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

Volume Four

Appendices

Sole Member: Gráinne McMorrow S.C.

Appendix 1 Chronology (Abridged)

ABRIDGED CHRONOLOGY OF WORK

8th Jun 2007	Gráinne McMorrow S.C. was appointed as Sole Member of the Commission.
Jun-Aug 2007	Meetings with the Department of Justice officials regarding the setting up of the commission, the provision of offices and equipment, I.T. needs, budget, and staffing. Appointment of Commission staff – 1 secretary (Ms Emma Rooney) & 1 registrar (Mr Tom Maguire). Preparation of offices in Dublin Castle – including installation & testing of security & IT equipment. Offices became functional in mid-August 2007. Appointment of Ms Mary Ellen Ring SC and Mr Colm O Briain BL as counsel to the Commission under s.8 of the Commissions of Investigation Act 2004. Appointment of Mr Éanna Hickey BL and Ms Jane Murphy BL to assist the Commission with research on specific matters as and when required. The Commission visited Mountjoy Prison on the anniversary of Gary Douch's death (1st August 2007). The Commission also placed public notices in national newspapers inviting submissions from any interested person/organisation.
Aug-Sep 2007	Contact made with various relevant persons, agencies and organisations, seeking voluntary disclosure of all material of

	relevance to the work of the Commission. Informal discussions held with a number of relevant persons/organisations including the Irish Prison Service, An Garda Síochána, the Office of the Attorney General, the Clinical Director of the Central Mental Hospital, concerning the Commission's work and proposed methodology. General guidelines were obtained from the Minister for Justice, Equality and Law Reform regarding the payment of legal costs and other expenses to persons who become involved with the Commission, as required by section 23 of the Commissions of Investigation Act 2004. Following consultation with the Commission's own legal advisers and with the Garda Síochána, the Commission decided to postpone interviewing or taking evidence from any prisoner or member of staff at Mountjoy prison, the Central Mental Hospital or any other prison or institution in relation to any matter which could impinge upon the criminal trial of Stephen Egan for the murder of Gary Douch, until such time as the trial process was complete. The Commission made this decision because of the risk that carrying out such interviews might prejudice the criminal proceedings. The Commission was supported in this view by the Attorney General, the Director of Public Prosecutions, the Garda Síochána and by the mother of Gary Douch, Mrs. Margaret Rafter and her legal advisers. Accordingly, the Commission was unable to proceed with this important aspect of its work until April 2009, when the initial criminal process in relation to Mr Egan had reached a conclusion.In fact Mr.Egans criminal proceedings including the Appeal did not finally conclude until Late November 2010, and even at that stage

	it was indicated that he intended to explore taking a case to the European Court.
Oct 2007-Apr 2009	The principal work of the Commission during this period involved gathering evidence relevant to its Terms of Reference, the collation, review and analysis of all documentation/submissions received. In some cases, this review process revealed the existence of other relevant information or documentation which was then requested and searched for. The Commission developed and finalised its Rules and Procedures, along with designing templates for other necessary working documents, notices and correspondence. Following a period of research, including informal consultation with the Clinical Director of the Central Mental Hospital, the Commission identified an appropriate independent external high calibre expert in psychiatry competent to conduct a peer review of the clinical management of Stephen Egan, and thereafter secured the services of Dr Paul Lelliott, a consultant psychiatrist and Director of the Centre for Quality Improvement at the Royal College of Psychiatrists, London as an expert S.8 Advisor to assist the Commission in reviewing all evidence relating to mental health and psychiatric interventions. Correspondence was maintained with a variety of relevant persons and organisations, including the Irish Human Rights Commission and the firm of solicitors appointed by the Prison Officers' Association to represent prison officers in their dealings with the Commission. In some cases, letters were sent requesting written submissions from relevant organisations.

	During this period the Commission also conducted research into international best practice in prison management, prison healthcare and related issues. This included attendance at conferences where issues relevant to the Commission's Terms of Reference were discussed by domestic and international experts. The Commission conducted visits and carried out research at a number of prisons throughout the State in relation to practices and procedures associated with the reception, committal, assessment and accommodation of prisoners at those prisons. In December 2007 the Commission submitted an Interim Report to the Minister outlining the progress made and problems encountered to date. The Report also contained analysis and interim recommendations on issues including overcrowding, single cell occupancy and the treatment of bereaved families following the death of a prisoner.
Apr-Dec 2009	Following the conclusion of Stephen Egan's first criminal trial in April 2009, the Commission commenced preparation for a series of oral hearings with relevant persons, which were conducted between June and December 2009. Further requests for information and documentation were made arising from the hearings. In June/July 2009, formal directions were issued to National Forensic Mental Health Service under s.16(1)(g) of 2004 Act for disclosure of all relevant records and documentation. Relevant information was collated and sent to expert witness Dr Lelliott to enable him to begin his work.

