, and the manner and conditions in which some are being held, are appalling, dangerous and amounts to cruel and inhuman treatment of persons in custody. Our members have to work in these conditions and are adversely affected by them.*

*A particular area of concern is the two holding cells in the ‘B Base’ area. The all too frequent use of these cells to house anything from 10 to 22 inmates is shocking. Each of these cells measures approximately 3 metres x 4 metres. They contain only a built-in bench and a toilet. After 10 p.m. at night, each cell holds on average 5 inmates. The remaining inmates (usually 10) are taken from the holding cells and brought to the waiting area in the reception where they are then required to sleep. No beds are provided for any of the inmates, only filthy mattresses. These are placed on dirty floors in the holding cells and equally dirty seats in the reception area. Between 6am and 7am the inmates in the reception area waiting room are transferred back to the holding cells in the ‘B Base’ area. These inmates are then required to have their breakfast, dinner, tea, and late supper in these cells”.*

The Prison Officers' concerns were also conveyed to the Inspector of Prisons, who visited Mountjoy immediately on receipt of the POA report and echoed its views in his own subsequent report on the prison.

In response both the Director General and the Director of Operations for the IPS made several visits to Mountjoy to assess the situation for themselves. Following these visits the IPS Director of Operations issued a circular to all prison Governors on 9 March 2004 entitled "Prison Movement Policy". The circular stated:

*"Over the next few weeks an operation will be carried out to ensure that the prison population is distributed more evenly across the State...*

*Prisons are requested to continue providing lists of prisoners considered suitable for transfer. This should be done as early in the day as possible. Operations Directorate will also examine the records to look for possible candidates.*

*Until further notice the following general movement policy will operate:*

*(1) No arrangement should be made to transfer or return any prisoner to Mountjoy without clearing it in advance with this Directorate. Approval will only be given in exceptional circumstances..."*

The circular also stated:

*"Each morning all prisons should, in addition to their daily figures, be in a position to supply a figure for vacancies as per the attached form which should be faxed to Operations".*

The document ended by stating:

*"Once we have completed the redistribution the position will be reviewed".*

The documentation disclosed to the Commission does not indicate for how long the abovementioned general movement policy was implemented. However, subsequent events make clear that overcrowding at Mountjoy remained a significant issue in 2006, some two years later.

On 17 February 2006 the Prison Officers' Association submitted another report to Governor Lonergan concerning overcrowding at Mountjoy, with particular reference to the B Base. The report stated:

*“On the night of the 15<sup>th</sup> February 2006, Mountjoy Prison had 513 persons in custody. There were not enough mattresses or duvet covers for all the inmates. On Thursday, 16 February 2006, the two holding cells in the B Base contained over twenty inmates...*

*That any person would be held in such conditions is evidence of the complete and utter disregard that the Irish Prison Service authorities have for the basic human rights of persons in custody. These conditions pose a serious health hazard for all within the prison.*

*It is fully acknowledged and recognised that you [Governor Lonergan] are not in control of who is committed to Mountjoy Prison; or who is transferred out of it; or who is granted temporary release from it. The transfer of prisoners and the granting of temporary release are vested solely in the Minister. There were vacancies in other prisons on this date.*

*The Minister for Justice, Equality and Law Reform and his Department along with the Irish Prison Service H.Q. have serious questions to answer in respect of these type of conditions and the way in which the prisons are managed.”*

The POA report concluded:

*“Warehousing inmates in these type of conditions, within such a prison, along with even a further withdrawal / reduction of services to inmates, are the ingredients for violent unrest in this prison.”*

On 29<sup>th</sup> June 2006 Governor John Lonergan wrote to the IPS Director General Brian Purcell concerning the overcrowding crisis in Mountjoy. He informed Mr Purcell that

*“At unlock this morning 71 prisoners were confined in the B Basement area. This is dangerous, inhumane and totally unacceptable placing the safety of both staff and prisoners at serious risk”.*

The letter continued:

*“When the Separation Unit and ‘A’ Division closed some years ago, Director General Sean Aylward gave an undertaking that the maximum number of prisoners in Mountjoy would be 450.*

*As you know we have no control over the number of prisoners being committed here and neither have we any control over the transfer of prisoners out of Mountjoy.*

*I am therefore requesting that the number of prisoners in custody here be significantly reduced immediately. This can be achieved by either transferring prisoners out of Mountjoy to other prisons or by the use of temporary release”.*

Governor Lonergan told the Commission that he received no written response to this letter.

On 26 July 2006 the Governor of Mountjoy Prison received a faxed letter from solicitors representing a prisoner who was being held in one of the holding cells in B Base at that time. The letter stated:

*“We are instructed that the conditions under which [our client] is currently being held fall far short of the minimal acceptable standards required for sentenced prisoners.*

*We are formally requesting you to immediately rectify this situation otherwise we will have no option but to make an application on his behalf to the High Court.”*

Leave to apply for judicial review was granted to the prisoner by the High Court at a hearing on 27 July 2006. On the following day, the prisoner was moved out of the Base area to a cell on D2 wing of Mountjoy. Following a succession of adjournments, the High Court proceedings initiated by the prisoner were eventually struck out with no order on 6 May 2010.

The existence of this legal complaint regarding conditions in B Base, launched only a few days before the fatal assault on Gary Douch took place in holding cell 2, was not disclosed to the Commission by the Irish Prison Service – a fact that causes the Commission no little concern. The Commission became aware of the case in 2012 through its own inquiries, and obtained further information and documentation from the firm of solicitors who represented the prisoner

in question. Following this, in response to a formal direction by the Commission, the IPS disclosed a number of files and folders relating to this prisoner's complaint and the subsequent legal proceedings.

Amongst the documents disclosed to the Commission by the prisoner's solicitors was an affidavit sworn in July 2009 by a prison officer from Mountjoy Prison who had prepared the POA reports of December 2003 and February 2006 concerning conditions in the B Base area. With reference to conditions in the B Base he stated:

*"Because of my concerns in relation to the conditions of the holding cells, I visited the holding cells on a regular basis. Often the cells were overcrowded with up to 25 persons in one cell....*

*I witnessed on many occasions men stripped down to their underwear and sweating profusely and a sauna-like heat within the cell coupled with an inhuman stench from body odour and lack of ventilation."*

The officer referred to a specific visit conducted by him on 25<sup>th</sup> July 2006:

*"On July 25<sup>th</sup> 2006 I visited the holding cells. A person that I now know to be the applicant was present in the holding cell along with approximately twenty other people. The stench and heat in the holding cells were unbearable, given the hot July weather. Some of [the] inmates in the holding cell were very angry and tension was very evident. Four of five of the inmates were stripped to their underwear and were sweating profusely. I entered the cell and listened to their concerns.*

*During the said visit, at least two persons, including the applicant, asked me to contact their solicitors... in relation to the conditions of their detention."*

Figures disclosed to the Commission by the IPS show that the number of prisoners contained in the two holding cells varied considerably throughout each day, but that overcrowding remained a problem throughout the month of July 2006, as the table below indicates:



<b>Date (2006)</b>	<b>Number of prisoners (minimum-maximum) contained between 2 holding cells, 8am-11pm</b>	<b>Total number of prisoners in both holding cells at 11pm</b>
10 July	3-7	4
11 July	3-13	13
12 July	10-21	21
13 July	14-20	15
14 July	6-23	15
15 July	13-20	13
16 July	9-14	9
17 July	9-15	12
18 July	11-20	17
19 July	7-17	14
20 July	12-17	16
21 July	11-20	20
22 July	19-24	20
23 July	4-20	20
24 July	4-21	21
25 July	18-29	29
26 July	12-29	12
27 July	5-16	16
28 July	12-16	<i>[number not given in IPS table]</i>

The Commission has been given to understand that the number of prisoners contained in the two holding cells at 11pm on any given night does not necessarily reflect the number who slept in

those cells overnight, as prisoners were frequently taken out of the holding cells to sleep in the reception area if the holding cells were chronically overcrowded.

On 31<sup>st</sup> July 2006 – the date Gary Douch was killed – there were 527 prisoners in Mountjoy, some 82 more than the stated bed capacity at that time. This included 68 prisoners in the “B Base” area.

## **Overcrowding Since the Death of Gary Douch**

In the immediate aftermath of Gary Douch’s death, a concerted effort was made by the Irish Prison Service to reduce the number of prisoners in Mountjoy. By 12<sup>th</sup> September 2006 it was reported that the number in custody at Mountjoy had been reduced from 527 to 429, which was below the stated bed capacity at that time of 445.

Other measures taken at that time included the designation of Wheatfield and Midlands Prisons as committal prisons (dating from 1<sup>st</sup> September 2006) and a review of the bed capacity of both Wheatfield and the Midlands with a view to possible increases. At Mountjoy, the two holding cells in “B Base” at Mountjoy were closed immediately following Gary Douch’s death. One was subsequently converted into a shower unit for prisoners in the Base, with the other being split into a special observation cell (with a glass door) and a smaller holding cell.

Governor Lonergan and the Building Services Division of the IPS also examined the possibility of re-opening A2 and A3 landings, providing a further 82 cells. By September 2007 these two landings had been refurbished and re-opened.<sup>88</sup> The purpose of opening these extra cells was not to increase the overall prisoner capacity of Mountjoy, but rather to allow for more single cell occupancy within the prison. This is not how matters turned out, as Governor Lonergan explained to the Commission in December 2009:

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<sup>88</sup> See Govt response to CPT report, Sept 2007.

*“...our understanding was that we would still be held around 500 or 480 and the 80 extra cells would give us an opportunity to give a lot more people single cell occupancy. The outcome really has been the opposite, that instead of getting – even if we were to fill the 82 cells, we have on top of that at times over 100 more than the extra 80 cells. Before the summer recess this year we were up around 680 that meant we were 150-ish more than the 80 extra cells...”*

The Inspector of Prisons’ annual report for 2008 makes it abundantly clear that within 18 months of the death of Gary Douch, overcrowding in Mountjoy had once more reached crisis proportions. The Inspector singled out one particular night of 24<sup>th</sup> February 2009, when the population of the prison was 660 – 87 over the stated bed capacity of the prison at that time. He stated:

*“I was so concerned at the situation that I wrote on the 27<sup>th</sup> February 2009 to the Department and to the Irish Prison Service expressing my fear that this practice could lead to possible serious injury or loss of life”.*

The situation with regard to “protection prisoners”, housed on C2 landing and in the “B Base” area of Mountjoy, was highlighted as a particularly serious violation of prisoners’ human rights and dignity:

*“The stated bed capacity on the 16<sup>th</sup> February 2009 of C2 was 35. On that date there were 46 prisoners accommodated on this landing. 11 were on mattresses on the floor or in cells not meant to be used for accommodation purposes.*

*There are 6 single and 8 four man cells in B Basement. This gives a bed capacity of 38. On the 16<sup>th</sup> February 2009 there were 48 prisoners in this area. 10 were on mattresses on the floor or in cells not meant to be used for accommodation purposes.*

*Accommodating prisoners in excess of the design capacity in these conditions where they are on 23 hour lock up is inhuman and degrading”.*

On 13<sup>th</sup> August 2009 the Inspector of Prisons presented the Minister for Justice with a report which gave “a factual overview of Mountjoy Prison covering eight months from my initial

unannounced visit on 25<sup>th</sup> and 26<sup>th</sup> of November 2008 to my last visit on the 2<sup>nd</sup> July 2009". The Inspector visited Mountjoy on 11 occasions during that period.

In the course of the introductory observations contained in this report, the Inspector stated:

*"I am conscious that Mountjoy Prison is a very old institution and that this brings its own am conscious that the services that should be provided as a minimum can only be provided to a finite number of prisoners and I am also conscious of the constraints on the public finances. In this regard I must point out that none of these can be taken as an excuse for denying prisoners their basic human rights".*

Referring to the prospect of Mountjoy eventually being phased out in favour of a new prison at Thornton Hall, the Inspector stated:

*"Neither can the prospect of building a new prison be an excuse for not attending to all matters of concern as set out in this report".*

The Inspector continued:

*"From my observations and from my conversations with a wide cross section of people – prisoners, staff and service providers I am satisfied that, despite the efforts of management and staff, Mountjoy Prison cannot, at present, provide safe and secure custody for its prisoners. It is questionable as to whether the prison provides a safe environment for staff to work in".*

Nonetheless, the Inspector was unwilling to issue a total condemnation of the prison and made a number of recommendations for improving conditions there, stating:

*"There are many positives in the prison and if my recommendations... are acted on Mountjoy Prison can continue, in the short term, to play an important role in the Irish Prison System where safe and secure custody can be provided in an environment which respects human rights and human dignity, that is safe for staff to work in and where prisoners live in a structured environment".*

The first recommendation of the Inspector concerned overcrowding. At paragraph 2.27 of the report he stated bluntly:

*“If Mountjoy Prison is, in the short term, to remain part of the Irish Prison Estate the numbers must be reduced to 540 and not allowed increase beyond this figure”.*

The Inspector acknowledged that efforts have been made by the IPS to increase the number of places available within the prison system as a whole, referring to plans to provide an additional 400 spaces before the end of 2009. To date in fact, approximately 600 new prison places have been provided since 2008 as a result of investment in prison infrastructure by the IPS. This includes 100 new spaces at Castlerea Prison, 200 at Portlaoise Prison, and 200 at Wheatfield Prison.<sup>89</sup>

Notwithstanding these newly built prison spaces however, the overcrowding problem in Mountjoy was slow to improve. On 26<sup>th</sup> April 2010 the *Irish Times* published an opinion piece by Mr Paul Mackay, who had served as a member of the Mountjoy Visiting Committee for the previous three years. Mr Mackay began by stating:

*“Throughout my time on this committee, I have been horrified by the appalling conditions experienced by inmates in the prison, and by the indifference which official Ireland has shown regarding the issue”.*

Referring to conditions in the prison at that time, Mr Mackay stated:

*“On-going living conditions for prisoners at the prison are ‘inappropriate’, to say the least:*

*Prisoners in overcrowded cells sleeping on floors infested with cockroaches, mice, ants and other assorted vermin. Others sleeping in shower areas, reception areas and other unsuitable areas*

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<sup>89</sup> Report of Thornton Hall Project Review Group (July 2011), p.30.

*Prisoners forced to perform daily bodily functions in their cells in front of cell mates, and 'slopping out' when cell doors are reopened*

*Prisoners having to eat all their meals in the same confined cell area where they sleep and perform their bodily functions*

*23-hour lockup for those on protection, with just one hour of possible association / recreation.*

*The above inhuman practices and other malpractices arise, in the main, due to the severe and continuous overcrowding at the prison”.*

In a written response to questions in the *Dáil* arising from Mr Mackay’s article, the Minister for Justice stated, *inter alia*:

*“While Mountjoy Prison predominantly comprises single cell accommodation, multiple cell occupancy does exist, particularly in the Base area of the prison and some other areas. The Governor of the prison has recently re-issued an order concerning the use of holding cells, the shower room and other areas of the Base area of the prison, instructing staff that under no circumstances should these locations be used for the purpose of overnight accommodation. Instead, prisoners should be placed in the normal cellular accommodation on the landings, which as I have already stated, are predominantly single cell accommodation at present”.*

One might be tempted to infer from the above response that holding cells, shower rooms and other unsuitable areas were being used for overnight accommodation at a time when other, better options were available. The Commission has not seen any evidence to suggest that this was so. On the contrary, prison staff were driven to use these areas as measures of last resort. They were being placed in situations where they had no choice but to disregard management orders in the matter. This was the situation in 2006, and it remained the situation until very recently.

On 15<sup>th</sup> May 2010, the *Irish Examiner* reported that the number of prisoners in Mountjoy had reached 670. The same number was reported by the *Irish Times* on 6<sup>th</sup> June 2010. On 25<sup>th</sup> June 2010 that number stood as high as 697, according to the Irish Penal Reform Trust. Problems

continued into 2011. In a report on the prison dated 24 March 2011 the Inspector of Prisons noted:

*“On the 8<sup>th</sup> March 2011 Mountjoy Prison held 710 prisoners. The stated bed capacity according to the Irish Prison Service was 630 whereas... the maximum number that should have been accommodated was 517. This means that on that date the prison population stood at 137% of capacity based on the criteria set out in... my report dated 29<sup>th</sup> July 2010.”*

Since that time, however, it must be said that conditions in Mountjoy have undergone a considerable improvement. In May 2011 the ‘C’ Wing was closed for refurbishment, reopening in March 2012 with the inclusion of a new, dedicated committal area. The ‘B’ Wing was then closed in April 2012 and reopened in December of that year. Refurbishment was then carried out on ‘A’ Wing, and completed in September 2013. The final stage in this process is the renovation of ‘D’ Wing, with a projected completion date of January 2015.

As at September 2013, the stated bed capacity of Mountjoy Prison was 540, which matches the Inspector of Prisons’ stated maximum in his Assessment of the Irish Prison System dated May 2013. In that report the Inspector noted:

*“All the newly refurbished cells are now used as single cells and an undertaking has been given that they will not be doubled in the future. I accept this undertaking.”*

He concluded:

*“I am satisfied that, in so far as the provision of accommodation is concerned, Wings A, B, C and D in Mountjoy Prison do and will meet the highest of standards and will stand scrutiny by any inspection body.”*

## Thornton Hall

In response to the issue of overcrowding and growing prisoner numbers, the Irish Prison Service has sought to increase the number of available prison spaces. Since 2006, this has been done through a series of renovations and extensions to existing prisons, including Castlerea, Portlaoise, Wheatfield, and Mountjoy. Further such works are planned, including the construction of a new accommodation block in the Midlands Prison which will provide a potential 300 prison spaces alongside additional work training and education facilities.

In the longer term, the principal means by which the IPS would address the overcrowding issue was to be the construction of an entirely new prison complex at Thornton Hall, County Dublin. In a recently published response to the report of the European Committee for the Prevention of Torture (CPT) on Irish prisons, the Irish Government stated:

*“The Irish Prison Service is committed to the prison capital programme, which ... will result in the replacement and / or refurbishment of nearly 40% of the entire prison estate. The Government is also fully committed to developing a new prison campus at Thornton Hall, County Dublin. The new prison facility will provide 1,400 cells with operational flexibility to accommodate up to 2,200 in a range of security settings”.*<sup>90</sup>

The initial plan was to finance and construct the new prison by way of a Public-Private Partnership between the State and the successful bidder in an EU-wide tender competition, which took place in 2006. A preferred bidder was appointed in April 2007 and a final offer was submitted by that bidder in February 2009. However, changing economic circumstances during that period resulted in the offer being deemed “*not affordable in light of the significant increase in the cost of finance*”.<sup>91</sup> Nonetheless, it was decided to proceed with the development of Thornton Hall on a phased basis. At that stage it was hoped that the prison would become operational in 2015.

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<sup>90</sup> Response of the Government of Ireland to the CPT report, dated 10 February 2011, p.15.

<sup>91</sup> Ibid.



In April 2011 the Minister for Justice appointed a Review Group to examine the need for new prison accommodation and to consider the possible alternatives regarding the future development of the Thornton Hall site. In a report published on 28<sup>th</sup> July 2011, the Review Group recommended that a new prison be built at Thornton Hall, but on a reduced scale from that originally envisaged.

*“We recommend that the design of the prison should provide for 300 cells capable of accommodating 500 prisoners. In addition, the prison should have 20 secure step-down facilities... capable of accommodating up to 200 prisoners in an open centre typesetting within the secure perimeter”.*<sup>92</sup>

The Review Group acknowledged in its report that the building of a prison on such a reduced scale at Thornton Hall would mean that *“Mountjoy Prison will have to remain open for the foreseeable future”*.<sup>93</sup>

On 10<sup>th</sup> November 2011 the Minister for Public Expenditure and Reform announced that due to budgetary constraints, the building of Thornton Hall was to be deferred indefinitely.

A proposal to replace Cork Prison with a new prison at Kilworth has also been deferred for economic reasons. However, consideration is being given to building a new prison facility on the car park of the existing Cork Prison.