Jan 2010-Jan 2011	Review and analysis was carried out on information received via oral hearings/further disclosures of documentation. Further requests for information were made as required. Further submissions were received, including a submission from the Prison Officers' Association. The Commission conducted visits to Mountjoy, Cloverhill and Midlands Prisons. Informal interviews were conducted with relevant personnel and with certain prisoners, including Stephen Egan. The initial process of drafting sections of the Commission's Final Report was begun. The Commission met with the family of Stephen Egan. In June 2010 the Commission through its own researches became aware of important, hitherto undisclosed information concerning a visit to Stephen Egan by a clinical psychologist on 26 July 2006, four days prior to the death of Gary Douch. Further requests for information, documentation and submissions were made arising from this newly disclosed information. A long and detailed report was received from expert witness Dr Lelliott, and was circulated to the National Forensic Mental Health Service and other relevant persons for their consideration. Further written and oral submissions were received as a result of this process, which in turn revealed the existence of other relevant documentation not previously disclosed to the Commission. Additional reports were sought and obtained from Dr Lelliott in

	relation to issues arising from the response to his first report. Also circulated to relevant persons during this period was information and documentation concerning (i) the visit of a clinical psychologist to Stephen Egan on 26 July 2006, and (ii) the expert report of consultant psychiatrist Professor Tom Fahy, Professor of Forensic Mental Health, Institute of London, which had been prepared in connection with the trial of Stephen Egan for the murder of Gary Douch and only recently disclosed to the Commission.
Feb 2011-Apr 2012	Oral hearings were prepared and conducted with prison officers at Cork Prison in relation to a serious assault/escape attempt involving Stephen Egan (which took place on 27 November 2005). The Commission had discussions, prepared briefing documents and conducted correspondence with Professor Fahy regarding his accepting an appointment to assist the Commission as an expert advisor under s.8 of the 2004 Act. Further review/analysis was carried out on information and documentation obtained from oral hearings in Cork and Dublin. The Commission continued the process of drafting and editing sections of the Final Report. Detailed correspondence was maintained with a variety of persons and organisations concerning a variety of matters including potential third party legal costs and other expenses, the legal representation of witnesses, and the budgetary, staffing and administrative requirements of the Commission.
Apr 2012-Apr 2013	In April 2012 the Commission completed a draft Final Report.

	All persons/ organisations identified or identifiable in the draft Report were provided with a copy of the complete draft Final Report and were given the opportunity to make submissions in relation to it, as required by fair procedures and the Commissions of Investigation Act 2004. Submissions were received over the next 3 months from a number of persons and organisations. Also received by the Commission during this period were a number of relevant but previously undisclosed files from the National Forensic Mental Health Service. These files related to Stephen Egan's care and treatment at the Central Mental Hospital. In July 2012, the Commission was made aware for the first time of legal proceedings which had been brought by a prisoner in the days preceding Stephen Egan's arrival in Mountjoy Prison in July 2006 and which related to the care and management of prisoners in the holding cell in which Gary Douch was subsequently attacked and killed on 31st July/1st August 2006. The Commission sought relevant documentation from the State concerning the case in question, the last documents of which were obtained in November 2012. At or around the same time, the Commission became aware of files in possession of the IPS and the State Claims Agency which were directly relevant to the events that resulted in the death of Gary Douch. Formal Disclosure Directions were issued in relation to these files, both to the DOJ/IPS and the State claims Agency, copies of which were produced to the Commission in April and May 2013. In June/July 2012 the Commission was asked to vacate its offices

	in Dublin Castle in order for necessary fire and safety installation works and alterations to be carried out to the offices, in advance of preparations to facilitate Ireland's Presidency of the European Union. Following this requirement in July 2012 The Commission had to prepare all its confidential records and materials and move into another suite of offices in another part of Dublin Castle. In September 2012, the Commission offices were again moved, this time back to its original office location. In October 2012 the Commission was obliged to move offices once again, this time out of the Dublin Castle campus, following notification that all office space in Dublin Castle was then required to accommodate the Staff of the different E.U. Member States who would be Dublin based, for the duration of the Ireland's Presidency of the European Union. Following a process of inspecting various premises, suitable alternative accommodation was found for the Commission at offices in Hanover Street, Dublin 2. The Commission moved there in October 2012, with all the preparation and disruption that involved. In November 2012 the Inspector of Prisons contacted the Commission on behalf of a prisoner who claimed to have information of relevance and importance concerning the circumstances which culminated in the death of Gary Douch. A substantial number of submissions, records and documentation, were received in the months after the circulation of the Commission's Draft Report.

May 2013-Jan 2014	Further submissions were received in relation to the Draft final report. An interview was arranged with this prisoner in Midlands Prison June 2013, and his testimony created a need for further inquiries before the Final Report could be completed. All of the submissions and new documentation received following circulation of the draft Report required detailed consideration. Conflicts of evidence were identified which required revisiting transcripts of evidence from the Commission Hearings and other documentary evidence. As a result of which it proved necessary to issue further requests and formal directions for specific documentation. The Commission felt that in relation to evidential conflicts that it was necessary to hold further oral hearings in an effort to resolve certain conflicts of evidence between witnesses. The last of the Commission hearings took place on the 9th and the 16th December 2013. The process of seeking, obtaining, reviewing and processing new information and documentation continued up until January 2014. During this period the Commission also visited the Mountjoy complex and met with the Governor and other senior staff members to review all relevant operational and medical changes that had taken place since the circulation of the draft Report. A further Commission visit to the HSU, and the medical and other facilities was undertaken. A follow-up late request to the IPS to carry out a further search to

	be conducted in relation to a specific matter resulted in evidence being located and disclosed to the Commission on the 24th January 2014. The completed Final Report was submitted to the Minister on 31st January 2014.

Appendix 2 Interim Report

COMMISSION OF INVESTIGATION

INTO

THE DEATH OF GARY DOUCH

Interim Report

December 2007

Introduction

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 2nd May 2007.

I was appointed as Sole Member on 8th 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 27th 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 Interim Report.

The Commission is required to make a final report to the Minister for Justice Equality and Law Reform, as the specified Minister under the Act, not later than 31st December 2007.

This interim report is submitted to the Minister for Justice Equality and Law Reform pursuant to the provisions of section 33(3) of the Commissions of Investigation Act 2004.

Death of Gary Douch

Gary Douch, a young man from Dublin, was twenty-one years old when he died. On 15th June 2005 he had been sentenced to three years' imprisonment (backdated to 27th July 2004) for the offence of assault causing harm. He was committed to Mountjoy Prison on transfer from Midlands Prison on 24th July 2006, and was placed in a cell on 'C' Wing. On 31st July 2006, while detained in C Wing, Gary Douch expressed concerns for his personal safety to a prison officer. As a result of this he was moved to a holding cell in 'B' Base, which is the basement floor of B Wing.

Gary Douch arrived in holding cell #2, B Base at approximately 6.45 pm on 31st July. There were 5 other prisoners in the cell at that time. At one stage during the evening, the cell contained as many as 14 prisoners. However, when the cells were locked for the night at around 9pm, the number of prisoners in holding cell #2 had been reduced to 7, including Gary Douch.

This holding cell was effectively a waiting room with a narrow 18-inch wooden seating bench around its perimeter. It was never designed or intended for use as a cell. The 7 prisoners who remained there overnight were all categorised as 'protection' prisoners, who each had particular personal difficulties warranting extra care and attention, supervision and monitoring.

Whilst in holding cell #2 during the early morning of 1st August 2006, Gary Douch became the victim of a vicious and brutal attack. His unconscious body was found by prison officers when they unlocked the cell at approximately 6.50am that morning. Medical staff at the prison and at the nearby Mater Hospital were unable to revive him. Gary Douch was pronounced dead at 7.35am.

Garda investigation

One of the prisoners who had been in the holding cell with Gary Douch overnight was arrested by Gardaí investigating the incident on 1st August 2006. This prisoner was detained under section 4 of the Criminal Justice Act 1984, and was subsequently charged with the murder of Gary Douch. At the time of writing, the criminal trial in relation to this charge is expected to take place early in 2008.

Report of Mr. Michael Mellett

On 1st August 2006, the then Tánaiste Mr. Michael McDowell T.D. later appointed Mr. Michael Mellett, a former Civil Servant in the Department of Justice Equality and Law Reform 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:*

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

> *The minister intends that the report by Mr Mellett will be published in due course (except for any parts which could be deemed prejudicial to potential criminal proceedings)"*

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 the prisoner who had been charged with the

murder of Gary Douch. This prisoner was referred to throughout Mr. Mellett's report as 'Prisoner A'.

On 23rd April 2007, the Tánaiste announced that a Commission of Investigation was to be set up to carry out further inquiries into matters arising from the death of Gary Douch. Having thanked Mr. Mellett for his report he 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."*

At an early stage of its inquiries, the Commission had a very useful meeting with Mr. Mellett to discuss his findings and recommendations. As a result, the Commission has identified matters that necessitate further investigation pursuant to its terms of reference.

Establishment of the Commission

Premises

With the assistance of the Department of Justice, Equality and Law Reform, office accommodation was secured for the Commission at Dublin Castle. The rooms were unfurnished, and the process of converting them into an appropriate working environment for the Commission took longer than anticipated.

In particular, the setting up of an appropriate I.T. system posed an early challenge, given the sensitive nature of the Commission's work and the range, complexity and sensitivity of the information that it would be holding. As the Commission's inquiry is running essentially

parallel to a criminal prosecution, an absolute prerequisite was to establish a robust system that would meet the Commission's security requirements in a stand-alone environment operating independently of the Department of Justice Equality and Law Reform. The successful implementation of such a system took some time, and it has to be said that it is not without ongoing problems.

As a result of these delays and difficulties, the Commission's offices and working systems were not fully operational until the middle of August 2007. Prior to this, I engaged in preparatory work from my home office. This work included devising a methodology and programme of work for the Commission, and conducting initial research.

Staff

Two civil servants from the Department of Justice, Mr Tom Maguire and Ms Emma Rooney, were assigned to assist the Commission in an administrative capacity, as Registrar and Secretary respectively.

Legal counsel

The Commission appointed a Senior Counsel, Ms Mary Ellen Ring S.C. and a Junior Counsel, Mr Colm O'Briain B.L. under the provisions of Section 8 of the Commissions of Investigation Act 2004 to advise it. Mr Éanna Hickey B.L. and Ms Jane Murphy B.L. were also commissioned for specific research referable to their respective expertise to assist the Commission periodically.

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;

1. *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;*
2. *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 1st August 2006 and*

3. *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 and,*
    - *safeguarding the public interest."*

The magnitude of the task faced by the Commission is clear from even a cursory reading of the terms of reference.