## 5.3 Prisoners on Protection

On 31<sup>st</sup> 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.

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<sup>92</sup> Report of the Thornton Hall Review Group (July 2011), p.68.

<sup>93</sup> Ibid. p.69.

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.

The Irish Prison Chaplains' Report for 2010 points out that in December 2009, there were 972 prisoners on protection for their own safety – approximately 20% of the Irish prison population at that time. The report goes on to state:

*“The overcrowding in our prisons prevents management from providing relatively safe conditions for prisoners (we accept that totally safe conditions can never be guaranteed in a prison with some difficult and dangerous prisoners), apart from the provision of almost total isolation (23-hour lock up). This is unacceptable”.*

Just as overcrowding can impede a prison's capacity to protect prisoners, the requirement to accommodate prisoners who seek protection can itself result in overcrowding. As the Inspector of Prisons points out in his Assessment of the Irish Prison System (May 2013):

*“A serious complicating factor in computing the maximum numbers that could be accommodated in each prison is the high number of ‘protection prisoners’ in the majority of the closed prisons. The amount of out of cell time that such prisoners enjoy ranges from reasonable to the bare minimum provided for in the Irish Prison Rules. Those prisoners who are on 23 hour lock up have little or no access to the school, gym etc... In many cases such prisoners are accommodated two to a cell. The accommodation of such prisoners (two to a cell) even in double cells can amount to overcrowding.”*

To give a contemporary indication of the scale of the problem, the Inspector provided a table setting out the number of protection prisoners in various prisons on 31<sup>st</sup> March 2013. On that date there were 115 prisoners on protection in Mountjoy, out of a total of 543 in custody – approximately a fifth of the Mountjoy prison population on that day. All of those 115 prisoners

were on a restricted regime which resulted in them being locked up for 23 hours a day. In Cloverhill on the same day, 107 prisoners out of a total population of 392 were on protection – although only 17 were on restricted regimes. Cork prison had 55 out of a total of 240 prisoners on protection – again, around a fifth of the prison population – with 14 on restricted regimes.

## European Committee for Prevention of Torture

In May 2002 a delegation from the European Committee for the Prevention of Torture (CPT) visited a number of Irish prisons. The CPT delegation reported hearing accounts of inter-prisoner violence in all prisons visited, and sought information from the Government as to what strategies were in place to address the problem.

In a written response to the CPT report the Irish Government outlined its strategy on this issue as follows:

*“Every reasonable effort is made to ensure that prisoners are kept in safe and secure custody including:*

*Supervision by staff. Staff vigilance plays a key role in preventing assaults. Prison intelligence is used to pre-empt incidents.*

*Location of prisoners within the prison system. Prisoners deemed to be most at risk from other prisoners are segregated from the general population for their own protection.*

*Prisoners and their effects are searched to prevent them having in their possession weapons or instruments that could be used for offensive purposes.*

*In addition, a range of programmes are in existence aimed at tackling offending behaviour. These programmes, of which anger management is an example, are considered not just to benefit the wider community in terms of reduction of the risk of re-offending but also to have a beneficial effect on the prisoners behaviour while in Prison and on his or her ability to relate to fellow prisoner in a non-aggressive manner.*

*The Irish Prison Service has also set up a working group on inter-prisoner assaults to refine its approach to this issue. Part of the Group's remit is to agree a standard clearly understandable system of classification and recording of assaults across the prison estate...*

*A related aspect is the bullying of prisoners by other inmates. A working group has been set up to enquire into this. The group which is due to report shortly will examine how widespread bullying is at present in the Prisons and how it is dealt with. Reference to the practice in other jurisdictions will also be made. The group will recommend an anti-bullying policy for launch in the Prison Service".*

The Commission has not seen the report of the abovementioned working group, and is not aware of any policies arising from the group's research.

The CPT returned to the subject of inter-prisoner violence in a report following a further visit in October 2006. The report (published by the Government in October 2007) stated:

*"The Committee is also very concerned when it discovers a culture which is conducive to inter-prisoner intimidation and violence. In the view of the CPT's delegation, at least three of the prison establishments visited can be considered as unsafe, both for prisoners and for prison staff (notably, Limerick and Mountjoy Prisons and even St. Patrick's Institution). The extent of the inter-prisoner violence in these prisons is worrying, and the increasing numbers of persons seeking the protection of the prison management is a symptom of this development... Stabbings and assaults with various objects are frequent and many prisoners met by the delegation bore the marks of such incidents.*

*The reasons behind the increase in inter-prisoner violence are varied but there are a number of interlinking issues that stand out, notably the availability of drugs and the lack of purposeful activities. The increased use of and demand for drugs within prisons is fuelling a younger, more aggressive prison population, who have little to do besides plotting how to get their next fix. Further aggravating factors include the existence of feuding gangs carrying on their vendettas within the prison environment; the lack of an individualised risk and needs assessment for all prisoners; the lack of space and poor material conditions in prisons".*

The report referred specifically to the death of Gary Douch, stating:

*“The killing of a prisoner at the hands of a cell-mate in Mountjoy Prison on 1 August 2006 represents a tragic illustration of the unsafe nature of certain prisons in Ireland”.*

The CPT report went on to give further consideration to the issue of protecting prisoners from other prisoners, stating:

*“In the course of the 2006 periodic visit, the CPT’s delegation examined the issue of prisoners on protection in all of the prisons visited. While statistics were not available, the impression gained from prison management and staff was that the numbers of inmates on protection had increased dramatically in recent times. For example, the basement of B Block at Mountjoy Prison was now a dedicated unit for prisoners on protection; however, even these cells – accommodating 41 prisoners at the time of the visit – were insufficient and a further sixteen inmates were kept on protection in cells on the first floor of C Block (C2). In other prisons a similar situation prevailed.*

*There was no standard approach towards prisoners placed on protection, other than the recognised duty of care owed by the authorities to prevent harm coming to the prisoners under their ward. In Mountjoy, Limerick, Cork, and Cloverhill Prisons and in St. Patrick’s Institution, inmates on protection were concentrated, as far as possible, in a given unit or area of the prison, while in Wheatfield Prison the policy was to avoid taking inmates on protection off the accommodation units to which they had been assigned.*

*The common denominator was that in nearly all cases prisoners on protection were being kept locked in their cells for 23 hours a day, with only the possibility of one hour of outdoor exercise...*

*The CPT ... considers it essential for additional measures to be taken in order to provide prisoners placed on protection with appropriate conditions and treatment; access to activities, educational courses, and sport should be feasible. Moreover, there needs to be a more proactive approach by the prison health-care service towards prisoners on protection, particularly as regards psychological and psychiatric care, especially as*

*many of them might spend a year or more virtually in solitary confinement. There should also be an individual assessment of their needs at regular intervals and, where appropriate, transfer to another prison should be considered.*

*The CPT recommends that the Irish authorities give due consideration to the situation of prisoners placed on protection, in the light of the above remarks”.*

The CPT report also commented:

*“More generally, there should be a process of regular independent reviews of placement on protection, with the possibility for prisoners to appeal against any decisions to place them on protection against their will. **The CPT would like to be informed about the reviews and safeguards in place”.***

In a response published alongside the CPT report in October 2007, the Irish Government stated:

*“While the prison regime is designed to limit the scope of acts of violence, it is not possible to completely eliminate the possibility of such acts in prisons holding a high proportion of violent offenders without introducing a regime that would be unacceptable. The CPT has rightly identified an emerging problem with violence in Irish prisons. While not accepting that within a prison context the three prisons mentioned could be classified as unsafe, nevertheless it is accepted that further measures are required to address the issue and this is expanded upon below”.*

Regarding the specific issue of protection regimes for prisoners, the Government response stated:

*“In relation to the number of prisoners on protection, this is regarded by the Irish Prison Service as an indicator of the steps taken in individual prisons to ensure in so far as possible the safety of prisoners. The fact that prison management immediately separates prisoners seeking protection from the general prison population or from specific prisoners identified as presenting a threat, clearly demonstrates prison management’s commitment to ensuring safety and security.*

*It is at the committal stage that the majority of prisoners who seek protection express their wish. External influences imported to the prison on committal include gang rivalry, drug debts and perceived cooperation with the police. On committal, all prisoners are interviewed by the Governor and based on all the information available, a decision is made as to where a particular prisoner will be accommodated. In some instances, prisoners are transferred to other establishments”.*

The Government response continued:

*“All of the measures identified by the CPT are incorporated in the Irish Prison Service’s management of protection prisoners. All prisons review prisoners’ needs at the point when they request placement on protection and subsequently in the light of changing needs and requirements. Inmates on protection are seen on the same basis as any other inmate by the Doctor, Nurse Officer, Psychologist and Psychiatrist and have the same access to dental care and addiction services. They are seen regularly by the Nursing staff to monitor for deterioration in their physical or mental health”.*

The safety of prisoners in Irish prisons was again raised by the CPT following a visit in January / February 2010. Referring to the fact that the CPT report in 2006 had described Limerick, Mountjoy and St Patrick’s Institution as being unsafe, the CPT went on to observe:

*“In the intervening period, the CPT’s delegation noted that a number of measures have been taken to address safety concerns, and this was particularly noticeable at St Patrick’s Institution where the levels of violence have reduced considerably. However, the situation in Mountjoy Prison remains worrying and the prison, in the view of the CPT’s delegation, remains unsafe for prisoners and prison staff alike. The increasing number of prisoners seeking the protection of the prison management from other prisoners is a symptom of this development. Stabbings, slashings and assaults with various objects are an almost daily occurrence.*

*The contributors to the continued high rates of inter-prisoner violence in Mountjoy Prison remain those identified in the report on the 2006 visit; availability of drugs, lack of purposeful activities, existence of feuding gangs, continued lack of an individualised risk and needs assessment for all prisoners, and lack of space and poor material*

*conditions. In addition, the design of the facilities combined with overcrowding do not permit an appropriate classification and separation of prisoners”.*

Responding on this issue, the Irish Government stated:

*“The Irish authorities acknowledge that the CPT has rightly identified a level of violence in some Irish prisons; while not accepting that within a prison context Mountjoy Prison could be classified as unsafe... it is accepted that continuous efforts are required to address the issue of inter-prisoner violence stemming, in general, from external influences brought into the prison on committal”.*

In relation to the levels of violence in Irish prisons, the Government stated:

*“In 2009 the Irish Prison Service provided over 1.4 million bed nights to predominantly young males. There were a total of 814 incidents of violence among prisoners during the year 2009 and this includes very minor incidents. This amounts to an average of 2 incidents a day among a population at the time of more than 3,800.*

*In relation to Mountjoy Prison, the records show that there were 142 incidents of prisoner on prisoner violence in Mountjoy Prison. In 2009 nineteen incidents involved the use of a weapon.*

*Attacks by prisoners on prisoners are not usually random acts of violence – they are related to matters on the outside – such as drug debts, gang rivalries, etc”.*

Concerning the increasing number of prisoners being placed on protection, the Government commented:

*“...this is regarded by the Irish Prison Service as an indicator of the steps taken in individual prisons to ensure, in so far as possible, the safety of prisoners. The fact that prison management immediately separates prisoners seeking protection from the general prison population or from specific prisoners identified as presenting a threat, clearly demonstrates prison management’s commitment to ensuring safety and security”.*

With regard to the increasing problems caused by gang-related violence, the Government stated:



*“It is fully acknowledged by the Irish authorities that the emergence in recent years of criminal gangs has had significant implications for the management of Irish prisons. Prison management have to ensure that the various factions are kept apart and, as far as possible, that gang members do not have influence over other inmates or criminal activities outside the prisons. Gang members are being managed on a daily basis through segregation and separation throughout the prison system. Membership or allegiance to these criminal gangs fluctuates on a continuous basis with some persons breaking links and others becoming affiliated”.*

## **Protection in Mountjoy Prison**

### **Assessment of Protection Requests**

Members of staff at Mountjoy have informed the Commission that prior to August 2006 there was no written protocol or check-list for officers to follow when they received a request from a prisoner to be put on protection.

As a matter of practice, prison officers would normally seek to establish the reasons why the prisoner concerned was asking for protection. Whether or not reasons were provided, a request for protection would inevitably result in the prisoner being moved. As one prison officer told the Commission:

*“If somebody wants to go on protection you would talk to them and try to find out why they want to go on protection, but they will always be put – if they ask for protection we are duty bound to give them protection”.*

In a response to the CPT report published in February 2011, the Irish Government outlined current practice in Mountjoy as follows:

*“On committal, all prisoners are interviewed by the Governor and based on all the information available, a decision is made as to where a particular prisoner will be accommodated. In some instances, prisoners are transferred to other establishments”.*

### ***Use of “B Base” in Mountjoy for Protection Prisoners***

In 2006 the usual “first stop” for prisoners who requested protection was the “B Base” area. It is important to note that the “B Base” was not envisaged as a place for keeping prisoners on a long-term basis; rather, it was intended as a short-term solution until such time as the prisoner could be either returned safely to their previous cell or placed in another part of the prison.

However, as the number of prisoners seeking protection increased, alongside the overall increase in prisoner population at Mountjoy, prisoners on protection found themselves residing in the “B Base” for increasingly long periods.

On 9 March 2004 the IPS Director of Operations issued a circular to all Governors entitled “Prisoner Movement Policy” which sought to address this problem. The circular stated:

*“The Director General and I have visited Mountjoy to review the situation there on several occasions lately. Two problems are apparent:*

*(a) There is a general ‘silting up’ of the numbers generally. In this regard, methadone is clearly a contributory factor.*

*(b) There is a build-up of protection prisoners there held in the Base for excessively long periods.*

*Action to alleviate these problems is clearly necessary and the D/G has directed that the overall numbers in Mountjoy are to be reduced to 450 with minimum delay”.*

The policy document went on to outline a plan to redistribute prisoners more evenly across the prison estate, which included the taking of a more active role by the IPS in both promoting and overseeing inter-prison transfers. From the documents disclosed to the Commission it is not clear to what extent this plan was adopted and put into effect by the IPS. What is clear however is that by July 2006, despite the efforts of the IPS and the Governors at Mountjoy in this regard, the problem of “B Base” becoming “silted up” with prisoners on protection had returned.

At that time the “B Base” contained three single cells, nine multiple occupancy cells, 2 special observation cells, plus two holding cells. All single and multiple occupancy cells contained protection prisoners.

### *Use of Holding Cells in “B Base”*

The holding cells were never intended to accommodate prisoners on an overnight basis, but were designed as a place to hold prisoners temporarily who were awaiting either committal to, or discharge from the prison. Governor John Loneragan explained to the Commission that the entire “B Base” area (including the holding cells) was refurbished sometime in the mid-1990s with the intention of creating a dedicated committal / discharge facility. However, this plan did not last long:

*“Now that operated for about six or eight weeks... but what happened then was that we weren’t able to move on the prisoners from the B Basement to other places in Mountjoy because it filled up, or to other prisons because no one wanted to take [them].*

*We ended up with over 70 people down in the B Basement and we had to dispense with the whole idea of it being a committal / discharge because at night time there were no cells there...”*

It seems that the holding cells continued to be used to some extent as a temporary placement for new committals until such time as proper cell accommodation could be found for them elsewhere in the prison. However, as the number of prisoners requiring protection began to exceed the capacity of the cells available in “B Base”, it became increasingly common to house protection prisoners in the holding cells, often alongside newly arrived prisoners.

The problems caused by lack of appropriate accommodation in turn led to some of the holding cell prisoners being placed in the reception area in the “B Base” overnight. The Commission has been given to understand that the usual practice in those circumstances was for non-protection prisoners to sleep in the reception area, with protection prisoners being left in the holding cells, but clearly this would depend on what percentage of prisoners in the holding cells were on protection at any given time.

In December 2003 the Prison Officer's Association (POA) submitted a report to the Governor of Mountjoy Prison which highlighted both security and humanitarian concerns arising from the use of the holding cells and reception area for overnight accommodation.<sup>94</sup> With regard to security concerns the report stated:

*"A number of very serious issues arise in respect of this on-going practice, the following being just three of them:*

*(a) These movements [of prisoners] take place at a time when staffing levels are at their minimal and place the security of the prison at serious risk.*

*(b) The ability of staff to observe prisoners in the 'B Base' holding cells is limited and virtually impossible in the reception area. Furthermore, this reception waiting area does not have a cell call system.*

*(c) Vulnerable and weak inmates are then at the mercy of other more violent inmates and serious assaults (sexual and otherwise) may occur, as has been the case in the past..."*

The report went on to state:

*"The branch committee have repeatedly expressed our very serious concerns in respect of these issues to the following:*

- *all governor grades*
- *all Chief Officers*
- *[Doctor H] and [Doctor A]*
- *all Mountjoy (Male) Prison chaplains*
- *the Probation and Welfare Service at Mountjoy Male Prison*

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<sup>94</sup> See 'Overcrowding', p. 326

*All of the above agreed that this amounts to cruel and inhuman treatment of persons in custody and that there is a knock-on effect for staff. Furthermore, the writer personally brought [Doctor H] [and] [Doctor A] ... to the holding cells at a time when there were 20 inmates locked in them. The dirt, the medical / health and safety issues were all too evident to them. They were appalled and undertook to raise this matter within the remit of their professional roles within the prison”.*

A copy of the Prison Officers Association report was sent to the Inspector of Prisons on 5<sup>th</sup> January 2004. The Inspector was so concerned by the contents of the report that he proceeded directly to Mountjoy for an unannounced visit in order to examine conditions for himself. In his next annual report submitted to the Minister for Justice, the Inspector appended a copy of the POA report, together with a report of his own subsequent visit to Mountjoy. In the latter report the Inspector added his own voice to those expressing concern about safety in the “B Base” holding cells, stating:

*“The officer and the prisoners say there is frequently violence. There was also bullying and on occasion, sexual assaults”.*

Notwithstanding these concerns, the practice of using both the holding cells and the reception area to accommodate protection and non-protection prisoners continued until the death of Gary Douch on the night of 31<sup>st</sup> July 2006.

## **Response to the Death of Gary Douch**

In the days and weeks that followed the killing of Gary Douch, a number of measures were taken by the prison authorities with a view to addressing some of the issues that had contributed to this tragic incident.

### ***Single Cell Occupancy***

On 2<sup>nd</sup> August 2006 Mr Michael Mellett, who had been tasked by the Department of Justice with carrying out an initial investigation of the circumstances of Gary Douch’s death, made an interim recommendation which he set out subsequently in his report as follows:

*“...where a prisoner seeks special protection alleging a threat from another prisoner, and the Prison Authorities accept that there may be some substance to the allegation, the threatened prisoner should be removed to a single-occupancy cell or room for at least 24 hours. This would allow time for the Prison Authorities to investigate the source, nature and seriousness of the threat, to evaluate the risk to the prisoner and so inform decisions on how best to deal with the situation”.*

The Minister for Justice directed that the IPS implement Mr Mellett’s recommendation with immediate effect. This was conveyed by the IPS to the Governor of Mountjoy on 2<sup>nd</sup> August and then to all other Governors by means of a circular dated 3<sup>rd</sup> August.

In response to the Minister’s direction, Mountjoy and other prisons designated a number of cells for use by prisoners falling into this category. In Mountjoy a Governor’s Order dated 4 August 2006 stated:

*“In the event of a prisoner alleging a threat, the threatened prisoner is to be immediately placed in a single cell on C2 landing or relevant area / section.*

*Particulars of the threat to the prisoner in regard to its source and nature must be reported in writing for the attention of the Governor.*

*Prisoners who are temporarily classified in this manner must be highlighted in a Special Journal to be kept in the Chief’s Office. This book is to be readily accessible to Chief Officers and Assistant Chief Officers who will be required to inspect same in regard to prisoners on protection in their area of responsibility.*

*Under no circumstances are such prisoners to be doubled up until decisions are made by the Governor who will take the first available opportunity to interview the prisoner.*

*Any decisions made in regard to future classification of the prisoner concerned shall be recorded in the journal provided”.*

Further to this Governor’s Order a document entitled *Standard Operating Procedure / Assessment of Prisoners Requesting Protection* was issued on 13 August 2006. The document stated:

*“There are three single cells set aside on C2 Class for the assessment of prisoners claiming the need for protection...*

*After assessment if the prisoner is deemed in need of protection he will be moved into a double cell if safe on C2...*

*The three single cells listed above should only be used for protection accommodation if there are no other vacancies in suitable protection areas. Outside of this requirement these cells will be vacant and retained for use as assessment cells in line with Governors Orders”.*

In October 2006 the number of available single cells on C2 was increased from three to four, and the number of double cells from four to 14.