In the first place, the Commission must investigate, to the extent it considers necessary, any matters or circumstances which may have had a bearing on the death of Gary Douch. Such circumstances are not limited to the events of the 31st July and 1st August 2006, but must also include the treatment, and management (including prison transfers) of Gary Douch and 'Prisoner A' who is accused of killing him, during the days and months leading up to the attack.

It is important to note at this point that the terms of reference instruct the Commission to carry out its investigations "without prejudice to any criminal or disciplinary proceedings". As we shall see this restriction, whilst undoubtedly necessary in the interests of justice, has inevitably hampered the Commission's ability to proceed with certain aspects of its inquiry in advance of the prospective criminal trial of 'Prisoner A' in connection with the death of Gary Douch.

In addition to investigating matters relating specifically to the death of Gary Douch, the Commission is also asked to conduct "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…" This review must include – but is not limited to – a review of protocols for prisoners with specific behavioural problems or vulnerabilities, together with any amendments made to such protocols since the death of Gary Douch.

The reference to "practices and procedures" in this part of the terms of reference implies that the Commission is not merely tasked with reviewing the adequacy of stated policies concerning prisoner safety, but must also investigate the manner in which such policies are applied in every institution in the State where prisoners are kept in custody. The Commission must also evaluate current practice regarding the delivery of psychiatric care to prisoners, and if necessary, design a model for more effective psychiatric care interventions that meet the highest standards of professional practice and legal obligations.

Finally, the Commission is tasked with making recommendations as to what "cost-effective policies and / or legislative measures" could be adopted to improve the treatment and management of both vulnerable prisoners and violent or disruptive prisoners. The Commission must also include "an estimate of the approximate implementation costs" for each recommendation made by it.

Methodology

Rules and procedures

The Commission prepared "Rules and Procedures" as required by the provisions of Part 3 of the Commissions of Investigation Act 2004. A copy of these 'Rules and Procedures' is contained in Appendix A of this Interim Report.

Public consultation

The Commission committed itself to public consultation and placed a public notice in national newspapers on 8th and 9th August 2007 inviting anyone in a position to help the Commission in its work to make contact. Organisations and groups including professional bodies concerned with prisoners, both statutory and voluntary, and those working in the fields of prisoners' rights and mental health were also written to and invited to make submissions or make contact. A number of submissions have been received to date.

Privacy

The Commission is required in general to carry out its investigation in private and evidence given in private shall not be disclosed or published by anyone, save in statutorily defined circumstances.

Voluntary co-operation

In keeping with the provisions of Section 10 of the Commissions of Investigation Act 2004 and with an ethos of engaging openly with all those individuals and agencies affected by this inquiry, the Commission has been anxious from the outset to establish voluntary co-operation with all parties. This will significantly enhance the quality and efficiency of the Commission's work.

In order to encourage and facilitate such co-operation, the Commission held informal meetings with a number of key individuals and organisations, including members of Gary Douch's family and their legal representatives, members of An Garda Síochána investigating the death of Gary Douch, the Governor of Mountjoy Prison, Mr. Michael Mellett, senior representatives from the Department of Justice, the Irish Prison Service, the Central Mental

Hospital, the Mental Health Commission and the Irish Human Rights Commission, and other relevant persons.

After the completion of the criminal trial the Commission will also seek to engage with 'Prisoner A', his family and legal representatives.

Programme of Work

Each task expressed or implied by the Commission's terms of reference has been identified, and initial templates for action have been drawn up. Typically, this process involves identifying, sourcing, collating, analysing and summarising the information required by the Commission with reference to each task.

Documentation

Given that much of the information required by the Commission is likely to be contained in documents of a sensitive and confidential nature, the Commission was unable to begin the process of formally requesting documentation until mid-August 2007, when the necessary systems for storing, securing and tracking documents were in place.

Since that time, the Commission has written to a number of relevant persons, agencies and organisations, seeking voluntary disclosure of all material relevant to the terms of reference.

Copies of all relevant Government policy documents, guidance, protocols etc. have been sought and are being reviewed. Also all reports touching on matters of relevance are being studied. A bibliography will be included with the Final Report.

Meetings

Meetings have been held with relevant persons, professional bodies, agencies and institutions who are likely to be affected by, or have a contribution to make to the Commission's work.

Inspections

An early task carried out by the Commission was to visit Mountjoy Prison on the anniversary of Gary Douch's death on the 1st August 2007, to inspect the Base area where he died and to assess the environment. During that visit the Commission met with the Governor Mr. John Lonergan, and other prison staff as well as prisoners then housed in the Base.

It should be noted that, since the death of Gary Douch, the room known as holding cell #2 is no longer used to hold prisoners. It has been completely refurbished, and now functions solely as a shower room.

The Commission has begun a process of visiting prisons and related institutions around the country, in order to witness at first-hand the operational process for prisoner reception following remand or sentence from the Courts or following transfer from other prisons.

A separate task of evaluating the implementation of and / or compliance with current policies and procedures regarding the management of 'protection' prisoners, including those regarded as vulnerable and disruptive, will also be undertaken.

Review of training procedures

A thorough review of the Training Programme for Prison Officers has also been undertaken by the Commission, in order to assess whether such training equips prison officers to deal with issues covered by the terms of reference, and further to assess whether the training corresponds with current practice in prisons in the State.

Comparative research

The Commission is carrying out extensive research into the policies, standards and practices in other countries concerning prison management - including prisoner assessment, categorization, risk assessment and allocation - in order to establish best practice models. In addition we are researching operational models for the delivery of psychiatric health care to mentally ill offenders, as adopted in other countries. This research, which is ongoing, includes material from the European Union, the United Nations, the World Health Organisation (WHO) and from other international bodies and agencies.

Legal obligations and compliance

An ongoing task for the Commission concerns an evaluation of the extent to which we are compliant with our legal obligations, both nationally and internationally.

Oral hearings

Following consultation with the Commission's own legal advisers and with the Garda Síochána, the Commission decided not to interview or take evidence from any prisoner or member of staff at Mountjoy prison, the Central Mental Hospital or any other prison or institution in relation to any matter which could impinge upon the criminal trial of 'Prisoner A', the man accused of killing Gary Douch, until such time as the trial process is complete. The Commission made this decision because of the risk that carrying out such interviews might prejudice the criminal proceedings.

The Commission is supported in this view by the Attorney General, the Director of Public Prosecutions, the Garda Síochána and by the mother of Gary Douch, Mrs. Margaret Rafter and her legal advisers.

Accordingly, this part of the Commission's work must be postponed until such time as the criminal process has reached a conclusion.

Time frame

Under its terms of reference, the Commission is required to submit its final report to the Minister for Justice Equality and Law Reform, as specified Minister under that Act, by the 31st December 2007. Completion of the Commission's work within this time frame is not feasible, for the following reasons:

1. Although I was appointed as sole member on 8th June 2007, the length of time required to recruit staff and to set up an appropriate working environment meant that the Commission was unable to begin meaningful work until mid-August 2007.

2. For reasons described elsewhere in this report, the Commission cannot embark on the process of scheduling the hearing of evidence relevant to its investigation in advance of the conclusion of the criminal trial of 'Prisoner A' in relation to the death of Gary Douch. At the time of writing, this trial is scheduled to begin on 22nd January 2008, but further delays to the criminal process cannot be ruled out.

3. The scope of the tasks assigned to the Commission in its terms of reference is extremely broad. It includes requirements to investigate matters of fact; to review relevant policies, practices and procedures (both before and after the death of Gary Douch) regarding prisoner safety and the delivery of mental health care to prisoners; to make recommendations as to policies and possible legislative measures, and to supply financial estimates for the cost of implementing such recommendations. On the basis of its work to date, the Commission is certain that, even without the delays caused by administrative issues and by the projected criminal trial, the completion of the tasks

assigned to it by the terms of reference would not have been feasible within the time frame as originally set out.

The Commission remains conscious of the need to complete its work as expeditiously as a proper consideration of the matters referred to the Commission permits. The Commission remains determined to do so, taking into account the importance of its task, the requirements of its governing statute and the need to ensure fair practices and procedures for all affected by its investigation. With this in mind, the Commission is of the view that a revised date of 31st December 2008 is a realistic date for the conclusion of its investigations.

Accordingly, the Commission requests the Minister for Justice, Equality and Law Reform, as the specified Minister, pursuant to section 6(6) of the Commissions of Investigation Act 2004, to revise the time frame for the submission of the Commission's final report.

Initial observations

As the Commission has not yet concluded its work, it does not wish to comment extensively on the matters investigated by it to date. However, the Commission believes that certain observations are worthy of mention at this stage. They concern the following matters:

1. the continuing problem of overcrowding, with particular reference to Mountjoy Prison, where the assault on Gary Douch took place;
2. the application of a policy of single cell occupancy in prisons in the State;
3. systems for assessing and categorising prisoners;
4. the management of prisoner-related documentation; and
5. the media and prisoners.

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 31st 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 Mountjoy Prison will be taken out of service once the proposed prison complex at Thornton Hall is built and made operational. At the time of writing, this is expected to occur some time 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.

Single cell occupancy

The idea that, as a rule, cells should not hold more than one prisoner 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 next significant review of the Irish prison system took place in 1985 with the publication of the Report of the Committee of Inquiry into the Penal System - also known as the Whitaker Report. This report 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."*[1]

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.*
>
> *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*

1 Report of the Committee of Inquiry into the Penal System (July 1985), para. 7.4.

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."[2]

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 accommodated more than one to a cell, care shall be taken that each prisoner has a separate bed, bedding and utensils."*[3]

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2 The Management of Offenders (1994) Draft Prison Rules, Part II, rule 1.

3 The Management of Offenders (1994) Draft Prison Rules, Part IV, rule 1.

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."[4]

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."*[5]

However, the next new prison to be designed and built – Cloverhill Prison, which opened in June 1999 – contained 120 triple cells, 5 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

> *"…eliminate pockets of overcrowding and facilitate movement towards a model of predominantly single-cell accommodation for prisoners."*

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4 Report of the European Committee for the Prevention of Torture (publ. 13/12/1995), para. 98.

5 Government response to CPT Report, 13 December 1995.

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…*
>
> …
>
> *1. Prisoners shall normally be accommodated during the night in individual cells except where it is preferable for them to share sleeping accommodation.*
> *2. Accommodation shall only be shared if it is suitable for this purpose and shall be occupied by prisoners suitable to associate with each other.*
> *3. 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.[6] However the new Prison Rules issued by the Minister for Justice, Equality and Law Reform [S.I. No.252 of 2007] make no mention of single cell occupancy. Rather, rule 18(2)(a) states:

> *"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."*

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6 IPS draft Strategy Statement 2006-2008 (unpublished), quoted in the Irish Prison Service Capital Expenditure Review (Nov 2006).