In his report of March 2007 Mr Michael Mellett noted that his interim recommendation of 2 August 2006 had been implemented, and recommended that the practice should continue.

### ***Recording of Protection Requests***

Also around August 2006, Mountjoy and other prisons introduced written forms to be filled in by officers when a prisoner (a) requests protection and (b) requests to be taken off protection. The forms for recording a request for protection vary from prison to prison, but each contains a section where the reasons why protection is being sought can be filled in. The form used in Mountjoy Prison is the most detailed in this regard, containing the following questions:

- Why do you request to be placed “on protection”?
- From whom specifically do you require protection?
- Is there a location where you are at risk?
- Is there a location where you would not be at risk?
- Why do you think you would not be at risk in this location?

- Do you wish to transfer to another prison?

Needless to say, the usefulness of such forms is dependent on the prisoner in question supplying the requested information.

The forms are signed by the prisoner and the officer filling out the form. The forms also stipulate that details of the information contained on the form are to be entered on PRIS, in the sections headed ‘Intelligence’ and ‘Special Features’. In the event that it is decided to forward information to the IPS or to the Garda Síochána, that fact is also to be recorded on the forms.

For prisoners looking to come off protection, the form used in Mountjoy simply consists of a signed statement confirming (i) that the prisoner no longer wishes to be on protection, and (ii) that he will not hold the prison authorities responsible in the event that harm befalls him subsequently. The form used in Cloverhill is more detailed, having spaces to record (i) the reasons why protection was sought in the first place, and (ii) the reasons why it is no longer being sought.

### ***Closure of Holding Cells in “B Base”, Mountjoy***

The two holding cells in “B Base” were closed immediately following the death of Gary Douch. One of the cells was subsequently converted into a shower unit for prisoners accommodated in the Base; the other was split, with one side converted into a single cell and the other into a refurbished “general waiting area”.

### ***Efforts to Reduce Prisoner Numbers in Mountjoy***

In addition to these specific measures, a renewed effort was made to reduce the number of protection prisoners in the “B Base” area of Mountjoy by transferring some prisoners to other institutions and relocating others within the prison itself. These measures formed part of a larger effort to reduce the overall population of Mountjoy which produced immediate results: within one month of Gary Douch’s death, the prisoner population in Mountjoy was reduced by over 100.



Notwithstanding all of the above measures, the resources available in Mountjoy continue to fall short of what is necessary to deal with the number of prisoners requiring protection on an on-going basis. Since August 2006 the prison has seen a gradual increase both in overall prisoner numbers and in the percentage of prisoners seeking protection.

During one week in June 2009 for example, the Commission was told that the number of prisoners on protection was hovering around 100, and that an average of seven people were being accommodated in the shower unit which was built on the site of the holding cell in “B Base” where Gary Douch had lost his life. On 31<sup>st</sup> March 2013, the number of protection prisoners in Mountjoy was 115.

With so many prisoners requesting protection, it is inevitable that many of them will also require protection from others who are also on protection. The need to further segregate protection prisoners because of drug or gang-related feuds places further significant demands on a system which is already at breaking point.

The scale of the crisis makes a mockery of any attempt by the prison to obey the existing policy directives concerning the appropriate treatment of protection prisoners, as the then Governor of Mountjoy Mr John Lonergan illustrated while giving evidence to the Commission in December 2009 reflecting the position there in that year:

*“Someone comes in and says he needs protection. You are looking for – as the directive says, you need to put him in a single cell. There is not a single cell to be found in Mountjoy... Pads [i.e. special observation cells] are being used as single cells to comply with the directive, but undermining my directive that says you should never put a person in a padded cell unless he is certified or unless he is ill or is there on the basis that the doctor has recommended it. One directive is being implemented while another directive is being undermined.*

...

*Now the B Basement traditionally was always the place where such people went for safety, but that was undermined... and is still being undermined on the basis that there is*

*not sufficient accommodation there now. We are still running Mountjoy with between 95 and 100 protections on a daily basis. That is impossible to manage...*

*100 is a sixth of our population and they cannot all even be mixed together. The next difficulty that the staff finds is, who you can mix with who... Sometimes that is hit and miss. The individuals themselves don't know who they can be safe with because they don't know the other people... and the staff have no way of knowing. So again, the reality would be that in 99% of cases we would have no idea. We had a man a couple of weeks ago who came in doing a three month sentence and everybody would regard him as an absolute light weight in terms of any security risk or any danger and he wasn't within ten minutes of the wing when he was very badly beaten up and cut up".*

The scale of the problems faced in Mountjoy can be further illustrated by reference to the C2 landing in the prison. As we have seen, following the death of Gary Douch in August 2006 and the resulting Ministerial directive concerning single cell accommodation for protection prisoners, a number of cells on C2 were immediately reserved for protection purposes.

However, when the CPT delegation visited Mountjoy in October 2006, they found that the cells on C2 were "...particularly dilapidated and in need of urgent renovation", with window panes broken or missing and plaster peeling off the walls. The CPT delegation were so concerned with the violation of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment which was implicit in the condition of the cells on C2 that they issued an immediate observation under Article 8 (5) of the Convention calling on the Irish authorities to ensure that no further use was made of the cells on C2 until they were refurbished. Thus all the protection prisoners who were being held there pursuant to the Minister's directive had to be removed for a period of 12 weeks or more, pending the renovation of the cells.

Even after the cells on C2 had been renovated, compliance with the Minister's directive was soon made impossible once more, as Governor Lonergan outlined to the Commission:

*"We got 23 single cells refurbished. We put 23 people in them – single cells – and we felt... [that we had] improved the quality of life for those 23. Within three weeks all 23 were doubled up; so instead of 23, we had 46. And on occasions now we can have over 50, so there can be three [in a cell] sometimes because of protection".*

In August 2009 the Inspector of Prisons submitted a report on Mountjoy Prison to the Minister for Justice. On the issue of accommodating protection prisoners the report stated:

*“Protection prisoners account for approximately one sixth of the population of the prison at any one time. These prisoners are accommodated in the ‘B Base’ and on C2 landing. Both areas are consistently overcrowded.*

*Protection prisoners are locked up for 23 hours each day. They get a maximum of one hours exercise, have minimal access to teachers and have no access to the gyms or the workshops.*

*Protection prisoners typically belong to gangs which reflect the situation that exists in certain sections of Irish society. Other prisoners, while not belonging to gangs, are nevertheless on protection because of threats made against them. The gangs in the prison must be kept apart. This causes great logistical difficulties for management”.*

The report referred to examples of the on-going security problems at Mountjoy, stating:

*“In the 12 months to the 31<sup>st</sup> July 2009, there have been many serious incidents in the prison ranging from a serious riot in July 2008, a hostage taking incident in March 2009 to a death in July 2009. There were numerous other incidents involving serious injuries to prisoners and on occasions to prison staff. Bullying and intimidation between prisoners is common”.*

With regard to protection prisoners the Inspector recommended that a unit in Mountjoy referred to as the Segregation Unit be opened by the end of 2009 with protection prisoners from the “B Base” to be moved there. This suggestion was accepted by the IPS. The Segregation Unit, which is a self-contained unit, opened in March 2010. It is comprised of six single cells and 24 double cells, giving a current bed capacity of 54 prisoners. The Unit has three exercise yards, a gymnasium, a library, and its own surgery.

## Protection Prisoners on 23-Hour Lock-Up

Following its visit to Irish Prisons in 2010, the CPT made the following observations concerning the conditions in which prisoners on protection were being held:

*“The CPT recognises that a primary duty of the prison authorities is to prevent harm coming to the prisoners under their ward, and that the need to take protective measures in favour of certain inmates may inevitably have negative repercussions on the activities they can be offered. However, the prisoners concerned should not be left to languish in their cells on ‘23-hour lock-up’.*

*For those prisoners placed on protection for more than a few weeks, additional measures should be taken in order to provide them with appropriate conditions and treatment; access to activities, educational courses and sport should be feasible. Furthermore, there needs to be a more proactive approach by the prison health-care service towards prisoners on protection, particularly as regards psychological and psychiatric care, especially as some of them might spend a year or more in conditions akin to solitary confinement. There should also be an individual assessment of their needs at regular intervals and, where appropriate, transfer to another prison should be considered. More generally, 23-hour lock-up should only be considered as a temporary respite, whereas in the Irish prison system it has developed into a general measure”.*

In a written response to the CPT report, the Irish Government identified a total of 308 prisoners who were on 23-hour lock-up, with 153 of those being in Mountjoy Prison. The Government went on to state:

*“The majority of these prisoners are located in our older prisons which because of constraints on space, resources, staffing levels and the number of factions which have to be kept separate from each other, are not in a position to offer enhanced regimes to these prisoners”.*

In a June 2012 report the Inspector of Prisons referred to the ongoing practice of keeping children and young adult protection prisoners on 23-hour lock-up at St Patrick's Institution, stating:

*"I have already stated... that the running of any prison is a difficult task and that the incarceration of children and young adults poses great difficulties for prison management. However, from my thorough investigation of St Patrick's it is my view that using 23 hour lock up has been the preferred option considered by management as the solution to the maintenance of safety in the prison to the exclusion of any other option."*

The Commission notes that in July 2013 the Minister for Justice announced that St Patrick's would be closed permanently within 6 months<sup>95</sup>, following a recommendation by the Inspector of Prisons in his Annual Report for 2012 (submitted on 20<sup>th</sup> May 2013), that the institution be closed forthwith. The Inspector stated:

*"I am satisfied that the Irish Prison Service can no longer guarantee the safe and secure custody of young offenders detained in St Patrick's Institution."*

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<sup>95</sup> *Irish Times*, 3 July 2013.

## **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. There follows a brief history of prison policy in this regard, beginning with the establishment of an expert review group by the Government in 1999.

### **National Strategy on Managing Disruptive Prisoners**

#### **Commissioning of Working Group**

The multi-disciplinary review group referred to above was set up in 1999 in order to review prison policy on the management of disruptive prisoners, and to outline a national strategy in that regard. As part of this the group (hereinafter referred to as “the Working Group”) was tasked with examining:

*“...regime and operational matters related to the new purpose built facility at the new Midlands Prison in terms of how it will be utilised in the management of disruptive prisoners”.*<sup>96</sup>

The Commission has been provided with a draft report of the Working Group. The report is undated, but appears to have been prepared some time prior to September 2003<sup>97</sup>. It is six pages long and appears to be more in the nature of an executive summary than a full report. Most of the issues examined by the Working Group are labelled as *“to be described”*, and the report appears to be unfinished. The Commission has been informed that the Working Group’s final report was never completed. The reasons for this are not known to the Commission.

The draft report of the Working Group defines “disruptive prisoner” in the following terms:

*“This definition does not include the large number of prisoners whose conduct routinely leads to disciplinary action by Governors on a daily basis in the closed prisons. It covers the much smaller number of prisoners whose disruption or potential to disrupt is more serious and who exhibit one or more of the following behaviours:*

- *Repetitive violent acts on staff or prisoners.*
- *Personality disorders associated with significant risk of violence.*
- *Extensive subversive behaviour associated with undermining the fabric of prison.*
- *Those posing severe control problems within the system”.*

It appears from the draft report that a considerable amount of research was carried out by or on behalf of the Working Group over a period of maybe two years or more. As well as visiting prisons throughout the State to examine current practices in managing disruptive prisoners, members of the group visited a Close Supervision Centre which had been opened in 1998 at HMP Woodhill in the United Kingdom. International research on the topic was also reviewed.

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<sup>96</sup> Operations Directorate Business Plan 2000.

<sup>97</sup> Operations Directorate Business Plan 2003.

## Working Group Draft Findings and Recommendations

The recommendations contained in the draft report of the Working Group can be summarised as follows:

- Where possible, disruptive prisoners should be managed within the prison where they reside.

The draft report stated:

*“In-house management should remain as the first principle for containment of a disruptive prisoner. Where possible, disciplinary sanction of disruptive prisoners should take place in the prison where the offences occur and each closed prison should have its own Segregation Unit for this purpose.*

*Only when local containment is likely to result in danger to staff or prisoners or to severe disruption to the regime should an alternative location on transfer be sought”.*

- Disruptive prisoners who cannot be managed by a prison should be transferred to D Unit in Cork Prison or to C1 landing in Midlands Prison.

In its draft report, the Working Group came out strongly against the idea of a special, segregated unit for highly disruptive prisoners. Based on its research, and in particular on observations of prison facilities in England, the draft report expressed the view that:

*“The practice of detaining the most highly disruptive prisoners together in a special segregated unit is at best unproven and at worst may reinforce disruptive and violent behaviour”.<sup>98</sup>*

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<sup>98</sup> The draft report notes that a paragraph was to be added to the report concerning the risks attached to segregated special units, but it appears that this was not done.



The draft report also went on to state that in the Irish context, the number of highly disruptive or dangerous prisoners was not sufficient to warrant the opening of a special segregated unit.

However, the draft report did recommend the use of existing units in Cork and Midlands Prisons to house particularly disruptive prisoners for short periods of segregation. The draft report stated:

*“Experience has shown that the restricted regime in Cork D Unit acts as a significant deterrent for many disruptive prisoners. For some such prisoners it is sometimes necessary for them to spend a number of separate periods of time in Cork D Unit before their behaviour moderates. It is recommended that this practice continue...*

*Taking account of the increase... in the prisoner population... there is a requirement for additional short-term segregated disciplinary places in the system. To meet this requirement there are 2 options available at the Midlands Prison: the stand alone special unit or landing C1. The group recommends that C1 be designated to assist Cork D Unit as a segregated disciplinary unit for the prison system”.*

The Commission has been given to understand that at present, one side of C1 wing in Midlands is used to contain prisoners on punishment, with the other side being used for violent or highly disruptive prisoners.

- There should be a management group within the Prison Service specifically tasked with managing disruptive prisoners.

According to the draft report, the primary function of such a group would consist of:

*“...systematically overseeing the management of those prisoners who display disruptive behaviour over a period of time or who commit a particularly serious single offence. Particular emphasis should be given by this group to identifying*

*the causes of the disruptive behaviour in each case and devising plans to address these”.*

## **The Commission’s Analysis**

The extent to which the above recommendations of the Working Group’s draft report have been addressed or implemented by the Irish Prison Service is considered below, starting with the principle of “in-house” management as a first resort for disruptive prisoners.

### ***“In-house” Management of Disruptive Prisoners***

As stated above, the draft report of the Working Group recommended that where possible, disruptive prisoners should be managed within the institution where they are kept. Only in circumstances where this would create unacceptable risks to prisoners, staff or to the operation of the prison regime should a transfer be contemplated.

The extent to which a given prison regime can meet this goal is dependent on the available resources in that prison.

The management of disruptive or violent prisoners requires:

- a system of early and on-going risk assessment in order to identify disruptive prisoners and prescribe an appropriate level of security for them
- a sufficient number of appropriately trained staff to carry out the increased levels of observation and supervision which may be required for disruptive prisoners
- appropriate cell accommodation which allows the possibility of isolating disruptive prisoners from the general prison population, while still respecting their own rights as prisoners and as human beings
- access to psychiatric, psychological, and other resources, such as education and recreation

It is currently the case, and has been for many years, that access to all of the above varies significantly from prison to prison. For example, the psychiatric resources available in Cloverhill Prison have no parallel in any other prison in the State. At the other end of the scale, massive overcrowding in Mountjoy Prison has frequently undermined attempts to create an appropriate environment in which to manage disruptive prisoners.

The fact that some prisons are significantly under-resourced in terms of their capacity to manage disruptive prisoners reinforces the need for a system-wide approach. Traditionally, prisons have been viewed almost as independent fiefdoms, each ruled by a Governor who must do the best with whatever resources he has. Negotiations between prisons are viewed as being between equals, regardless of the reality. Prisons are not obliged to help each other and have little motivation to do so, except insofar as a refusal to help might rebound on them if and when it is their turn to request help in the future.

Governing any of the prisons in the State is a difficult and stressful job. In these circumstances, it is hardly surprising if the management in a given prison seeks to minimise the number of troublesome prisoners under its care. The effective independence of each prison leads to a situation where Governors may sympathise with their colleagues in less well-resourced prisons, but have little motivation or desire to seek to improve that colleague's position by taking on some of their problematic prisoners. This in turn gives rise to the practice of “horse-trading”, in which prisons such as Mountjoy can relieve themselves of one burden only by taking on another – as evidenced by the swap of prisoner “B” for Stephen Egan on 29<sup>th</sup> July 2006.

In the course of giving evidence to the Commission [Senior Clinical Psychologist B], a psychologist attached to Mountjoy Prison, expressed the view that bad experiences with trading prisoners in this way has led to a reluctance on the part of some prisons to engage in inter-prison transfers. He told the Commission:

*“I think a culture has developed, and maybe for very good reason, but it has developed where I think there is almost a fear to kind of look for transfers and so on at local levels, Chief to Chief, Governor to Governor, in case of what they might get back”.*

The Commission considers that the IPS must take a pro-active role in overseeing the management of difficult prisoners on a system-wide basis. The management and distribution of

disruptive or violent prisoners within the prison system is a matter that cannot be left to the prison Governors alone. It is ultimately a matter for the IPS to ensure that such prisoners are kept in the prisons which are best suited to manage them.

### ***Use of High Security Regimes at Cork and Midlands Prisons***

#### **Cork Prison**

Cork Prison is a small prison dating back to the 19<sup>th</sup> century, with a current bed capacity of 210 prisoners<sup>99</sup>. The “D” block, which is separate from other parts of the prison, is used as a segregation unit for disruptive prisoners, mostly from other prisons. It contains 10 single cells, 2 of which are special observation cells.

Following a visit to “D” block, Cork Prison in January / February 2010, the European Committee for the Prevention of Torture (CPT) was critical of the cell conditions on D block, stating that “...*access to natural light was adequate but the ventilation was poor*”.

#### **Midlands Prison**

Midlands Prison is a modern prison, which has been opened on a phased basis from November 2000 onwards. C1 landing is on the ground floor of C Division. C1 differs from other parts of the prison in that there is a dividing wall which runs down the centre of the landing. The right-hand side contains 15 single cells and is used to accommodate prisoners on punishment. The left-hand side of C1 contains the medical area plus a further 15 cells, one of which currently accommodates Stephen Egan.

When the CPT visited Midlands in January / February 2010 they were satisfied with the conditions there, stating:

*“The cellular accommodation in the Midlands Prison provides good living conditions: all cells were suitably equipped, of an adequate size, and possessed partitioned in-cell sanitation; cells had good access to natural light and the artificial lighting and*

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<sup>99</sup> Irish Prison Service website, 13<sup>th</sup> September 2013.