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 Commission will be carrying out a survey of current practice with regard to single cell provision in the State. It will also continue to review all available studies evaluating single cell occupancy vis-à-vis its efficacy in prisoner safety and in improving and enhancing prison management.

Assessment and Categorisation of prisoners

The Commission intends to review models for the assessment and categorisation of prisoners as a means of better informing the process of cell allocation, with a view to enhancing the safety of prisoners and prison staff.

Documentation relating to prisoners

The Commission has identified a need to review the adequacy and consistency of practice and procedure regarding the documentation which accompanies a prisoner (i) when committed to prison from the courts, and (ii) when transferred from one prison, place of detention or related institution to another.

The media and prisoners

Regrettably, the Commission has had to involve itself in correcting misinformation which was disseminated by the media concerning the circumstances in which Gary Douch died. The publication of such false information was deeply distressing to the family of Gary Douch, and could conceivably have had an adverse effect on the Commission's work. The Commission hopes that proper restraint will be shown in any future coverage of matters relating to the death of Gary Douch.

Recommendations

At this stage of its inquiries, there is one issue upon which the Commission wishes to make recommendations. It concerns the treatment of bereaved families, in the event of the sudden and unexpected death of a prisoner.

Further recommendations regarding the other issues raised by the Commission's terms of reference will be made in the Commission's final report.

As far as the treatment of bereaved families is concerned, the Commission's recommendations 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 to be followed in the event of the sudden and unexpected death of a prisoner, where at a minimum 2 prison officers, 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.

Dated 20 December 2007.

Gráinne McMorrow, SC,

Sole Member.

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Appendix 4 The Prison Estate

Arbour Hill Prison

Arbour Hill is a closed, medium security prison for adult male prisoners. The prisoner profile is largely made up of long term sentenced prisoners.

Arbour hill is situated in Dublin 7 and was opened in 1848 and was initially used to accommodate military prisoners. In 1973 it was taken over by the Department of Justice and was renovated and opened as a civilian prison in 1975. There are 95 single cells. Some of the cells are doubled and trebled to cater for the Prison capacity of 139 prisoners.

Castlerea Prison

Castlerea is a closed, medium security prison for adult male prisoners in County Roscommon. It's a committal prison for remand and sentenced prisoners in Connaught and also takes prisoners from Cavan, Donegal and Longford.

The complex was originally the site of a psychiatric hospital and sanatorium which opened in 1939 and continued to function as a hospital until 1994. Upon the closure of the Hospital it was decided to locate a prison on the site and works commenced in 1994. The complex has been used as a prison since in or around 1996.

Cloverhill Prison

[see report chapter 1.1].

Cork Prison

[see report chapter 1.1].

The Dóchas Centre (Mountjoy)

The Dóchas Centre, which forms part of the Mountjoy Prison complex, is a closed, medium security committal prison for female prisoners aged 17 years and over. It is the Committal prison for females committed on remand or sentenced from all Courts outside of the Munster area.

The Dóchas Centre is a campus style female prison which was purpose built and has been in use since 1999.

Limerick Prison

Limerick prison is the oldest operating prison in the State, having been built between 1815 and 1821. It is a small prison, which holds both sentenced and remand prisoners, male and female, aged 17 and upwards. The bed capacity of the prison at the time of writing is listed as 248.

Loughan House

Loughan House is an open, low security prison for male prisoners age 18 and over who are regarded as requiring lower levels of security.

Situated in Blacklion, County Cavan, Ireland, the building was originally built in 1953 as a noviciate and was purchased by the Department of justice in 1972 to be converted into a prison facility.

Midlands Prison

[see report chapter 1.1].

Mountjoy Prison

[see report chapter 1.1].

Portlaoise Prison

Portlaoise Prison is a closed high security prison for adult male prisoners, including the detention of high security prisoners. It is also generally the committal prison for prisoners placed in custody by the Special Criminal Court.

Portlaoise Prison is located on the Dublin Road, Portlaoise, County Laois and is adjacent to the Midlands Prison. The Prison itself was a purpose built prison and has been in use since the 1830’s.

Shelton Abbey

Shelton Abbey is an open, low security prison for male prisoners aged 19 years and over who are regarded as requiring lower levels of security.

Shelton Abbey is located in Arklow, County Wicklow. It was previously used by the State as a residential forestry training facility but has been used as a prison since in or around 1973.

St Patrick's Institution

St Patrick's Institution is a closed, medium security place of detention for males aged 16 to 21 years. It accommodates both remand and sentenced prisoners. It is located on the grounds of the Mountjoy Prison complex.

The detention of children in St Patrick's Institution has been the subject of both domestic and international criticism for more than 25 years. In April 2012, the current Minister for Children and Youth Affairs announced that the detention of 16 / 17 year-old boys at St Patrick's will be phased out within 3 years.

The Training Unit (Mountjoy)

The Training unit is a semi-open, low security prison for male prisoners aged 18 years and over, with a strong emphasis on employment and training.

The Training Unit is located on the grounds of the Mountjoy Prison complex but operates completely independently of Mountjoy. The Unit was purpose built in or around 1974 and has accommodated prisoners since 1975.

Wheatfield Prison

Wheatfield Prison, which is adjacent to Cloverhill Prison, was opened in 1989. A new block containing 176 cells was opened in October 2010 which increases the bed capacity of the prison to approximately 670.

Appendix 5 Hospital and Guardianship Orders

Hospital and Guardianship Orders

The power to make hospital or guardianship orders was introduced in England and Wales by s.37 of the Mental Health Act 1983.

Subsection (1) of s.37 (as amended) provides:

> *"Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be, place him under the guardianship of a local social services authority or of such other person approved by a local social services authority as may be so specified."*

Subsection (2) (as amended) sets out the following conditions:

> *"The conditions referred to in subsection (1) above are that-*
>
> *(a) The court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from a mental disorder and that either-*
>
> *i. The mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or*
>
> *ii. In the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and*
>
> *(b) The court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section."*

Subsection (3) allows a magistrate's court the option of making a hospital or guardianship order without convicting the accused person concerned:

> *"Where a person is charged before a magistrates' court with any act or omission as an offence and the court would have power, on convicting him of that offence, to make an order under subsection (1) above in his case, then, if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him."*

Subsection (4) deals with the criteria to be considered by the court in deciding whether or not to make a hospital order:

> *"An order for the admission of an offender to a hospital (in this Act referred to as 'a hospital order') shall not be made under this section unless the court is satisfied on the written or oral evidence of the approved clinician who would have overall responsibility for his case or of some other person representing the managers of the hospital that arrangements have been made for his admission to that hospital, and for his admission to it within the period of 28 days beginning with the date of the making of such an order; and the court may, pending his admission within that period, give such directions as it thinks fit for his conveyance to and detention in a place of safety."*

Subsection (5) allows the Secretary of State to direct that the patient be admitted to a different hospital from the one specified in a hospital order where *"… by reason of an emergency or other special circumstances it is not practicable for the patient to be received into the hospital specified in the order…"*

In relation to guardianship orders, subsection (6) ensures that such an order can only be made where the proposed guardian consents to the making of the order:

> *"An order placing an offender under the guardianship of a local social services authority or of any other person (in this Act referred to as 'a guardianship order') shall not be made under this section unless the court is satisfied that that authority or person is willing to receive the offender into guardianship."*

S.38 of the 1983 Act allows the making of interim hospital orders for periods of up to 12 weeks, renewable for periods of not more than 28 days at a time, up to a total of 12 months.

Under s.39 of the 1983 Act a court when considering the possibility of making a hospital order may request information from the appropriate local or national bodies as to hospitals in respect of which a hospital order could be made.

Similarly, under s.39A, a court may request information from the appropriate local services authority when considering the making of a guardianship order.

The purpose and effect of a hospital order was described as follows by the Court of Appeal in *R. v. Birch* (1989) 11 Cr.App.R.(S.) 202, 210:

> *"Once the offender is admitted to hospital pursuant to a hospital order or transfer order without restriction on discharge, his position is almost exactly the same as if he were a civil patient. In effect he passes out of the penal system and into the hospital regime. Neither the court nor the Secretary of State has any say in his disposal…*
>
> *… In general the offender is dealt with in a manner which appears, and is intended to be, humane by comparison with a custodial sentence. A hospital order is not a punishment. Questions of retribution and deterrence, whether personal or general, are immaterial. The offender who has become a patient is not kept on any kind of leash by the court, as he is when he consents to a probation order with a condition of in-patient treatment. The sole purpose of the order is to ensure that the offender receives the medical care and attention which he needs in the hope and expectation of course that the result will be to avoid the commission by the offender of further criminal acts."*

Appendix 6 Community Treatment Orders

Community Treatment Orders

The concept of Supervised Community Treatment (SCT) was introduced in England and Wales by the Mental Health Act 2007, with a view to filling a perceived gap in the mechanisms of treatment and compliance afforded by the Mental Health Act 1983. Supervised Community Treatment is provided by means of a Community Treatment Order (CTO). This can apply to persons who have been detained under s.3 of the 1983 Act or who have been the subject of a hospital order under s.37 of the 1983 Act.

The Code of Practice published by the UK Department of Health describes the aim of SCT as follows:

> *"The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery.*
>
> *SCT provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary."*

In order for SCT to apply to a patient, s.17A(1) gives the responsible clinician power to grant a detained patient leave (subject to recall) if:

(a) The patient is suffering from a mental disorder (any disorder or disability of mind) of a nature or degree which makes it appropriate for him to receive medical treatment;
(b) It is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
(c) Subject to his being liable to be recalled, such treatment can be provided without his continuing to be detained in a hospital;
(d) It is necessary that the responsible clinician should be able to exercise the power, under s.17E(1) of the Act, to recall the patient to hospital; and
(e) Appropriate medical treatment is available to the patient.

It is for the Responsible Clinician (as defined in s.34 of the 2007 Act) to decide whether a patient meets the above criteria or not. The employment of SCT also requires the agreement of an Approved Mental Health Professional (defined in s.114 of the 2007 Act) that such a course of action is appropriate.