*ventilation were sufficient. Moreover, the state of repair on the detention wings was good and the landings were kept clean”.*

### ***Treatment of Prisoners on High-security Regimes***

Following a visit to “D” block, Cork Prison in October 2006, the European Committee for the Prevention of Torture (CPT) expressed concern about confining prisoners in “D” block as punishment for disruptive behaviour, particularly in light of the fact that this frequently involved a withdrawal of all privileges from such prisoners for periods of up to two months:

*“The CPT’s delegation observed that prisoners were deprived of all privileges (family visits, letters, work, smoking, recreation, radio, television, and newspapers) throughout their time in D Unit. Outdoor exercise took place in a small inner yard; the amount of time prisoners could associate together in the yard varied depending on the numbers in the unit and the mix of prisoners...”*

*The Committee is particularly concerned that prisoners in D Unit continued to be denied virtually all contact with the outside world... As the CPT has emphasised in the past, although the implementation of a regime under which prisoners are segregated from others for prolonged periods may, in exceptional cases, be justified for reasons of order and security, the application of such a measure as a punishment is unacceptable.*

*Further, it is generally acknowledged that all forms of solitary confinement without appropriate mental and physical stimulation are likely, in the long term, to have damaging effects, resulting in deterioration of mental faculties and social abilities. The delegation found that the regime applied in Unit D at Cork Prison still did not provide such stimulation”.*

*Concerns about keeping prisoners in conditions akin to solitary confinement for disciplinary reasons were renewed when the CPT visited again in January / February 2010:*

*“The CPT does, however, continue to have major reservations over the effect in practice of the authority invested in the governor of a prison to impose on a prisoner who is found*

*to have committed a breach of discipline, the sanction of 'loss of all privileges' for a period of up to 60 days (see Article 13.1(d) of the Prisons Act 2007). The delegation observed that such a measure is not infrequently applied and that it can result in inmates being held for prolonged periods in conditions akin to solitary confinement (i.e. confined alone in a cell with no stimulation or contact with the outside world). The Prisons Act 2007 states under Article 13.1(c) that cellular confinement cannot exceed three days. As the CPT made clear in its report on the 2006 visit, the imposition of such a regime for up to 60 days as a disciplinary sanction is totally unacceptable...*

*As the CPT has emphasised in the past, although the implementation of a regime under which prisoners are segregated from others for prolonged periods may, in exceptional cases, be justified for reasons of order and security, the application of such a measure as a punishment is unacceptable.*

*Further, it is generally acknowledged that all forms of solitary confinement without appropriate mental and physical stimulation are likely, in the long term, to have damaging effects, resulting in deterioration of mental faculties and social abilities. The delegation found that the regime applied in Unit D at Cork Prison still did not provide such stimulation.*

*... the CPT calls upon the Irish authorities to review the operation of the segregation units at Cork, Midlands and Portlaoise Prisons, in the light of the above remarks”.*

Another difficulty with the use of high-security wings in Cork and Midlands Prisons to contain disruptive prisoners is that the high levels of security can seriously inhibit any efforts by medical, educational, or remedial services to work with the prisoners on addressing the causes of their disruptive behaviour. [Senior Clinical Psychologist C], a psychologist attached to Mountjoy Prison, described the problem as follows:

*“...what happens currently is that a disruptive prisoner is sent to a punishment block, usually down the country, Cork or Midlands... and that is 23-hour lock up. Now while they are there they don't really have access to services because there is no room to see them. Psychologists can go and check in on them, but they cannot really offer them work... So I don't really see that is an appropriate way to manage these types of*

*disruptive prisoners, particularly people who maybe have massive personality difficulty, self-harming as well as harming others. So certainly at the moment I don't think there is a strategy for the management of that group".*

### ***IPS Disruptive Prisoners and Security Group***

The third major recommendation of the Working Group concerned the setting up of a specific management group for disruptive prisoners.

The Commission has been informed that since the late 1990s, regular meetings took place between the Operations Directorate and the Governors of Mountjoy, Wheatfield, Cloverhill, Cork, Limerick, Portlaoise and Midlands Prisons, at which the management of particular disruptive prisoners was discussed. In some of the documentation disclosed to the Commission, this informal group is referred to as the Disruptive Prisoners and Security Group. It is presumed that the Working Group was aware of this group's existence at the time of making its draft recommendations.

The IPS has provided the Commission with a document created in 2005 – 2006, which offers the following description of the Group:

*"The purpose of the Group is to look at the small group of cases involving prisoners who are sufficiently disruptive as to require to be managed on a national basis. The focus is generally on containment and in spreading the load around the system. It is also the case that prisoners who are disruptive in one prison may benefit from a change of location".*

The document states that as of March 2006 the Group were meeting every 4 – 6 weeks. Lists of prisoners to be discussed were requested from the Governors in advance of each meeting. Each meeting was chaired by the IPS Director of Operations. Brief notes were taken of any decisions made in relation to each prisoner discussed at the meeting. From examples seen by the Commission, these notes were usually little more than an indication of whether it had been decided to move the prisoner or not.

The Commission has been told that from 2007 onwards the number of meetings of the Disruptive Prisoners and Security Group was reduced to two or three per year. It has been

suggested to the Commission that this was due to a number of factors, including a reduction in the number of disruptive prisoners, the increased ability of some prisons (notably Midlands Prison) to deal with such prisoners on an “in-house” basis, and the fact that other demands were being placed on the Governors’ time. In December 2009 the Commission was informed by the IPS Director of Operations that the Disruptive Prisoners and Security Group is no longer meeting.

The Commission considers that the ambit of the Disruptive Prisoners and Security Group during its existence was significantly narrower than that recommended in the draft report of the expert Working Group set up in 1999. The Working Group clearly envisaged a multi-disciplinary approach which, in addition to dealing with security concerns, would also seek to address the root causes of disruptive behaviour on a case-by-case basis.

But the documentation disclosed to the Commission suggests that the Disruptive Prisoners and Security Group focused on maintaining the security and stability of the prison system by “spreading the load” of disruptive prisoners, rather than on seeking to address the needs of those prisoners and the individual factors which give rise to their disruptive behaviour. Governor John Lonergan of Mountjoy Prison described the purpose of the Group’s meetings as being “*to decide on a strategy of who would take who for how long*”.

In a letter to the Commission dated 17 June 2010 the then Director of Operations Mr William Connolly confirmed that “the dispersal approach” to disruptive prisoners remains the governing policy. Whilst there are some advantages to this approach in terms of security, the emphasis on distributing disruptive prisoners throughout the prison system has resulted in what has been described as a “carousel” policy, where troublesome prisoners are moved between prisons on a frequent basis. The positive and negative aspects of this policy are considered further below.



## Transfer of Disruptive Prisoners

### A “Carousel” Policy

The draft report authored by the Working Group on a national management strategy for disruptive prisoners referred to the existence of a policy whereby troublesome prisoners are moved on a frequent basis. The report stated:

*“At any one time there is a small number of prisoners who present particular difficulties through disruptive behaviour including assaults on staff, assaults on prisoners, damaging property, etc. Up to around 1998 ad hoc meetings with some of the closed prison Governors chaired by the Head of Operations Division were called to oversee ‘trading’ of these prisoners with a view to sharing the load. For some prisoners this resulted in their placement on a transfer ‘carousel’ whereby they were frequently transferred around the close prisons. Some carousel prisoners tended to become increasingly unsettled and more disruptive”.*

According to the draft report, it was concern over the risks attached to such a carousel policy which led the Working Group to recommend the introduction of a formal management group for disruptive prisoners, as outlined above.

The benefits of operating a “carousel” policy were referred to in the November 2006 report of the Operations Directorate into the death of Gary Douch:

*“The practice of moving troublesome prisoners between closed prisons on a regular basis is also one which has been in operation for many years. It assists the orderly management of prisons by preventing such prisoners from getting too settled in a prison where they can then instigate trouble and plan disturbances or even escape attempts”.*

Regular transfers of troublesome prisoners can also be beneficial in providing prison staff with a period of respite from managing the prisoner concerned.

On the other hand, the frequent movement of a prisoner could result in that prisoner “falling through the cracks” in terms of their individual management and treatment. As the case of Stephen Egan makes clear, the more frequently a prisoner is transferred, the greater the risk that vital information concerning the security, management or the medical care and treatment of that prisoner will not be transferred with them owing to deficiencies in prison record-keeping. As [Senior Clinical Psychologist B], a psychologist working in Mountjoy Prison told the Commission:

*“It doesn’t contribute to good information sharing, and it doesn’t allow a kind of systemic multi-d, or multi-disciplinary perspective to be adopted”.*

Frequent transfers may in fact be responsible for some deficient record-keeping practices. If a prisoner is transferred to and from a prison on a regular basis, prison staff may be less inclined to complete all the prescribed documentation, simply because the prisoner is (a) well-known to them and (b) unlikely to be staying in the prison for a long period. This may be one of the reasons why, according to one medical orderly interviewed by the Commission, a practice evolved at Mountjoy whereby committal forms were often not completed for inter-prison transfers.<sup>100</sup>

## **Security and Inter-prison Transfers**

For some years now the policy of the Irish Prison Service in relation to transporting disruptive or difficult prisoners is that they should be transported separately from other prisoners, and be accompanied by a three-man escort. However, it is clear that this policy has not always been followed. A particularly significant instance of this was the transport of Stephen Egan together with eight other prisoners from Cork Prison to Cloverhill Prison on 27<sup>th</sup> November 2005, during which Mr Egan committed a serious assault on a prison officer.<sup>101</sup>

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<sup>100</sup> See above p.292

<sup>101</sup> See above p. 130

Following this incident, cellular prison vans (which were already in existence but had not been used) were introduced to transport prisoners to and from Cork Prison.

Notwithstanding the protocol that disruptive prisoners should be transported separately, [Assistant Chief Officer A] told the Commission that at the present time, such separate transport is rarely arranged:

*“What they will do is they will give you... an extra man... So if I am going to court and there is a three-man escort, they classify it as, I have a spare man for that individual prisoner, that’s the three-man escort but I could also have four or five more other fellas to deal with in court as well”.*

## **Disruptive Prisoners – A Multi-Disciplinary Approach**

In February 2006, the IPS Psychology Service produced a discussion paper for the benefit of the Disruptive Prisoners and Security Group. The introduction states:

*“A small group of disruptive prisoners within the IPS presents particular management difficulties, with concomitant risks to both staff and other inmates. While the existence of such a group has long been recognised, there is an absence of agreed policy and practice guidelines for the management of this group”.*

The discussion paper refers to the incomplete work carried out by the Working Group set up to develop a national strategy in 1999, noting the criteria adopted by the Working Group for classifying prisoners as disruptive. In relation to “personality disorders associated with significant risks of violence” the discussion paper states:

*“The term ‘personality disorder’ indicates an enduring pattern of personality organisation which significantly deviates from the norms of a culture... personality disorder is associated with increased risk of causing harm to self and others and many*

*high-risk offenders would present with a diagnosis of personality disorder. Psychopathy is widely accepted as a particularly severe form of personality disorder and those described as psychopathic are responsible for a markedly disproportionate amount of serious crime”.*

The discussion paper goes on to state:

*“At present these prisoners lack the benefit of a co-ordinated case management system. This is reflected in the absence of multi-disciplinary assessment aimed at identifying their risks and needs and inadequate interventions and case management strategies to address these. Recent evidence from other jurisdictions indicates the benefits of such an approach for both the prisoners and prison management and sees this as essential to avoid the pitfalls of previous experiences”.*

The discussion paper stresses the need for the IPS to develop its own approach, based on the composition of its prison population. It also outlines several principles that could inform the development of such a system. At the prisoner level it identifies the following needs:

- The need for an “individual case conceptualisation” approach, integrating clinical assessment and treatment into care plans for individual prisoners. The discussion paper states:

*“While most of this client group will present with at least one personality disorder... Care and management is complicated by the presence of co-morbid psychological problems e.g. anxiety, depression, additional psychiatric diagnoses, neuropsychological problems and deep-seated hostile beliefs associated with violence and non-compliance”.*

- The need to include a “comprehensive, reliable, and valid” assessment of risk in each case. The discussion paper states:

*“This assessment should be multi-disciplinary, multi-agency and comprehensive. It is also essential that the assessment not only identify relevant risk factors for*

*each client, but also relate to issues of risk management both within custody and post-release...”*

- The need for appropriate therapeutic intervention. In this regard, the discussion paper notes that the U.K. approach had shifted:

*“...from structured programmes to less structured, small-group based interventions and in particular individual therapeutic work, with a particular focus on motivational issues...”*

In relation to possible staffing issues, the discussion paper states:

*“Managing a therapeutic regime within conditions of security poses its own challenges to staff and their management. Lessons learned seem to suggest that it is important that staff working in such environments have a basic grounding in the ethos of the unit / area where these prisoners are housed and that they be regularly supervised and supported by others whose task it is to maintain that ethos...”*

Concerning therapeutic intervention at the system level, the discussion paper states:

*“The experiences of other jurisdictions indicate strongly the need for joint information sharing and collective responsibility as well as input from staff and the various services with regard to the overall care and management of these prisoners. A shared understanding among all stakeholders of the needs of this group and of the best practice regarding their management would appear essential. This may entail, for example, agreement on a national management strategy to address issues such as their movement, appropriate assessment and treatment, options for housing and finally, development of a system of monitoring and evaluating of their progress over time”.*

In conclusion, the discussion paper reiterates the need for a high-level, multi-disciplinary group within the Prison Service to review and formulate policy with regard to disruptive prisoners:

*“There is a pressing need to re-convene a multi-disciplinary group similar to that established to produce the 1999 report. Such a group could:*

- *Review the 1999 report in light of current circumstances*
- *Conduct an up-to-date survey as to the composition of a group of difficult / disruptive prisoners within the IPS*
- *Detail policy and practice guidelines for the management of this group”.*

The need for such a multi-disciplinary approach was reiterated to the Commission in June 2009 by [Senior Clinical Psychologist B] and [Senior Clinical Psychologist C], two senior clinical psychologists working in Mountjoy Prison. Commenting on the 2006 discussion paper [Senior Clinical Psychologist B] told the Commission:

*“We were simply arguing, in our submission that the Prison Service needed to sit down and... develop a national strategy, include all the stakeholders, including psychiatry, who traditionally perhaps wouldn’t have been involved in this area, even in other jurisdictions”.*

Documentation disclosed to the Commission by the IPS indicates that one month after the death of Gary Douch on 1 August 2006, a meeting took place on 31<sup>st</sup> August 2006 of the Disruptive Prisoners and Security Group. Amongst other matters it was agreed at this meeting that

*“An individual regime was needed for disruptives so that each was assessed by a multi-disciplinary team and a plan agreed and carried through for each”.*

The information disclosed to the Commission does not indicate what further steps, if any, have been taken by the IPS or by the Disruptive Prisoners and Security Group in pursuit of this stated goal of multi-disciplinary assessment and care for highly disruptive prisoners.

## **Case Conference**

One procedure that can be employed by a prison in seeking to manage a particularly difficult prisoner and which allows for a multi-disciplinary approach is the case conference. An IPS document disclosed to the Commission describes the procedure as follows:

*“A Case Conference may be requested by any member of the disciplinary services, i.e. Prison Staff, Probation and Welfare Service, Teachers, Chaplaincy, Prison Medical Services, Psychology or Psychiatric Services or Operations Directorate. Requests are usually made to the Governor or may arise from a recommendation from a local Review Meeting. A conference is deemed necessary when it is very obvious that the normal interventions are not working and the need for a more intensive intervention is required.*

*The conference is usually held in the Institution and chaired by a Governor who issues invitations to member(s) of the services deemed most appropriate to deal with the issues and / or those already dealing with the prisoner”.*

Conferences may be called for several reasons, including:

- psychiatric or psychological intervention
- behavioural problems
- addictions
- extreme violence
- prisoners who present a high risk on release
- on-going review of a sentence management plan for a prisoner

According to the IPS document the role of the Operations Directorate representative at a case conference is “...to listen to the views of the other attendees and to take this into account in guiding the conference towards reaching a recommendation”. The document continues:

*“In most cases the recommendations will need to be submitted to (a) the Director of Operations and / or (b) the Director General and in some cases the Minister... The Operations representative should ensure that the recommendations made are reasonable, justifiable and have a good chance of being approved.*

*In a case where the Operations representative cannot support the recommendations made, the conference should be made aware of the situation and the reasons why. However, a balanced submission should be prepared outlining the views of the conference and how they reached their conclusions and detailing why Operations Directorate cannot support the recommendations made”.*

The Commission does not have accurate figures as to the number of disruptive prisoners who have been the subject of case conferences in recent years, but the information disclosed to the Commission suggests that it would be rare for such case conferences to be called.

## **Assessment and Management of Risk**

Documentation disclosed to the Commission indicates that the absence of a formal system for assessing, categorising, and managing risk throughout the Irish prison system has been a matter of concern for the National Forensic Mental Health Service for some time. On 5<sup>th</sup> October 2006, for instance, Professor Harry Kennedy wrote to the Director General of the IPS stating:

*“The mixing of vulnerable, dangerous and other categories of prisoners appears now to be quite common across the prison population... this is not good risk management at the systems level”.*

This particular issue of mixing categories of prisoners was referred to previously by Professor Kennedy in a letter to the IPS Director General dated 13<sup>th</sup> May 2005 and in a letter of 15<sup>th</sup> December 2004 to the Secretary General of the Department of Justice.

The issue of categorising risk was considered by the Disruptive Prisoners and Security Group at a meeting on 19<sup>th</sup> October 2006. At this meeting it was decided to adopt a three-way classification of risk:

- Top risk
- High risk



- Other

The categories of ‘top risk’ and ‘high risk’ were described as follows in the IPS Operations Directorate report into the death of Gary Douch, issued in November 2006:

***“Top Risk:** The ‘top risk’ category refers to a very small number of prisoners whose disruption or potential to disrupt is of the highest seriousness... The category comprises:*

*Prisoners who exhibit one or more of the following behaviours:*

- *engage in repetitive violent acts on staff or prisoners*
- *are diagnosed with personality disorders associated with significant risk of violence*
- *engage in extensive subversive behaviour associated with undermining the fabric of prison*
- *pose severe control problems within the system*

*and*

- *they are required to be isolated from the general prisoner population or be subject to a special regime because of risk of violence, escape or orchestration of violence or escape*

*and*

- *their escape would be extremely dangerous and pose an exceptional risk to the community.*

***High Risk:** Prisoners in the ‘high risk’ category exhibit one or more of the following behaviours:*

- *engage in repetitive violent acts on staff or prisoners*

- *are diagnosed with personality disorders associated with significant risk of violence*
- *engage in extensive subversive behaviour associated with undermining the fabric of prison*
- *pose severe control problems within the system*

*or*

- *either they are overly affiliated with a significant criminal gang or faction or*
- *they have current or former ‘subversive’ affiliations.*

*and*

- *They can live as part of the general prisoner population but may be subject to a special regime because of risk of violence, escape or orchestration of violence or escape*

*and*

- *their escape would be highly dangerous and [would] pose a serious risk to the community”.*

Notwithstanding the adoption of a classification system for risk by the Disruptive Prisoners and Security Group, concerns about the management of risk in the prison system continued to exist. On 24<sup>th</sup> January 2007 Professor Kennedy wrote to Mr Michael Mellett concerning Mr Mellett’s inquiry into the death of Gary Douch. Professor Kennedy’s letter stated:

*“The IPS has not embraced a modern risk management system at the institutional / systemic level”.*

The letter continued:

*“The Irish prison system... has an informal, unstructured system [of risk management]. Portlaoise Prison has always been treated as a maximum security prison but the criteria for going there are not structured or formalised. Since the end of the Troubles the ‘political’ groupings have diminished while typical category A prisoners (high ranking members of criminal gangs with access to outside help) have increased substantially. The structures on which Portlaoise formally depended – a system of honour and command within the politicised groupings – has declined without a modern risk management system to replace it. New Category A prisoners such as Mr Egan are not placed there due to continuing informality concerning such risk management systems”.*

Professor Kennedy returned again to the specific issue raised in his earlier letters, stating:

*“...as outlined in my letters to the Irish Prison Service, it is increasingly common in remand prisons such as Cloverhill and committal prisons such as Mountjoy for those at high risk of violence to be mixed indiscriminately with those who are vulnerable. This is a common feature of prison systems which are breaking down due to overcrowding or levels of turnover which are in excess of capacity”.*

The letter continued:

*“An appropriate prison risk assessment and risk management plan... would have indicated that Mr Egan was at a continuing high risk of violence to others and if moved off D2 should be placed [in] an appropriate environment for the management of such prisoners”.*

In the absence of a formal risk management system, prisons are forced to rely almost entirely on the knowledge and experience of prison staff in assessing and confronting risk. There is no doubt that such knowledge and experience is important in the management of risk. However, without formal risk assessment procedures in place, there is a danger that this information will not be circulated to those who need it. This can be seen in the communication failures at Cloverhill and Mountjoy Prisons concerning Stephen Egan’s transfer in July 2006, as documented earlier in this report.

One of the dangers of managing risk on an informal basis is that it encourages reliance on an oral prison culture – that is to say, on the memory and experience of individual officers. In the absence of a formal system for gathering and distributing such intelligence on disruptive prisoners, it is likely that important information can be lost once a staff member leaves or retires. This is of particular significance in the current prison system, where prisoner numbers are rising at the same time as many experienced prisoner officers are leaving the system. As Governor John O’Sullivan pointed out to the Commission in evidence:

*“...prison staff are younger because the older element is retiring and people are retiring younger. You don’t know the individual concerned. You have never previously met him so you have no knowledge of the violent tendencies or pattern of behaviour that this guy could have and you put him into a cell. That is a danger, and I am surprised more incidents haven’t occurred... That is a huge danger in prison now”.*

In a recent report (published in February 2011) the Government confirmed that “considerable” levels of retirement had been experienced by the prison service in 2009 and 2010.<sup>102</sup>

## **Integrated Sentence Management**

The importance of risk assessment in managing prisoners was adverted to by the European Committee for the Prevention of Torture (CPT) following a visit to Irish prisons in October 2006. Referring to the “gross overcrowding” of the holding cells on the day on which Gary Douch was killed, the CPT noted:

*“Further, it was evident that there was no individualised risk assessment of prisoners prior to them being placed in these holding cells”.*

In October 2007 the Irish Government published a response to the CPT report of October 2006. On the issue of risk assessment the Government responded as follows:

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<sup>102</sup> Response of Irish Government to report of European Committee for the Prevention of Torture (CPT), 10 February 2011.

*“Implementation of an individual risk and needs assessment will be a core element of the Integrated Sentence Management (ISM) system that is being introduced in the Irish Prison Service. The system is being piloted in two prisons at present and will be rolled out progressively thereafter. Information on ISM is included in the proposed Chief Officer training programme.*

*Under the new system, prison officers nominated as Personal Officers will receive training which, it is envisaged, will include a mentoring role in assisting the prisoner contribute to development, implementation, and review of their individual sentence management plans and to act as a conduit between the prisoner and the multi-disciplinary team”.*

However, when the CPT returned to visit Irish prisons in January 2010, the promised implementation of the Integrated Sentence Management system had not yet taken place:

*“...ISM was still only being run on a pilot basis in a few establishments, one of which was Midlands Prison (where only some 20 prisoners were involved in the ISM system)”.*

An update in relation to ISM was provided by the Government in a written response to the CPT, published in February 2011:

*“Integrated Sentence Management (ISM) is being rolled out progressively and is now in place in ten prisons for new committals serving sentences of one year and upwards. It is intended to roll out ISM to the remaining four institutions before the end of 2010... The scope for incorporating ... prisoners serving life or lengthy sentences in the formal ISM system will be kept under review but the priority, with limited resources, is to ensure its establishment on a sound footing for new committals”.*

Although individualised risk assessment has been promised as a part of the ISM system being rolled out, the details of how such risk assessments will be carried out, recorded and utilised remain unclear to the Commission at the time of writing. The Commission notes that the Inspector of Prisons, in a report on St Patrick’s Institution completed in June 2012, concluded that ISM was operating “...in name only” in St Patrick’s, stating:

*“As of the 1<sup>st</sup> May 2012 there was no full time Integrated Sentence Management Officer appointed in St Patricks. As of that date 88 prisoners were enrolled in Integrated Sentence Management with 36 waiting assessment.”*

The 2012 Annual Report of the Mountjoy Prison Visiting Committee also expressed concerns about ISM, stating:

*“We are not satisfied that the current level of staffing makes for an effective coverage required to deal with the large number of prisoners in Mountjoy. We are impressed with the level of dedication to the system by the staff in ISM, and by Gov. Whelan. However we believe an evaluation of staffing levels as well as a root and branch analysis of how the system is working is needed.”*

## **Staff Training and the Management of Risk**

Following its visit to Irish prisons in October 2006, the CPT commented on the necessity for prison staff to be given appropriate training and support in dealing with the problems posed by violence amongst prisoners, stating:

*“Addressing the phenomenon of inter-prisoner violence requires that prison staff must be alert to signs of trouble and both resolved and properly trained to intervene. The existence of positive relations between staff and prisoners, based on the notions of dynamic security and care, is a decisive factor in this context; this will depend in large measure on staff possessing appropriate interpersonal communication skills. It is also obvious that an effective strategy to tackle inter-prisoner intimidation/violence should seek to ensure that prison staff are placed in a position to exercise their authority in an appropriate manner. In addition, the prison system as a whole may need to develop the capacity to ensure that potentially incompatible categories of prisoners are not accommodated together.*

*Further, prison staff are unlikely to be able to protect prisoners if they fear for their own safety or if they lack effective management support. Tackling effectively the problems posed by inter-prisoner violence requires the implementation of an individualised risk*

*and needs assessment, the availability of sufficient members of staff and ensuring that staff of all grades receive the requisite initial and on-going training throughout their careers, including in the management of inter-prisoner violence”.*

Responding on this issue the Government stated:

*“With regard to the CPT remarks that prison staff are unlikely to be able to protect prisoners if they lack effective management support, the Government would point to the fact that the importance of effective support and development of staff under supervision is included in Assistant Chief Officer and Chief Officer training programmes. Training in the immediate management of inter-prisoner violence is the focus of both conflict resolution skills training (for Recruit Prison Officers, ACOs and Chief Officers) and effective Control and Restraint techniques. Strategy, proactive contingency planning and management of imminent violence are modules in the Chief Officer training programme”.*

In the most recent CPT report, published on 10 February 2011, the above paragraphs from the 2006 CPT report were repeated verbatim – indicating a view that the concerns expressed in 2006 regarding staff training and individualised risk assessment had yet to be addressed.<sup>103</sup>

## **Stratification of Risk**

In his evidence to the Commission, the Clinical Director of the Central Mental Hospital Professor Harry Kennedy explained stratification of risk as a process whereby patients or prisoners are managed according to the level of risk which they represent to themselves or to others.

In the first place, stratification is based on the assessment of risk in each individual case. As [Consultant Psychiatrist A] told the Commission:

*“If you don’t measure risk you cannot manage risk”.*

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<sup>103</sup> Report of CPT on visit to Ireland from 25 January to 5 February 2010..

However, risk assessment is of little use unless there are appropriately stratified systems for managing different levels of risk. Professor Kennedy identified three elements which were essential to such stratification:

- the physical layout and design of the prison or place of detention
- the ratio of staff to prisoners / patients
- practices and procedures to do with maintaining a safe environment (such as preventing access to drugs or weapons)

It is clear that some prisons are significantly better off in this regard than others. From the information available to the Commission it appears that Cloverhill Prison represents the high-watermark in terms of risk management in the Irish Prison Service. This is partly due to physical factors such as the nature of accommodation available there and partly due to an investment of resources – most notably, the creation of a dedicated Psychiatric Prison In reach and Court Liaison Service (PICLS). This service was instituted in 2006 following growing concern over the number of persons going through the criminal justice system who suffer from major mental illness.

The decision to locate the service at Cloverhill was explained in an article by forensic psychiatrists Dr Conor O'Neill and Clare McInerney as follows:

*“There are several points on the pathway through the criminal justice system where an individual with severe mental illness can be identified and diverted to appropriate treatment. These include the point of arrest, the holding Garda station, the first or subsequent court appearance, and the prison to which he is committed. Resources do not at this time permit a psychiatric presence distributed through all of Ireland’s widely-spread courts and Garda stations, so the most equitable base for such a service in*



*Ireland was assessed as being Cloverhill Prison, in which the majority of Ireland's remand prisoners are placed".<sup>104</sup>*

Prior to the establishment of the PICLS, Cloverhill had been served by regular psychiatric clinics carried out by various members of the National Forensic Mental Health Service staff. [Consultant Psychiatrist D] states:

*"The success of this service was hampered by the rapid throughput in remand prisons, limited continuity of care, failure to maximise detection of severe mental illness and, when identified, challenges in ensuring that prisoners received timely treatment in an appropriate setting... The Prison In reach and Court Liaison Service aimed specifically to address these shortcomings".<sup>105</sup>*

## **Risk Management at Cloverhill Prison**

When prisoners arrive at Cloverhill Prison, the initial assessment stage is a committal interview, conducted by prison nursing staff. All of the medical staff in Cloverhill are trained nurses or doctors; no medical orderlies are employed. The nurses are provided with desks and computer equipment necessary to carry out the assessment. This screening process incorporates issues relevant to offending behaviour, general medical, addiction and psychiatric issues. Details obtained during the interview are entered on PHMS, the computerised medical records system for the Irish Prison Service. Screening takes place on a daily basis; weekend committals are screened on Monday.

Nursing staff at Cloverhill can refer a prisoner directly to the Psychiatric In reach Service, and this is frequently done.<sup>106</sup> The screening forms filled out by the nurses are further reviewed by psychiatric nursing staff at the next psychiatric clinic.

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<sup>104</sup> *Prison psychiatric In reach and court liaison services in Ireland*, C. McInerney & C. O'Neill, (2008) JSIJ 147 at 148–149.

<sup>105</sup> *Ibid.*, p.149.

<sup>106</sup> PICLS Staff Manual p.6.

In addition, members of the Psychiatric In reach Service carry out daily screening of any committals who meet one or more of the following criteria:

- a previous psychiatric history
- a psychiatric issue identified in PRMS on committal interview or on previous contact with prison psychiatric services
- a history of deliberate self-harm
- a charge of homicide or arson
- a history of homelessness or observed unusual behaviour or
- a prisoner identified as disturbed or distressed at committal interview

A key feature in the management of risk at Cloverhill Prison is the use of D2 wing. As described elsewhere in this report, D2 is divided into two sections. One section is used to contain vulnerable or mentally ill prisoners; the other section is used for violent or disruptive prisoners.

In his evidence to the Commission [Consultant Psychiatrist A] pointed to what he considered significant differences between Cloverhill and Mountjoy Prisons in terms of their capacity to manage risk appropriately. The principal evidence of this, according to [Consultant Psychiatrist A], was the use of D2 wing to enable a form of risk stratification. [Consultant Psychiatrist A] explained this to the Commission as follows:

*“So, within D2 there is the special observation cell, i.e. padded cell. Then there are the strip cells... and then you have a semi-bare cell. So even within D2 you are stratifying risk. So I wouldn’t go straightaway from someone on the strip to go out, I would go and stratify and tell them to go down to D2. Then, not infrequently on my watch, someone who would come in on the weekend, they would be seen by one of my colleagues, they would be detoxed, and by the time they get to Thursday they were ready to go back to the ordinary landing, so that there was a procedure and a system in place to measure the risk and manage the risk”.*

In essence, [Consultant Psychiatrist A]’s evidence to the Commission was that in 2006 there was a step-down procedure to be followed in relation to prisoners on D2 – someone placed in a special observation cells would be moved initially to a strip cell, then to an ordinary cell on D2, and only from there to one of the ordinary wings of the prison.

It is not clear to the Commission whether this step-down procedure is applied only to prisoners on the “vulnerable” side of D2, or if it also applies to “security” side prisoners such as Stephen Egan in July 2006.

The Commission notes that in Stephen Egan’s case, the step-down procedure operated initially insofar as he appears to have been placed in a strip cell on the “security” side for a few days, and then moved to another cell, still on the “security” side. The next step would have been a move from D2 to a multiple occupancy cell on one of the ordinary wings of the prison. As we have seen, this did not take place, as he was transferred directly from D2 to Mountjoy Prison.

Since July 2009 the step-down procedure described by [Consultant Psychiatrist A] has been cemented at Cloverhill by the circulation of a Standard Operating Procedure [SOP] for the removal of prisoners from special observation cells. The SOP states:

*“Prior to removal the prisoner must be seen by one of the medical professionals (Nurse Officer, Medical Officer or member of CMH in-reach team) and a record of the reason for removal recorded contemporaneously.*

*The Step Down should be one or more of the following:*

- *Relocate to Strip Cell*
- *Implement Strip by Lock Up procedure*
- *Relocate to Ordinary Cell*
- *Once relocated to ordinary cell to Remain on D2 in ordinary cell for 24 hours prior to moving from D2”.*

In theory, the same stratification of risk which operates in Cloverhill could be employed in Mountjoy, in terms of movement from special observation cells to strip cells and then to ordinary, multiple occupancy cells. The problem has not been one of principle but one of resources. In reality, persistent overcrowding in Mountjoy has rendered it impossible to operate an effective stratification of risk in circumstances where there are simply not enough special cells to cope with the need.

The Commission however is happy to report enormous positive changes have taken place in Mountjoy since the death of Gary Douch and in particular under the stewardship of Governor Edward Whelan, to the extent that the prison has effectively been transformed in terms of accommodation and facilities and environment, and most importantly in its regimes. This can be attributed in part to the economic realisation that the plans for Thornton Hall had to be deferred indefinitely and of necessity resources had to be then made available to the IPS to refurbish and extend the existing prison estate. However the Commission has repeatedly heard evidence that the tragic death of Gary Douch in such appalling circumstances and the setting up of this Commission by then Minister for Justice Michael McDowell, with the predictable scrutiny that would follow, was a watershed which spurred prison governors and staff and the IPS to reflect and question whether our prison system was fit for purpose. A momentum and determination to change things for the better emerged, and this is ongoing.

## **High Support Unit at Mountjoy Prison**

As far as the management of risk is concerned, the most significant improvement which has taken place at Mountjoy Prison since the death of Gary Douch is the opening in December 2010 of a 10-bed High Support Unit (HSU) for vulnerable and mentally disordered prisoners. The HSU has been acknowledged internationally as a success, winning the prestigious ‘Health in Prison – Best Practice Award’ from the World Health Organisation (WHO) in October 2011.

The rationale for the establishment of the HSU was described in an article for the *International Journal of Mental Health Systems* as follows:

*“This project was driven by two needs. The first was a recognised need to reduce the use of special observation (isolation) cells (SOCs) in the prison. Extra*

*resources were not available for enhanced staffing. A solution was required that could reduce the use of SOC's without any increase in injuries or self-harm, and by means of re-organising existing resources. The second need arose from the necessity to provide for those sentenced prisoners with major mental illnesses who had been transferred to a forensic psychiatric hospital where they had responded well to treatment. If returned to prison to serve out the remainder of their sentence however, they were prone to relapse due to ready availability of cannabis and other drugs in prison wings, and the stresses of over-crowding and interactions with other prisoners. If such prisoners could be safely returned to finish their sentences by clarifying a safe pathway, much more efficient use could be made of scarce hospital places.”<sup>107</sup>*

In November 2010, prior to the opening of the HSU, the National Forensic Mental Health Service and IPS nursing staff combined to provide a number of training sessions for prison officers who would be working in the new unit. Topics included suicide awareness,

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<sup>107</sup>Giblin, Mohan et al; 'Reducing the use of seclusion for mental disorder in a prison: implementing a high support unit in a prison using participant action research', *International Journal of Mental Health Systems* 2012, 6:2.

risk assessment, psychiatric screening and the role of the Psychiatric In-reach Service. A series of workshops were conducted in order to address concerns and fears of prison staff regarding the risks and stigma associated with mental illness:

*“Heretofore, prison staff felt much safer when behaviourally disturbed prisoners who were perceived to be more dangerous were placed in isolation. The challenge was to demonstrate that this group of prisoners could be safely managed by increasing staff supervision within a dedicated area rather than locking them for prolonged periods in isolation, having to wear refractory clothing and with minimal human contact, apart from their food and sanitation needs.”<sup>108</sup>*

Figures for the first 12 months of the operation of the HSU show a significant reduction in the use of Special Observation Cells in Mountjoy Prison, along with other improvements in the transition of mentally ill prisoners to and from the Central Mental Hospital:

*“The care pathway for sentenced prisoners with severe mental illnesses from prison to the secure forensic psychiatric hospital also became more effective, with no increase or decrease in the rate of transfers but much improved communication and continuity because the HSU afforded better access to the in-reach mental health team. All transfers from the prison to the forensic hospital were from the HSU and the majority (70%) of discharges from the forensic hospital to the prison were back to the HSU, thereby ensuring better continuity of care and continuation of treatment programmes on return to the prison.”*

In a letter to the Commission [Consultant Psychiatrist A], who heads the Psychiatric In-reach team attending Mountjoy Prison, summarised the effect of the HSU as follows:

*“The development of the High Support Unit is an important milestone in the history of Mountjoy Prison. It has already impacted on making the prison a safer*

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<sup>108</sup> Ibid.

*and more humane environment for all detainees, and more specifically for the most vulnerable group of prisoners.*

*We have received a positive endorsement from the Inspector of Prisons, Judge Reilly. It is now proposed to extend the Mountjoy HSU model to other prisons throughout the Irish Prison Service.”*

## **Committal area at Mountjoy Prison**

Another measure which should have a positive impact on the assessment and management of risk is the introduction of a dedicated area in Mountjoy Prison for the processing of new committals. This area – the first of its kind in the Irish prison system – was opened on 30<sup>th</sup> March 2012. It is located in the ground-floor of C Wing and is a separate, newly refurbished area with 22 single cells and a shower block. A Standard Operating Procedure (SOP) for the processing of committals at Mountjoy has been agreed, following consultation between the IPS, the prison Governor, the Inspector of Prisons and other stakeholders. The principal features of the SOP are set out by the Inspector in his Assessment of the Irish Prison System (May 2013).

The prisoner is brought to the committal area following the initial processing in Reception. He is to remain in the committal area overnight, but no longer than 24 hours – this is known as ‘the committal period’. During this time he is to be seen by a number of relevant persons including the Governor and Chief Officer, as well as a doctor, nurse, chaplain and the Integrated Sentence Management officer. Records of these meetings are to be kept.

With regard to risk assessment, the SOP provides:

*“The nurses in consultation with the doctor (where appropriate) and any other persons that they might deem relevant to consult should prepare a risk assessment of each prisoner. Details of the interviews, relevant medical histories, medical notes etc should be recorded in the medical files.*

*If, following the risk assessment, the prisoner is deemed to be a risk to himself or others an appropriate care plan to manage such risk must be formulated by the medical staff and recorded.*

*Subject to confidentiality issues the results of such risk assessments should be communicated to the Governor, if appropriate, together with the care plan referred to at (i) above.*

*The Governor in consultation with his / her management team will carry out a separate management assessment of the prisoner. The purpose of this assessment is to enable an informed decision to be taken from a management perspective as to where the prisoner should be accommodated. A record of such assessment must be maintained in the prison.*

*Only after the assessments... and the care plan referred to... have been completed should the prisoner be moved to a wing in the prison... or elsewhere. The decision by the Governor as to where the prisoner should be accommodated must have regard to the result of the risk assessment and to any representations or recommendations made by any of the persons [who saw the prisoner during his committal period].”*

## **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 are:

- 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

## Exchange of Prisoners between Prisons

The exchanging of prisoners between prisons on a “swap” basis – known colloquially within the prison system as “horse-trading” – is not objectionable per se; one can easily envisage circumstances where such an arrangement would be best for both the prisons and the prisoners concerned.

In practice however, such exchanges are not always negotiated from a position of equal strength between prisons. The swap involving Stephen Egan which took place on 29<sup>th</sup> July 2006 is an example of this. Mountjoy Prison was obliged by the terms of a standing order to move the other prisoner involved in the swap (referred to in this report as “prisoner B”). In those circumstances the management at Mountjoy felt they had little choice but to accept the terms on which Cloverhill were prepared to accept prisoner B – that is, as part of an exchange for Stephen Egan.

It is clear that overcrowding can also result in certain prisons being in a weaker position when negotiating prisoner transfers. This is particularly obvious in the case of Mountjoy Prison, where almost every day the management is faced with the task of trying to reduce prisoner numbers by a significant amount.

Mountjoy has a further problem when negotiating transfers in that many of its prisoners are on methadone programmes, which means effectively that they cannot be transferred. Governor John Lonergan told the Commission:

*“...we would find it almost impossible to get a prisoner transferred out of Mountjoy – not impossible, but very difficult... There are hundreds of prisoners in Mountjoy that will not be taken in any prison in this country... We have about 250 on methadone*

*maintenance; those are stuck in Mountjoy indefinitely. They cannot go to any other prison...”*

## **Medical / Psychiatric Aspects of Prisoner Transfers**

### **Rules for the Government of Prisons, 1947**

The importance of having some medical input into the movement of prisoners out of a prison was recognised by Rule 16 of the 1947 Rules, which states:

*“Every prisoner shall be examined by the medical officer before being removed to any other prison, or being discharged from prison. No prisoner shall be removed to any other prison unless the medical officer certifies that he is fit for removal...”*

The evidence before the Commission indicates that compliance with this protocol has been the exception rather than the rule in Irish prisons for many years.

### **Healthcare Standards, 2004**

In the 2004 Healthcare Standards the IPS reaffirmed the principle contained in the 1947 Prison Rules that medical personnel should be included in any pre-transfer assessment.

The purpose of the standards set out in that regard was said to be:

*“To ensure that the health care needs of prisoners are considered and taken into account before transfer to another prison and that these needs are provided for during transfer and on reception at the receiving prison”.*

The following protocols are set out under the heading ‘Transfer to another prison’:

*“4.1.1. Prisoners being considered for transfer will be assessed regarding their health care needs and fitness to travel.*

4.1.2. *The Health Care Team of the sending prison will be given a minimum of 24 hours' notice of the planned transfer of a prisoner...*<sup>109</sup>

4.1.3. *Prior to transfer relevant clinical information will be communicated to the receiving prison.*<sup>110</sup>

4.1.4. *Prisoners requiring special nursing care or supervision while being transferred to another prison establishment will be accompanied by a Nurse.*

4.1.5. *In considering planned transfers due attention will be given to the issue of outstanding hospital appointments or pending in-patient procedures.*

4.1.6. *A prisoner's medical file must be transferred with him / her".*

Further protocols are outlined under the heading 'Reception following transfer' as follows:

"4.2.1. *All prisoners received on transfer will have a Nursing assessment undertaken on reception...*

4.2.2. *All transferred prisoners will receive within 24 hours a physical and mental health interview and assessment by a Doctor.*

4.3.3. *Any prisoner on on-going medical treatment will have the treatment reviewed by the receiving Doctor and appropriate follow-up arrangements made as necessary".*

Also of relevance is standard 3.3.10, which appears under the heading of "Suicide and self-injury strategy" and states:

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<sup>109</sup> In 2009 the IPS published a revised version of the Health Care Standards. The requirement of 24-hour notice in protocol 4.1.2 was removed and replaced as follows: "*The Health Care Team of the sending prison will have access to data regarding the planned transfer of a prisoner and will arrange the assessment accordingly ....*"

<sup>110</sup> In the 2009 Health Care Standards, this protocol was amended to read: "The Nurse Manager will ensure that a system is in place to ensure all relevant clinical information will be communicated to the receiving prison to ensure continuity of care."

*“Where a prisoner considered to be at risk of suicide or self-injury is transferred within or to another institution for any reason, suitable arrangements will be made to ensure that appropriate contact and monitoring is maintained”.*

One of the main authors of the Health Care Standards was Dr Enda Dooley, who served as the IPS Director of Prison Health Care Services between 1990 and 2008. Dr Dooley informed the Commission that, notwithstanding the publication of the Standards, the practice of consulting medical personnel prior to a prisoner being transferred remained exceptional rather than routine.

Similar views were expressed by other witnesses with whom the Commission has spoken, including doctors, nurses, psychiatric consultants, and senior prison management. [Consultant Psychiatrist A] and [Consultant Psychiatrist B], consultant psychiatrists who have worked in the prison system for a number of years, both told the Commission that they have no recollection of ever being consulted regarding a proposed transfer of a prisoner to another prison.

## **Prisoner Healthcare Management System (PHMS)**

The Commission has been informed by the IPS Healthcare Directorate that work has taken place to allow a greater level of communication between PHMS (the computerised medical records system which was introduced in May 2010) and PIMS, the system for recording non-medical information concerning a prisoner.

The Commission has been told that alerts on PHMS are flagged on PIMS. In this way, for instance, medical and psychiatric staff are able to place an alert on PIMS requiring that they be consulted prior to the transfer or release of a given prisoner. A discharge docket will not issue until the box which requires such consultation has been ticked.

## **Communication of Information on Transfers**

The importance of observing proper procedures around prisoner transfers cannot be underestimated. As [Consultant Psychiatrist A] pointed out to the Commission

*“It is well known that times of transfer are times of greatest risk”.*

This is true firstly in the sense that the reduced levels of security associated with a transfer may provide prisoners with opportunities for escape, assault or other unwanted behaviour. Secondly, and perhaps more importantly, failures of communication or documentation during the transfer process can result in a receiving prison taking on a level of risk of which they are unaware. This can be seen in the case of Stephen Egan’s transfer to Mountjoy on 29<sup>th</sup> July 2006, where a series of administrative failures resulted in a situation where he was not examined by appropriate medical and psychiatric personnel, where he did not receive his anti-psychotic medication and where he was kept in circumstances which resulted in a brutal and fatal assault on another prisoner.

It appears from the information available to the Commission that there were significant failures of communication surrounding the transfer of Stephen Egan – not only as between Cloverhill and Mountjoy Prisons, but also within the prisons themselves.

The failures of communication which took place at Cloverhill in relation to Stephen Egan can be summarised as follows:

- Governor Dowling, who was the highest ranking person in Cloverhill to be consulted regarding the possible transfer of Stephen Egan, was not made aware of Mr Egan’s psychiatric history, or of his recent return from the Central Mental Hospital, or of the fact that he was on anti-psychotic medication.
- This failure to inform Governor Dowling occurred notwithstanding the fact that Governor Dowling had taken the Governor’s parade for the three mornings prior to Mr Egan’s eventual transfer; he also spoke to Stephen Egan in person on Friday 28<sup>th</sup> July and gave conditional approval to a request from Mr Egan to be moved from D2 back to a main landing in Cloverhill.
- The Psychiatric In-reach Team, who were supposed to be monitoring Stephen Egan’s progress at Cloverhill, were not informed of the decision to transfer him on 29<sup>th</sup> July. Nor were they notified when the transfer had taken place.

- The doctors in Cloverhill were not informed of the decision to transfer Stephen Egan on 29<sup>th</sup> July.
- In relation to communication between Cloverhill and Mountjoy Prisons, there was a failure to provide proper information in the following respects:
  - Mountjoy Prison was not informed in advance of the proposed transfer that Stephen Egan was under on-going psychiatric review or that he had been prescribed anti-psychotic medication.
  - Mountjoy Prison was not told that Stephen Egan was being held in a single cell on the “security” side of D2 wing at Cloverhill (although it should be noted that this information was available to Mountjoy Prison via the computerised records system PIMS).

As far as Mountjoy itself is concerned, the following internal communication failures can be noted:

- The Deputy Governor who accepted the transfer of Stephen Egan on 29<sup>th</sup> July 2006 was not aware that two weeks earlier, Governor Salley and Governor Lonergan had refused to accept Stephen Egan into Mountjoy on the basis that the prison lacked the medical and accommodation facilities to cope with him.
- The doctors on duty at Mountjoy from 29 – 31<sup>st</sup> July 2006 were not told that Stephen Egan had arrived into the prison. Nor were they informed of his apparent refusal to see a doctor when assessed on committal.
- Relevant medical and management personnel were not made aware of the fact that Stephen Egan should have been receiving anti-psychotic medication.
- The psychiatric in-reach team for Mountjoy were not told of Stephen Egan’s arrival. Nor were they alerted to the fact that he required psychiatric review on an on-going basis.

## **Role of the Irish Prison Service**

Every inter-prison transfer of a prisoner must be authorised in writing by the Minister for Justice. In practice, this function of the Minister is delegated to named officers of the Department of Justice (including the Prison Service). According to information provided by the IPS, the first option for signing such transfer orders is the IPS Deputy Director of Operations, or the Director of Operations if the Deputy is unavailable.

According to the IPS, the fact that a proposed transfer is approved does not mean that the transfer will necessarily take place. IPS approval of a transfer request is considered an approval in principle. This allows local prison management to confirm an appropriate date for the transfer and to arrange transport. Once the exact date of the transfer has been confirmed, the transferring prison should then make a Transfer Order request – that is, a request for the Ministerial order without which no transfer can legally take place.

Up until the implementation of the new Prisoner Information Management System (PIMS) in March 2012, the standard procedure was for the transferring prison to notify IPS Operations Directorate of a proposed transfer using a Transfer Order Request form, which was faxed and / or emailed to the Operations Directorate for approval. At night time or weekends, such requests were sent directly to one of two Assistant Principal Officers (APO) from the Operations Directorate who between them had responsibility for approving transfer requests from all prisons in the State.

TRANSFER ORDER REQUEST					
PRISON: _____			CONTACT NAME&NUMBER: _____		
Pria Noc	Prisoner Name	Destination Prison	Proposed Date of Transfer	Reason for Transfer	Has Transfer Been App. by HQ

A request to transfer a prisoner should include certain basic information, including the prisoner's name and number, the date of the proposed transfer, the institution he / she was transferring to, and the reason for the transfer. If the IPS officer agreed that the transfer should take place, the transfer request form was marked "approved", signed or initialled by the APO concerned and faxed back to the requesting prison.

Transfer Order requests received and approved by the IPS were written into a Transfer Record Book and onto a Transfer Order Sheet. The details were checked and the information typed into a computer database. A completed Transfer Order was then printed, checked, signed, and stamped.

Completed transfer orders were sent to the receiving prison, where they were placed on the prisoner's general file. The IPS retained a copy of the approval of the transfer order request. Paper copies of the transfer orders themselves are not kept by the IPS, but an electronic version remains on the Operations Directorate database.



Since March 2012, applications for transfers are now made via PIMS rather than by fax, email or telephone. In September 2013 the Commission received the following information from the IPS as to the procedures currently in place:

*“Applications for transfers between prisons are made on PIMS (Prisoner Information Management System). They are made in a standardised format on PIMS which entails various checks and balances. Certain mandatory information such as the reason for the transfer, a named Governors recommendation, and details why the transfer is requested is included. Operations Directorate also make extensive checks on PIMS which includes checking the following:*

- *Prisoner Basic Details*
- *Warrants*
- *Special Features such as committal to Special Observations cells for Medical Purposes,*
- *Incident Information Reports*
- *Garda Views*
- *Sentence Management decisions*
- *Disciplinary Record*
- *Previous moves*
- *Case notes*
- *Pre movement medical alerts which are input by Medical Staff at assessment stage and which would identify vulnerable prisoners, All committals are assessed by Medical staff on committal. The pre movement medical alerts include markers for the following:*
  - *Risk of self-harm or suicide*
  - *Vital medication*
  - *Medical condition*
  - *Not to be transported in cellular vehicle*

*Once the prison receives approval from Operations Directorate, they must adhere to Standard Operating Procedures which are in place for the movement of such prisoners which indicate that prison staff must contact the surgery and make the necessary arrangements pre-transfer and ensure that medical information is conveyed to the receiving prison so that the necessary safeguards can be put in place to protect vulnerable prisoners.*

*Operations Directorate provide an out of office on-call service to prisons to cater for emergencies / urgent matters. In relation to transfers this only applies to the dispersal of prisoners following a disturbance or riot to ensure the security of the institution or for*

*routine transfers such as where a prisoner was only transferred to that prison for the day such as for court, hospital appearance or medical assessment/appointment etc. In such routine transfers the prison where Operations would be approving his return to would have retained his file, medical records etc. Transfers for sentence management or accommodation reasons are not approved outside of office hours.*

This is a very positive development in the Commission's view.

*Even in emergency transfer situations prison staff must adhere to the standard operating procedures concerning medical markers and vulnerable prisoners and make the necessary arrangements."*

Although transfer requests are now made via PIMS, it remains the case in law that every transfer order must have written authorisation from the Minister for Justice.

## **Policy Statements**

On 21 September 2005 the IPS Director of Operations issued a circular headed "Re: Transfer Order Notifications – Urgent", which was concerned with procedures in relation to inter-prison transfers. The circular stated:

*"The process whereby persons sign orders on behalf of the Minister has come under close scrutiny as a result of recent court hearings. We have been advised to examine our procedures in relation to same in order to prove that careful consideration is taken when an Official, on behalf of the Minister, signs orders approving prisoner movements... The purpose of this review is to counter any allegation to the effect that all orders are 'rubber stamped' and not given proper consideration..."*

The circular continued:

*"I am therefore to advise that, with effect from Monday 26 September 2005, we will require the exact reason as to why each and every proposed prisoner transfer is taking place. Furthermore, this information should be relayed to this office prior to any prisoner movement taking place and the request will not be considered after the event.*

*As part of these new procedures, the attached form should be completed and forwarded to Operations Directorate... In most cases pre-approval by this Directorate will already exist, however, in other cases the move should not proceed until some form of clearance is received from this Office”.*

The Director of Operations went on to state:

*“In my experience the vast majority of prisoner movements are planned in advance and this new system should not therefore cause undue disruption. Situations where prisoner movements must be dealt with urgently (i.e. a serious disturbance) can be dealt with by contacting the Assistant Principal responsible for your institution.*

*I would, however, like to add that it will not be sufficient to advise that the move is taking place for ‘operational reasons’ and that more detailed information such as a future court appearance, prisoner being under threat, disciplinary reasons, family contact, failed drug test etc. will be expected. The absence of same will result in no transfer order being issued...”*

The Director of Operations concluded by requesting that the circular be brought to the attention of all staff involved in the movement of prisoners.

On 2<sup>nd</sup> November 2005 a further circular was issued by the Director of Operations concerning Transfer Order Notifications. In relation to transfers taking place at weekends the Director stated:

*“It is my experience that most weekend movements are planned in advance of them taking place as staff have to be detailed to cover such movements. I am of the view that in the vast majority of cases there should therefore be no reason why requests for such transfers cannot be sent to this office during normal working hours on the previous Friday for approval and I would like these procedures to be implemented with immediate effect. It is recognised that a number of weekend transfers will take place at short notice and in these cases the ‘out of office hours’ procedures in place should continue to apply”.*

In relation to the giving of reasons for transfers the Director reiterated that it was not sufficient to cite “operational reasons” without further explanation:

*“The nature of the operational reason must be given as it could cover a whole variety of issues such as overcrowding, protection because of the nature of the offence, an on-going feud, disciplinary reasons, intelligence received and / or numerous other matters. It is essential that this office is aware of these reasons if we are to make balanced sentence management decisions in the future and also to show that we have given the transfer request due consideration”.*

The Director of Operations returned to this subject in a circular to all Governors dated 10<sup>th</sup> August 2006, ten days after the death of Gary Douch. Referring to his earlier circulars of 21<sup>st</sup> September and 2<sup>nd</sup> November 2005 he stated:

*“It has been brought to my attention that this office is still receiving a number of requests from various prisons who give ‘operational reasons’ or alternatively no reason at all for proposed prisoner transfers. I am to again to reiterate my position that this office must be made aware of the background to any proposed move in order to make balanced sentence management decisions... It is not acceptable to submit applications for transfers without providing this office with appropriate and full background information.*

*Similarly, I am concerned that a number of prisoner transfers have taken place where no transfer order was ever requested or where the request was submitted to this office in a manner inconsistent with the procedures in place. I have also been made aware of instances where transfer order requests take place after the prisoner movement has taken place. Again, this is not an acceptable situation”.*

On 14 November 2006 the Director of Operations issued a further circular in which he stated:

*“It is still the case that a significant number of prisoner transfers are taking place without prior approval from this Directorate and as a consequence no subsequent transfer order is being issued...”*

*I am therefore to direct that each Governor put in place procedures whereby prisoners are not accepted on transfer unless the receiving prison has received a copy of the transfer order request (with approval from this Directorate) from the transferring prison...”*

The Director concluded by stating:

*“The actual transfer orders will be signed in this office on the day of the movement and forwarded onto the receiving prison a short time later”.*

In an appendix to the Operations Directorate report into the death of Gary Douch which was submitted to the IPS Director General in November 2006, specific rules were outlined in relation to prisoners categorised as ‘top risk’ and ‘high risk’ respectively: <sup>111</sup>

***“Top Risk:** The ‘top risk’ category refers to a very small number of prisoners whose disruption or potential to disrupt is of the highest seriousness. Proposed inter-prison transfers of such prisoners must be approved by the Senior Governor in the sending and receiving prison and by the Director of Operations IPS...*

***High Risk:** Prisoners in the ‘high risk’ category... can live as part of the general prisoner population but may be subject to a special regime because of risk of violence, escape or orchestration of violence or escape...*

*Proposed inter-prison transfers of high-risk prisoners must be approved by a Governor in the sending and receiving prison and the Director or Deputy Director of Operations.*

***Other:** The standard transfer procedures apply in respect of all other prisoners”.*

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<sup>111</sup> See ‘Assessment and Management of Risk’, p. 388, Assessment and Management of Risk for further details [CHECK THIS REFERENCE]

## Practice and Procedure

In 2006 there were two Assistant Principal Officers within the Operations Directorate who between them had responsibility for approving transfer requests from all prisons in the State.

During office hours, the officers in question would have access to the information available on the PRIS computer system. In the case of particularly disruptive or troublesome prisoners, the Operations Directorate might also have their own paper file. Outside of office hours or on weekends in 2006 it was not possible for the officers to access either paper or computer files. For reasons of medical confidentiality, Operations Directorate staff did not have access to prisoners' medical files at any time.

In a report of November 2006 to the IPS Director General concerning the death of Gary Douch, the Director of Operations gave the following summary of IPS practice in relation to approving transfers:

*“Practice for many years in this office is that ‘Governor to Governor’ or ‘Chief to Chief’ transfers between closed prisons will be approved unless there is an obvious reason on our files that such a move should not take place. It is expected that the senior prison management grades would bring any such information to our attention, particularly when moves take place on a Saturday, and where my staff would not have access to hard copies of prisoner files or the electronic prisoner database (PRIS)”.*

This was confirmed to the Commission by [Assistant Principal Officer A], the Assistant Principal Officer who approved the transfers which took place between Cloverhill and Mountjoy Prisons on 29<sup>th</sup> July 2006. [Assistant Principal Officer A] told the Commission:

*“I was nine years doing this job... in order to get the job done efficiently, you have to build up a rapport and a relationship with the Chief Officers and the Governors. A lot of my work was done out of hours. I was on call 24/7... we would get a lot of calls at night-time, especially at weekends. So I have to be able to trust the information and the accuracy of the information that the prisons are providing me.*

*Outside of normal hours I have no access to either paper files or the IT system... it's based on a relationship of trust and the accuracy of the information that you are being provided with. I might add it's in nobody's interest to deceive or not [to] provide accurate information because it would soon be discovered".*

[Assistant Principal Officer A] also told the Commission that he would rely to a certain extent on his own knowledge of prisoners, gained from dealing with transfer requests and reading prisoner files over a number of years:

*"From my experience over the years, if I suspect something is not as it should be I would ask questions and I would ask them to go back and check it".*

## **Missing / Unsigned Transfer Orders**

Stephen Egan's prison file as disclosed to the Commission contains a number of transfer orders which are neither signed nor stamped. Following further inquiries carried out by the IPS at the Commission's behest, signed and stamped orders were subsequently located for almost all of the transfers on record. However, the presence of unsigned copies of some transfer orders on Stephen Egan's file has not been satisfactorily explained. In a letter to the Commission the then IPS Director of Operations Mr William Connolly stated:

*"One possible explanation may be that copies of these orders were sought during the earlier investigations into the events surrounding the death of Gary Douch and these unsigned copies were inadvertently associated with Stephen Egan's original prison file. However, this explanation is purely conjecture on my part".*

The Commission has not seen signed or stamped transfer orders in relation to the following transfers of Stephen Egan:

- 03 Aug 2005      From Mountjoy to Cloverhill
- 16 Sept 2005      From Cloverhill to Mountjoy
- 16 Mar 2006      From Cloverhill to Mountjoy

The transfers on 3<sup>rd</sup> August 2005 and 16<sup>th</sup> September 2005 took place prior to the change in procedure which required the use of a standard IPS Transfer Order Request form.

Nonetheless, a signed and stamped transfer order should have issued in each case.

With regard to the transfer on 16<sup>th</sup> March 2006, the Commission has seen a Transfer Order Request, using the standard IPS form, which was faxed to the IPS from Cloverhill Prison on 15<sup>th</sup> March 2006, and was marked “approved”. Notwithstanding this fact, no entry was made in the IPS Transfer Order Book, and no signed transfer order issued.



## **5.6 Death of a Prisoner – Procedures and Protocols**

In its Interim Report, delivered to the Minister for Justice, Equality and Law Reform on 20<sup>th</sup> 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 below, 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.

In addition, the Commission acknowledges the distress of those working in the prison when a prisoner dies, and believes that having a protocol in place which outlines the immediate steps to be taken with regard to informing the next of kin will be of benefit to them.

The Commission's interim recommendations are as follows:

1. A protocol incorporating best practice guidance must be drawn up as a matter of urgency (following consultation with Prison Governors and the POA) to be followed in the event of the sudden and unexpected death of a prisoner, where at a minimum two prison officers, (or other designated persons) 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.

Never should the bereaved next of kin be expected to make their own way to the hospital or prison in these circumstances. Nor should it be tolerated that the next of kin hear of their family member's death or serious injury from the media in advance of official disclosure to them.

2. A suitably qualified person should 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.

The Commission believes that the above recommendations are cost-neutral as regards their implementation.

## 5.7 International Perspectives

In the course of the Commission's work we looked at a selection of models of prison management and of prison healthcare with a view to ascertaining whether we could avail of good practice protocols or mechanisms which would add value to our system here in Ireland. We were also able to attend a number of seminars funded by the EU, which focused on up-skilling new member States with regard to the management of their prisons and assist them with compliance with EU directives.

We also looked to some of the research available in this field, but by no means were we able to do so extensively. The Commission recommends that further research be undertaken to identify sources materials which would assist the stakeholders further in their task of designing the models and protocols suggested.

In a 2007 report *Health in prisons: a WHO guide to the essentials in prison health*, Blaauw and van Marle<sup>112</sup> describe the prevalence of psychosis internationally as approximately 4% of the prison population. In addition, 10% of male and 12% of female prisoners experience major depression; 42% of females and 65% of males have personality disorders. Research also indicates that 89% of all prisoners have depressive symptoms and 74% have stress related symptoms. They say that 6 – 12% of all prisoners need to be transferred to specialized institutions and that 30 – 50% require health care services. They recommend that forensic health care be available on a continuous basis to prevent the deterioration of the mental health state of the prisoners, and forensic psychiatric care should be available for prisoners who need it. They claim that maintaining good detention circumstances provide an additional safeguard against the deterioration of mental health and that the United Nations Standard Minimum Rules for the Treatment of Prisoners must be adhered to. According to Blaauw and van Marle, the best safeguard is ensuring that prison personnel are carefully selected and adequately trained in reducing mental harm and promoting mental health.

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<sup>112</sup> Blaauw, E. and van Marle, H.J.C. (2007) Mental Health in Prisons in Moller, L., Stover, H. et al (2007) *Health in Prisons : A WHO guide to the essentials in prison health*

In his paper *Mental Health in Prisons- because you're worth it* for the 14<sup>th</sup> Annual Conference of the Association for Criminal Justice Research and Development (ACJRD) *Mental Health in the Criminal Justice System* (2011)<sup>113</sup>, Dr Andrew Fraser, Director of Health and Care, Scottish Prison Service compares the health problems of prisoners and the general population in Scotland and the table below illustrates the findings. Compared to the community, the rate of medication in prison population is over ten times greater than the general population for certain anti-psychotic drugs and he posits this may be due to both the greater percentage of people with mental health problems in prison but also with the lack of use of alternatives to medication.

**Scotland: Comparison of prisoner and general population health**

<b>Health Issue</b>	<b>Prisoner Population Health (Male)</b>	<b>Prisoner Population Health (Female)</b>	<b>General Population Health (Male)</b>	<b>General Population Health (Female)</b>
Alcohol Problems	41%	36%	13%	7%
Illegal Drug Use	67%	67%	8%	8%
Smoking Rate	78%	No data	23%	No data
Hepatitis C	20%	20%	1%	1%
Asthma	12%	12%	5.4%	5.4%
Epilepsy	2.1%	2.1%	0.7%	0.7%
Chlamydia	12%	12%	0.8%	0.8%
Severe Dental Decay	9%	42%	10%	3%
Psychosis	9%	36%	0.5%	0.5%
Depression	25%	25%	5%	5%
Personality Disorders	66%	66%	5%	5%

With regard to screening tools, the Commission found that there are already some excellent screening instruments in use internationally that could be adapted for use in Ireland, for example,

<sup>113</sup> Fraser, A (2011) *Mental health in prisons – because you're worth it*, Mental Health in the Criminal Justice System, 14<sup>th</sup> Annual Conference ACJRD, Dublin

the Jail Screening Assessment Tool (T.L. Nicholls et al 2005); or the eight item checklist for screening incidence for suicide risk designed by Blaauw et al in 2001 to identify mental health problems and risk for suicide, self-harm, violence and victimisation among new admissions to pre-trial facilities.

Professor Kennedy and his team have utilised a screening instrument designed by Professor Patrick McGorry, the Irish-born Australian Psychiatrist, to good effect here in Ireland at St Patrick's Institution.

Prison staff will of course need training in administering these new screening instruments in due course.

Excellent prison healthcare research has also been published by Professor Andrew Coyle, Professor of Prison Studies at Kings College, University of London, formerly Director of the International Centre for Prison Studies, and a former UK Prison Governor.

Maintaining good general healthcare in prisons significantly impacts on a prisoner's mental wellbeing.

In his paper for WHO 2007 Health in Prisons Guide, 'Standards in prison health: the prisoner as a patient' – which the Commission adopts and extensively reproduces here, Professor Coyle outlined the following key points:

- People who are in prison have the same right to healthcare as everyone else.
- Prison administrations have a responsibility to ensure that prisoners receive proper health care and that prison conditions promote the well-being of both prisoners and prison staff.
- Healthcare staff must deal with prisoners primarily as patients and not prisoners.
- Healthcare staff must have the same professional independence as their professional colleagues who work in the community.

- Health policy in prisons should be integrated into national health policy, and the administration of public health should be closely linked to the health services administered in prisons.
- This applies to all health matters but is particularly important for communicable diseases.

The European Prison Rules of the Council of Europe provide important standards for prison health care. The fundamental principles underpinning best practice at the interface of health and justice, and those which have guided the development of our current legal obligations towards prisoners, warrant careful and frequent consideration. All of the international standards of health care need to be revisited, reflected upon and embedded in our approach. In looking to these we see that several international standards already define the quality of health care that should be provided to prisoners.

In the first place, the provision in Article 12 of the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966) establishes “*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*”. This applies to prisoners just as it does to every other human being. Those who are imprisoned retain their fundamental right to enjoy good health, both physical and mental, and retain their entitlement to a standard of health care that is at least the equivalent of that provided in the wider community.

The United Nations (1990) Basic Principles for the Treatment of Prisoners indicate how the entitlement of prisoners to the highest attainable standard of health care should be delivered: “*Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation*” (Principle 9). In other words, the fact that people are in prison does not mean that they have any reduced right to appropriate health care. Rather, the opposite is the case. When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary.

Prison administrations have a responsibility not simply to provide health care but also to establish conditions that promote the well-being of both prisoners and prison staff. Prisoners should not leave prison in a worse condition than when they entered.

This principle is reinforced by Recommendation No. R (98) 7 of the Committee of Ministers of the Council of Europe (1998) concerning the ethical and organizational aspects of health care in prison and by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), particularly in its 3<sup>rd</sup> general report (Council of Europe, 1993). The European Court of Human Rights is also producing an increasing body of case law confirming the obligation of states to safeguard the health of prisoners in their care. The argument is sometimes advanced that states cannot provide adequate health care for prisoners because of shortage of resources. In the 11th general report on its activities (Council of Europe, 2001), the CPT underlined the obligations state governments have to prisoners even in times of economic difficulty: The CPT is aware that in periods of economic difficulties ... sacrifices have to be made, including in penitentiary establishments.

However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases. In respect of the obligation to provide adequate health care to prisoners, there are two fundamental considerations. One concerns the relationship between the prisoner and the health care staff and the other concerns how prison health care is organized. Professor Coyle analyses these questions as follows:

## **The Relationship between the Prisoner and Healthcare Staff**

All healthcare staff members who work in prisons must always remember that their first duty to any prisoner who is their patient is clinical. This is underlined in the first of the United Nations (1982) Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which states: Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them

with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

The International Council of Prison Medical Services confirmed this principle when it agreed on the Oath of Athens (Prison Health Care Practitioners, 1979):

*“We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics”.*

This principle is particularly important for physicians. In some countries, fulltime physicians can spend their whole career working in the prison environment. It is virtually inevitable in such situations that these physicians will form a close relationship with prison management and indeed may be members of the senior management team of the prison.

One consequence of this may be that the director of the prison will occasionally expect the physician to assist in managing prisoners. See, for example, the cases of *Mouisel v. France* (application number 67263/010), *Henaf v. France* (application number 65436/01) and *McGlinchey and others v. The United Kingdom* (application number 50390/99) which have created difficulty. For example, the security staff may ask the physician to sedate prisoners who are violent to themselves, to other prisoners or to staff.

In some jurisdictions, prison administrations may demand that physicians provide them with confidential information about a person’s HIV status. Physicians should never lose sight of the fact that their relationship with every prisoner should be first and foremost that between physician and patient. A physician should never do anything to patients or cause anything to be done to them that is not in their best clinical interests. Similarly, as with all other patients, physicians should always seek consent from the patient before taking any clinical action, unless the patient is not competent on clinical grounds to give this consent.



An Internet Diploma course entitled *Doctors working in prison: human rights and ethical dilemmas* provided free of charge on the Internet by the Norwegian Medical Association (2004) on behalf of the World Medical Association focuses on many of these issues.

This primary duty to deal with prisoners as patients applies equally to other health care staff. In many countries nurses carry out many basic health care functions. These may include carrying out preliminary health assessments of newly admitted prisoners, issuing medicines, or applying treatments prescribed by a physician or being the first point of contact for prisoners concerned about their health. The nurses who carry out these duties should be properly qualified for what they do and should treat people primarily as patients rather than as prisoners when carrying out their duties. The International Council of Nurses (1998) published a statement saying, among other things, that national nursing associations should provide access to confidential advice, counselling, and support for prison nurses.

## **The Organization of Prison Healthcare**

One method of ensuring that prisoners have access to an appropriate quality of health care is by providing close links between prison-administered health services and public health. In recent years, some countries have begun to create and strengthen such relationships. However, many prison and public health reformers argue that a close relationship is not enough and that prison health should be part of the general health services of the country rather than a specialist service under the government ministry responsible for the prisons. There are strong arguments for moving in this direction in terms of improving the quality of health care provided to prisoners.

In Norway, for example, the process of giving local health authorities responsibility for providing health care services in prison was completed in the 1980s.

In France, legislation was introduced in 1994 placing prison health under the General Health Directorate for public health issues in the Ministry of Health.

In England and Wales, United Kingdom, responsibility and also the budget for prison health care was transferred to the National Health Service in 2002. The Committee of Ministers of the

Council of Europe (1998) has urged that “*health policy in custody should be integrated into, and compatible with, national health policy*”. The Committee points out that, as well as being in the interest of prisoners, this integration is in the interest of the health of the population at large, especially for policies relating to infectious diseases that can spread from prisons to the wider community.

The vast majority of prisoners will return to civil society one day, often to the communities from which they have come. Some are in prison for very short periods. When they are released, it is important for the good of society that they return to society in good health rather than needing more support from the public health services or bringing infectious diseases with them. Continuity of care between prisons and communities is a public health imperative. Many other people go into and come out of prison on a daily basis: staff, lawyers, officials and other visitors. This means that there is significant potential for transmitting serious disease or infection. For these reasons, prisons cannot be seen as separate health sites from other institutions in society. The WHO strongly recommends that prison and public health care be closely linked. The Moscow Declaration on Prison Health as a Part of Public Health (WHO Regional Office for Europe, 2003) elaborated on some of the reasons why close working relationships with public health authorities are so important.

- Penitentiary populations contain an overrepresentation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, vulnerable people and those who engage in risky activities such as injecting drugs and commercial sex work.
- The movement of people already infected with or at high risk of disease to penitentiary institutions and back into civil society without effective treatment and follow-up gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system. Prevention and treatment responses must be based on scientific evidence and on sound public health principles, with the involvement of the private sector, nongovernmental organisations, and the affected population.
- The living conditions in most prisons of the world are unhealthy. Overcrowding, violence, lack of light, fresh air and clean water, poor food and infection-spreading

activities such as tattooing are common. Rates of infection with tuberculosis, HIV, and hepatitis are much higher than in the general population. The Declaration makes a series of recommendations that would form the basis for improving the health care of all detained people, protecting the health of penitentiary personnel, and contributing to the public health goals of every Member State in the European Region of WHO.

- Member States are recommended to develop close working links between the health ministry and the ministry responsible for the penitentiary system to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism among penitentiary health care personnel, continuity of treatment between the penitentiary and outside society and unification of statistics.
- Member States are recommended to ensure that all necessary health care is provided to people deprived of their liberty free of charge.
- Public and penitentiary health systems are recommended to work together to ensure that harm reduction becomes the guiding principle of policy on preventing the transmission of HIV and hepatitis in penitentiary systems.
- Public and penitentiary health systems are recommended to work together to ensure that tuberculosis is detected early and is promptly and adequately treated and that transmission is prevented in penitentiary systems.
- State authorities, civil and penitentiary medical services, international organizations and the mass media are recommended to consolidate their efforts to develop and implement a complex approach to tackling the dual infection of tuberculosis and HIV.
- Governmental organizations, civil and penitentiary medical services and international organizations are recommended to promote their activities and consolidate their efforts to improve the quality of the psychological and psychiatric treatment provided to people who are imprisoned.
- Member States are recommended to work to improve prison conditions so that the minimum health requirements for light, air, space, and nutrition are met.

- The WHO Regional Office for Europe is recommended to ensure that all its specialist departments and country officers take account in their work of the health care needs and problems of penitentiary systems and develop and coordinate activities to improve the health of detainees.

## European Prison Rules

All the countries that are members of the WHO Health in Prisons Project are also members of the Council of Europe. The Committee of Ministers of the Council of Europe (1973) adopted the European Standard Minimum Rules for the Treatment of Prisoners, which were closely modelled on the Standard Minimum Rules for the Treatment of Prisoners adopted by the United Nations (Office of the United Nations High Commissioner for Human Rights, 1957). In 1973, the Council of Europe had 15 members. By the beginning of 1987, the Council had expanded to 21 members, and the Committee of Ministers of the Council of Europe (1987) had adopted a new set of European Prison Rules. At the time, the Committee of Ministers noted *“that significant social trends and changes in regard to prison treatment and management have made it desirable to reformulate the Standard Minimum Rules for the Treatment of Prisoners, drawn up by the Council of Europe (Resolution (73) 5) so as to support and encourage the best of these developments and offer scope for future progress”*. The membership of the Council of Europe expanded further to 46 states in 2005. For that reason, the Council of Europe decided to revise the 1987 European Prison Rules.

The revised European Prison Rules, adopted on 11<sup>th</sup> January 2006 by the Committee of Ministers of the Council of Europe (2006), contain a significantly expanded section on health care in the prison setting. For the first time, the European Prison Rules specifically refer to the obligation of prison authorities to safeguard the health of all prisoners (§39) and the need for prison medical services to be organized in close relationship with the general public health administration (§40). Every prison is recommended to have the services of at least one qualified general medical practitioner and to have other personnel suitably trained in health care (§41). Arrangements to safeguard health care begin at the point of first admission, when prisoners are

entitled to have a medical examination (§42), and continue throughout the course of detention (§43).

The commentary to the European Prison Rules refers to some recent developments in imprisonment with implications for health care. One is the increasing tendency for courts to impose very long sentences, which increases the possibility that old prisoners may die in prison. Related to this is the need to give proper and humane treatment to any prisoner who is terminally ill. The Council of Europe (1998) has also made a recommendation on the treatment of prisoners who are on hunger strike. In addition to dealing with the health needs of individual prisoners, those responsible for prison health are also recommended to inspect the general conditions of detention, including food, water, hygiene, sanitation, heating, lighting and ventilation, as well as the suitability and cleanliness of the prisoners' clothing and bedding (§44). The European Prison Rules also recommend make provision for prisoners who require specialist treatment (§46) and those who have mental health needs (§47).

One important change should be noted. The 1987 European Prison Rules provided that prison authorities could only impose *“punishment by disciplinary confinement and any other punishment which might have an adverse effect on the physical or mental health of the prisoner”* provided that the medical officer certified in writing that the prisoner was fit to undergo such punishment. This led to concerns that, by providing this certification, the physician was in effect authorizing the imposition of punishment, in contradiction to the Hippocratic Oath. The revised European Prison Rules remove this requirement.

## Conclusion

This concludes Professor Coyle's analysis of the guiding principles for prison health care. The starting point is the principle that health care decisions must be made on clinical grounds and with the patient's interests and consent underlying every clinical judgement and action. Professional independence and patient autonomy, even within prisons, are crucial, as is the need for equivalence of care. It has been suggested that these requirements are most likely to be met if the arrangements for delivering health care in prison are closely linked to the provision of health

care in the rest of society. These principles are linked to international human rights standards, including the revised European Prison Rules.

The United Nations Covenant on the Rights of People with Disabilities will also impact positively on how mental health and criminal justice interact for people with disabilities including mental disabilities.

## **U.K. Experience**

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 from the United Kingdom:

- 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 Christopher Edwards Inquiry

On 26<sup>th</sup> November 1994 Richard Linford was arrested in Maldon for assaulting a female friend and her neighbour. Mr Linford had a history of violent outbursts and assaults, including a previous assault on a cellmate whilst in prison. He had been admitted to a mental hospital in 1988, and was subsequently diagnosed as schizophrenic.

Mr Linford was initially placed in a cell on his own at Chelmsford Prison, but on 28<sup>th</sup> November 1994, owing to a shortage of space at the prison, he was moved into the same cell as Christopher Edwards. Mr Edwards had been arrested on the previous day for approaching young women in the street and making inappropriate suggestions. Mr Edwards' behaviour, both before and after his arrest had led police to suspect that he might be suffering from a mental illness.

In the early hours of the 29<sup>th</sup> November, upon hearing a disturbance, officers entered the cell which contained the two men and found that Christopher Edwards had been stamped and kicked to death. Richard Linford was making continual reference to being possessed by evil spirits and devils.

A subsequent private, non-statutory inquiry found “*a systemic collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner*”. The inquiry identified a series of shortcomings, including poor record-keeping, inadequate communication and limited inter-agency cooperation, and a number of missed opportunities to prevent the death of Christopher Edwards. These matters were also referred to by the European Court of Human Rights in *Edwards – v – The United Kingdom* – a case brought by the parents of Christopher Edwards.<sup>114</sup>

Some of the inquiry's findings, which were quoted in the judgement of the ECtHR, reveal similarities with the aspects of the management and treatment of Gary Douch and Stephen Egan:

- On Christopher Edwards' admission to prison, he was seen by a prison health care worker but was not seen by a doctor.

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<sup>114</sup> Edwards v UK 46477/99 (2002) ECt.HR303.

- The prison health care worker who assessed Mr Edwards was inadequately trained in the recognition of mental disorder and had been given insufficient guidance. The screening was rushed and superficial and did not take place in adequate conditions of privacy. Information provided by Mr Edwards' parents concerning his psychiatric background (he had been tentatively diagnosed with schizophrenia in 1991) was not pass on to the person who carried out the screening.
- Richard Linford had a history of violent outbursts and assaults, including a previous assault on a cell-mate in prison. He had been admitted to mental hospital in 1988, and subsequently had been diagnosed as suffering from schizophrenia. Despite psychotic episodes and further assessments, he was not admitted to hospital after September 1994, as he was not considered to be suffering from acute mental illness. A case conference was held on 24 October 1994, where one of Richard Linford's general practitioners and a police officer expressed the view that he was capable of serious violence or murder. However, no formal risk assessment was carried out. The consultant psychiatrist did not accept that the risk to public safety was serious and it was decided to make one last attempt to induce Richard Linford to take depot medication<sup>115</sup> before detaining him under section 3 of the 1983 Act. On 7 November 1994, it was reported to the consultant that Richard Linford was refusing depot medication.
- After Richard Linford's arrest on 26 November, no attempt was made to locate his medical notes before being assessed. The psychiatric registrar was unaware of the case conference or the outline plan to detain him.
- The person who conducted the screening of Mr Linford knew nothing about him except that he had been "*difficult*" in the police station.

The European Court of Human Rights concluded that that the failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass information about Richard Linford on to the prison authorities and the inadequate nature of the screening process on Mr

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<sup>115</sup> Antipsychotic medication given by injection.



Linford's arrival in prison disclosed a breach of the State's obligation under Article 2 of the ECHR to protect the life of Christopher Edwards.

## **The Bradley Report**

In 2007 Lord Bradley, a former British Home Office minister, was commissioned by the UK Ministry for Justice to conduct an independent review to determine to what extent offenders with mental health problems or learning disabilities could be diverted from the prison to other services and what were the barriers to such diversion. Lord Bradley's report was completed in February 2009.

### ***Staff Education and Training***

Whilst the focus of Lord Bradley's review was on schemes to divert mentally ill persons away from prison, it was recognised that an effective review could only take place in the context of what was described as "*a more comprehensive consideration of the 'offender pathway' and the associated mental health services*". There are, accordingly, aspects of the Bradley Report which touch on issues relevant to the work of this Commission. These are set out below.

The Bradley Report highlighted the importance of training non-medical prison staff in mental health awareness, pointing out that:

"Mental health services are still reliant on non-mental health trained staff, i.e. prison officers, to refer clients to them. Prison officers have the most contact with prisoners on a day-to-day basis, and as such often act as their primary carers".<sup>116</sup>

The Report made the following recommendations:

- Awareness training on mental health and learning disabilities must be made available for all prison officers.

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<sup>116</sup> *The Bradley Report* (April 2009), p.112.

- Where appropriate, training should be undertaken jointly with other services to encourage shared understanding and partnership working. Development of training should take place in conjunction with local liaison and diversion services.
- The training programme must be developed in conjunction with service users.<sup>117</sup>

### ***Dual Diagnosis***

The Bradley Report recognised that “dual diagnosis” prisoners – that is, prisoners with drug / alcohol problems as well as mental health problems – were common within the U.K. prison system. The Report stressed the need for mental health services and substance abuse services to work closely together in seeking to address the needs of dual diagnosis prisoners.<sup>118</sup>

### ***In-reach Services and Primary Care***

The Bradley Report found that in the U.K., prison psychiatric in-reach teams were struggling to provide services for prisoners with severe mental illness, as much of their time was spent treating prisoners with common mental health problems. The Report stated:

*“A large study of a local adult prison found that 55% of those with diagnosed mental health problems could be adequately and safely treated within primary care. This correlates with the results from the general community where it is estimated that 80% of mental health issues are treated without recourse to secondary services.*

*The findings of this particular study indicate that, in order properly to address the mental health needs of the population, current services need to be reconfigured away from a reliance on the provision of mental health inpatient care and towards the development of robust models of primary mental health services. The majority of the care delivered by*

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<sup>117</sup> Ibid.

<sup>118</sup> Ibid., p.107.

*these services would be focused on those with mood, anxiety, and adjustment disorders and be delivered through wing-based interventions”.*<sup>119</sup>

The Report went on to emphasise the importance of adopting a holistic approach to the mental and emotional health of prisoners, stating:

*“This was made apparent by the responses from prisoners when asked what contributed to improving mental health problems: they cited a range of non-health activities, such as reading, painting, going to the gym, and receiving support from others. It is important to remember that health services need support from the rest of the prison to ensure that ‘the whole environment of a prison... supports emotional wellbeing’”.*<sup>120</sup>

## **The Zahid Mubarek Inquiry**

In the early hours of 21st March 2000, Mr Zahid Mubarek, an Asian teenager, was brutally attacked by his cellmate, Mr Robert Stewart, at Feltham Young Offenders Institute. Mr Mubarek remained in a coma until he died on 28th March 2000 as a result of his injuries. Robert Stewart was found guilty of murder on 1st November 2000 and was sentenced to life imprisonment.

On 28th March 2000, the Prison Service set up an investigation into the episode led by a senior member of the Prison Service staff. The Commission for Racial Equality also conducted a formal investigation into the racial discrimination in the Prison Service, with specific reference to the circumstances surrounding the death of Zahid Mubarek.

Despite these investigations Mr Mubarek’s family called for a full public and independent inquiry to uncover the individual and systematic failings, which had led to their son and nephew being exposed to an attack that resulted in his death. The Home Office resisted the call for such an inquiry. The family brought the matter before the Courts and, on appeal; the House of Lords found that the State did not discharge its duty to investigate the death of a prisoner in its custody

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<sup>119</sup> Ibid., p.103.

<sup>120</sup> Ibid.

unless, as a minimum standard of review, there was an appropriate level both of publicity and of participation by the next of kin.

Arising from the House of Lords' decision, the U.K. Government set up a public inquiry “...to investigate and report... on the death of Zahid Mubarek, and the events leading up to the attack on him, and make recommendations about the prevention of such attacks in the future.”.. The report of the Inquiry was published on 29th June 2006.

The Mubarek Inquiry Report contains a number of detailed recommendations on matters which are of relevance to the Commission's work, including cell-sharing, the flow of information within the prison system, the management of mentally disordered prisoners, and improvements in the area of risk assessment. Those of particular significance to the work of this Commission are reproduced here.

### ***Cell-sharing***

#### **Recommendation 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.

#### **Recommendation 2**

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.

#### **Recommendation 3**

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.

### **Recommendation 9**

The Prison Service should publish guidelines to assist officers in allocating cells to those prisoners who have to share a cell.

### **Recommendation 11**

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 at an early opportunity. The suitability of the two prisoners to continue to share with each other should be reviewed at regular intervals, with the prisoners' personal officers being consulted over the issue.

### **Recommendation 15**

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

## ***The Flow and Use of Information***

### **Recommendation 27**

NOMIS [the U.K. Prison IT system] should include a facility for an alert to appear if information is held by the Security Department on prisoners which could affect their management but which is too sensitive for wider dissemination. An officer at the grade of senior officer or above should be able to ask for that information, and the request should be considered by the governor with line management responsibility for the Security Department. The governor should be able to refuse the request, or grant it on condition that the senior officer does not reveal the information to anyone, or on condition that the senior officer can tell their wing staff about it on the understanding that it is not to go any further.

### **Recommendation 29**

The training which staff receive on NOMIS should not merely address how to log on, enter information and retrieve it. It should reinforce the need for any information which is to be

entered to be accurate, comprehensive, and unambiguous. It should also reinforce the need for all staff to be aware of the background and offending history of the prisoners in their charge, as well as their previous behaviour in prison. Staff should learn that the system will be useless if they do not use it properly.

#### **Recommendation 35**

The Police National Computer should be linked to the whole of the prison estate. In the meantime, any intelligence the police may have about prisoners which could affect their management in prison should be sent to the police liaison officers for the establishments at which the prisoners are being held. A decision can then be made whether the intelligence can be disseminated widely within the prison or given to a governor for their eyes only.

#### **Recommendation 36**

Whenever a prisoner is transferred to another establishment, the receiving establishment should be told what the reason for the transfer is. If the transferring prisoner is a particularly problematic one, the receiving establishment should be warned beforehand.

#### **Recommendation 37**

To ensure that all files accompany prisoners on their transfer to another establishment, they should be ticked off at the reception of the sending establishment against a checklist. Prisoners should not be allowed to leave unless all their files have been ticked as present, except with the permission of a governor. Staff on reception at the receiving establishment should notify the department responsible for chasing up files which do not arrive with a prisoner, entering the action they have taken in a “missing file book”. Consequential action and the eventual receipt of the files should also be entered in the book.

#### **Recommendation 47**

The 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.

**Recommendation 48**

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.

**Recommendation 49**

Every establishment should appoint an officer not below the grade of governor to be responsible for overseeing the flow of information. 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.

***Risk Assessment*****Recommendation 51**

Staff who are tasked with initially completing the cell-sharing risk assessment form should be instructed on how to complete it by a senior officer. In particular, they should be reminded that they are only assessing the risk prisoners pose to other inmates.

**Recommendation 52**

The instructions for completing the form should give duty governors guidance on how to exercise the options available to them when dealing with prisoners who are both at risk of self-harm and a risk to their cellmate.

**Recommendation 53**

The first review of the initial assessment should take place within one week of the initial assessment, and should take place in every case. It should be a multi-disciplinary review, with representatives from the prisoner's wing, healthcare and the team responsible for implementing the establishment's violence reduction strategy all contributing to it.

#### **Recommendation 54**

The role of the duty manager or duty governor in the review process should be clarified.

#### **Recommendation 55**

Wing officers should be reminded of the need to call for a review of an assessment when the necessity for one is triggered by some occurrence which might affect the prisoner's emotional well-being.

### ***Mentally Disordered Prisoners***

#### **Recommendation 74**

When prisoners are referred for a mental health assessment, the assessment should address the risk which they pose to staff and other inmates.

#### **Recommendation 77**

The measures which should be taken to minimise the risk which a mentally disordered prisoner on ordinary location poses to staff and other inmates includes:

- Not placing such a prisoner in a shared cell
- If such a prisoner is to share a cell, carefully selecting their cellmate
- Ensuring that, whatever difficulties there may be in operating a proper personal officer scheme, such a prisoner has a personal officer who is fully aware of their background and who makes a particular effort to get to know them and keeps an eye on their state of mind
- Checking the correspondence and searching the cell of such a prisoner more frequently and carefully than would otherwise have been the case
- Ensuring, again regardless of the difficulties which might be faced in providing a good regime for all prisoners in the establishment, that such a prisoner is appropriately occupied with, for example, work, education or offending behaviour programmes



- Keeping a closer watch over material such as films, to which such a prisoner has access, and exercising control over their suitability
- Checking on NOMIS or with the Security Department about the existence of any useful intelligence about such a prisoner and what is known about their previous behaviour in prison.

### **Recommendation 78**

The Prison Service should prepare a readable guide, which explains the circumstances, in which personal information about a prisoner should be disclosed by healthcare staff to officers on the wing. The guide should contain practical examples of situations where disclosure should or should not be made.



## 5.8 Conclusions

### Overcrowding

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

It is clear from recent reports by the Inspector of Prisons that the prison population in the State has reached record levels. In 2000 the average number of prisoners in custody was 2948. In 2006 the daily average was 3,191. By 2009 this average number had risen to 3,881. As at 23 July 2010, the total prison population stood at 4,478. The prison population has fallen somewhat since, but remains around 4,000 at the time of writing.

However as a result of an overall increase in prison numbers in recent years, other institutions which did not have issues with overcrowding in 2006 – notably the Dóchas Centre and Cloverhill Prison – are now routinely operating in excess of their bed capacity.

- 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.

The Inspector of Prisons in his report on the Irish Prison Population dated 29 July 2010 acknowledged “...the grave economic situation that our country is in and... the reality that resources for all public services are, understandably, limited” but went on to state:

*“However, neither of these could be accepted for disregarding the obvious overcrowding of our prisons. I accept that the changes required of our prison system to deal with overcrowding cannot occur overnight. It is for this reason I point out that, provided certain minimum criteria are met, a degree of overcrowding may be justified which would not infringe our obligations. In the immediate short term certain levels of overcrowding may be necessary but this should only occur if a clear commitment is given to eliminate such overcrowding in a defined time and that the safeguards set out in this report are implemented”.*

The Commission fully endorses this statement of the Inspector of Prisons.

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

The Commission has been concerned about the artificiality of the statistics regarding prison capacity and prisoner numbers throughout its investigation. For example statistical tables regarding prison numbers provided to the Commission show that Mountjoy is described on the 28<sup>th</sup> July 2006 as having a design capacity for 547 prisoners yet only had a bed capacity for 445 prisoners at a time when the actual number of prisoners in Mountjoy was 520. On the 29<sup>th</sup> July 2006 we know that 525 prisoners were in Mountjoy when Mountjoy agreed to accept Stephen Egan on transfer from Cloverhill. The statistics suggest that there were 78 prisoners already in Mountjoy without beds, sleeping on floors.

## **Prisoners on Protection**

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

The unnecessary tragedy of Gary Douch's death is forcefully brought home by the fact that it was his request for additional protection that brought him to the cell where he would be fatally assaulted. More than anything else, this illustrates the toxic effect that chronic overcrowding has on prison security.

The Commission believes that certain practical improvements can be made, for instance in terms of risk assessment training and procedures. But the stark fact remains: whenever overcrowding forces prisons to keep protection prisoners on 23-hour lock-up in multiple occupancy cells, an unacceptable risk of violence is ever-present.

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

It is clear that chronic overcrowding creates unacceptable security problems for protection regimes. But it is also the case that the increasing demand for protection in Irish prisons is hampering any attempts to address the overcrowding crisis.

The Commission considers that there is an urgent need to review and implement a system-wide strategy in relation to accommodating protection prisoners. Individual prisons cannot be left alone in this regard: there is an essential role for the IPS to play in seeking to distribute protection prisoners within the system in such a way as to minimise overcrowding problems and potential security risks.

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

Proper, systemised risk assessment is an essential aspect of managing all prisoners, but particularly prisoners who request protection.

In addition to reducing the risk of violent assaults such as that by Stephen Egan on Gary Douch, individualised risk assessment on prisoners requesting protection may also help to reduce the overcrowding problems caused by the large numbers requesting protection.

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

A significant proportion of prisoners who request protection are being kept on 23-hour lock up, with little or no access to educational or recreational facilities. In effect, these prisoners are being punished for their vulnerability. This is unacceptable, and a clear violation of their rights under domestic and international law.

Such confinement can also place considerable strain on the mental and physical health of prisoners, and it appears to the Commission that the current psychological and psychiatric resources available in most Irish prisons are not sufficient to deal with this.

## **Management of Violent / Disruptive Prisoners**

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

The Commission considers that the IPS must take a pro-active role in overseeing the management of disruptive prisoners on a system-wide basis. The management and distribution of disruptive or violent prisoners within the prison system is a matter that cannot be left to the prison Governors alone. It is ultimately a matter for the IPS to ensure that such prisoners are kept in the prisons which are best suited to manage them.

It is accepted that the number of highly disruptive prisoners within the Irish prison system at any one time is likely to be small. Nonetheless, the importance of identifying and managing such prisoners correctly is evident from the death of Gary Douch in 2006 – a death which would not have occurred, had Stephen Egan been managed appropriately.

- **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.**

From the information disclosed to the Commission, it appears that the Disruptive Prisoners and Security Group when in operation has, by and large, confined itself to questions regarding the placement of disruptive individuals.

The Commission considers that it should be a priority for the Irish Prison Service to identify and address the causes of disruptive behaviour in each individual case, using input from psychologists, psychiatrists and other relevant services as appropriate.

Management plans for disruptive prisoners must balance the security of the prison system with respect for the human rights of individual prisoners. Thus, for instance, a practice of keeping disruptive prisoners on 23-hour lock up for extended periods must be reviewed in light of the potentially deleterious effects on the mental, emotional, and physical health of that prisoner. Similarly, the practice of frequently moving disruptive prisoners around the prison system – the so-called “carousel” policy – should be closely monitored for its effects on individual prisoners.

- **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.**

The acquisition, retention, and appropriate dissemination of information concerning individual prisoners are of course essential to the effective management of any prison. However, the Commission considers that particular emphasis must be placed upon documenting and communicating information in relation to disruptive or violent prisoners.

The principal reason for this is that disruptive prisoners are more likely to find themselves transferred between prisons on a regular basis – whether for brief periods as punishment for misbehaviour or as part of the “carousel” approach to managing disruptive prisoners which has characterised the IPS approach to date. Without a consistent commitment on the part of prison staff to documenting and communicating relevant information, there is a risk that a highly volatile prisoner can “fall through the

cracks” and end up being placed in a manifestly unsuitable environment, as was the case with Stephen Egan in July 2006.

- **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.**

In its most recent visit to Ireland (January / February 2010) the CPT expressed concern regarding the number of prisoners on psychotropic medication at Midlands Prison, *“without a clear rationale for this being noted in the medical records”*. In order to guard against the potential over-medication of prisoners – and in particular, violent, or disruptive prisoners – it is essential that full and detailed records are kept, not only of when and for how long such drugs are prescribed, but also the reasons for the prescription. Without such records, no effective review of prescription policies in a given prison can be carried out.

The Commission has been informed by the IPS Healthcare Directorate that a national protocol in relation to prison pharmacy services is currently being developed. The Commission considers that such a protocol is urgently needed, and calls upon all the relevant stakeholders in the prison system to engage in developing this protocol.

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



The effective implementation of a formal system of risk management across the Irish prison system is a matter of urgent necessity.

The information disclosed to the Commission by the IPS indicates that formal categories of risk were adopted by the IPS in 2006, but the extent to which these categories inform the on-going management of specific prisoners is not clear.

In any event, effective risk management depends on the availability of resources. Without a range of available cell accommodation and an appropriate number of properly trained staff, any formal system of categorising risk will have little or no effect. No risk management system can function in circumstances where overcrowding is endemic.

## **Transfer of Prisoners between Prisons**

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

In circumstances where certain prisons in the State (notably Mountjoy Prison) are often at a considerable disadvantage when negotiating inter-prison transfers, it is essential for the well-being of individual prisoners and for the safety and security of the prison system as a whole, that the IPS take an active, informed role in overseeing and approving any such transfers.

- **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.**

As well as the IPS, both the transferring and receiving prisons have a duty and a responsibility to ensure that they have in their possession all necessary information – including medical and security-related information – prior to a proposed transfer being approved.

In the case of Stephen Egan's transfer on 29<sup>th</sup> July 2006, the transferring prison (Cloverhill) made the decision to transfer Mr Egan without all relevant information being placed before the Governor in charge at the time. In addition, relevant information concerning Mr Egan's security status at Cloverhill and his on-going need for psychiatric review and medication was not communicated to the receiving prison (Mountjoy).

Given the accessibility of relevant information to the IPS and to all prisons via the recently improved PRIS and PMHS systems, any prison involved in a transfer can and should have access to all necessary information prior to making or approving a transfer request.

- **The protocols outlined in the IPS Health Care Standards in relation to prisoner transfers must be followed.**
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## **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 [Consultant Psychiatrist A] and [Consultant Psychiatrist D] 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 is 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.

<b>Ministers Responsible</b>	<b>Stakeholders</b>	<b>Facilitators for Evaluation/Re-evaluation</b>	<b>Cost</b>
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 2001 Act. 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 4<sup>th</sup> 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*, 21<sup>st</sup> December 2010,<sup>121</sup> 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 19<sup>th</sup> 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*

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<sup>121</sup> *Guidance on best practice relating to the Investigation of Deaths in Prison Custody*, 21<sup>st</sup> December 2010

*powers to enable me to compel witnesses to co-operate or to demand 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.



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