Formal consent by the patient to SCT is not required. However, the Code of Practice states:

> *"SCT may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it. Consultation at an early stage with the patient and those involved in the patient's care will be important."*

The making of a Community Treatment Order involves an assessment of risk by the Responsible Clinician – in particular, an assessment of risk as to compliance with medication, and the potential results of a failure to comply in that regard. The success of such an order is dependent on effective multi-disciplinary consultation and co-operation.

A Community Treatment Order may involve the attachment of conditions, including conditions aimed at reducing the potential risk presented by the patient in a community environment. Such conditions might include specific places of residence, places for treatment, and people or places that the patient should avoid.

Under the 2007 Act, treatment in the community of a community patient is permitted if:

- The treatment is immediately necessary and the patient is capable and consents to the treatment;
- The treatment is immediately necessary and there is consent from someone authorised under the Mental Capacity Act 2005 to make decisions on the patient's behalf;
- The patient lacks capacity and force is not necessary to secure compliance; or,
- Emergency treatment needs to be given, using force if necessary, to a patient who lacks capacity.

Persons who are the subject of a Community Treatment Order can be recalled for treatment in hospital under s.17E of the 2007 Act if the Responsible Clinician is of the opinion that:

- The patient requires medical treatment in hospital for his mental disorder; and

- There would be a risk of harm to the health or safety of the patient or to others if the patient were not recalled back to hospital.

If the Responsible Clinician is of the opinion that a CTO does not or cannot meet the needs of a patient and that detention in hospital is necessary – and if this view is shared by an Approved Mental Health Professional -, the CTO may be revoked under s.17F of the 2007 Act.

Appendix 7 S.M.A.R.T.E.R. Criteria

The Commission took the view that the Management by Objectives model could prove to be of great assistance to the government in implementing such recommendations as it sees fit. What follows is a more in depth outline of how S.M.A.R.T. criteria can be applied. These are broadly applied using the following analytical steps, as outlined in Meyers, 2003:

Specific

The first criterion stresses the need for a specific goal rather than a more general one. This means the goal is clear and unambiguous; without vagaries and platitudes. To make goals specific, they must tell a team exactly what is expected, why is it important, who's involved, where is it going to happen and which attributes are important.

A specific goal will usually answer the five "W" questions:

- What: What do I want to accomplish?
- Why: Specific reasons, purpose or benefits of accomplishing the goal.
- Who: Who is involved?
- Where: Identify a location.
- Which: Identify requirements and constraints.

Measurable

The second criterion stresses the need for concrete criteria for measuring progress toward the attainment of the goal. The thought behind this is that if a goal is not measurable, it is not possible to know whether a team is making progress toward successful completion. Measuring progress is supposed to help a team stay on track, reach its target dates, and experience the exhilaration of achievement that spurs it on to continued effort required to reach the ultimate goal.

A measurable goal will usually answer questions such as:

- How much?
- How many?
- How will I know when it is accomplished? Indicators should be quantifiable.

Achievable

The third criterion stresses the importance of goals that are realistic and attainable. While an attainable goal may stretch a team in order to achieve it, the goal is not extreme. That is, the goals are neither out of reach nor below standard performance, as these may be considered meaningless. When you identify goals that are most important to you, you begin to figure out ways you can make them come true. You develop the attitudes, abilities, skills, and financial capacity to reach them. The theory states that an attainable goal may cause goal-setters to identify previously overlooked opportunities to bring themselves closer to the achievement of their goals.

An attainable goal will usually answer the question:

- How: How can the goal be accomplished?

Relevant

The fourth criterion stresses the importance of choosing goals that matter. A bank manager's goal to "Make 50 peanut butter and jelly sandwiches by 2:00pm" may be specific, measurable, attainable, and time-bound, but lacks relevance. Many times you will need support to accomplish a goal: resources, a champion voice, someone to knock down obstacles. Goals that are relevant to your boss, your team, your organization will receive that needed support.

Relevant goals (when met) drive the team, department, and organization forward. A goal that supports or is in alignment with other goals would be considered a relevant goal.

A relevant goal can answer yes to these questions:

- Does this seem worthwhile?
- Is this the right time?
- Does this match our other efforts/needs?
- Are you the right person?
- Is it applicable in current socio- economic- technical environment?

Time-bound

The fifth criterion stresses the importance of grounding goals within a time frame, giving them a target date. A commitment to a deadline helps a team focus their efforts on completion of the goal on or before the due date. This part of the SMART goal criteria is intended to prevent goals from being overtaken by the day-to-day crises that invariably arise in an organization. A time-bound goal is intended to establish a sense of urgency.

A time-bound goal will usually answer the question:

- When?
- What can I do six months from now?
- What can I do six weeks from now?
- What can I do today?

Yemm (2013) argued that two further criteria should be added: Evalute and Re-evaluate, (S.M.A.R.T.E.R):

Evaluate

Once the objective is set, it is important or even essential that the leader is paying attention to how things are progressing. They need to evaluate the team's progress.

This is done by asking the questions:

- Were the time goals met?
- What were the impediments?
- How might they be avoided in future?

Re-evaluate

Once the time-goals have been met the overall effectiveness of the project must be assessed.

This is achieved by asking the following questions

- Have the goals specified been accomplished?
- With the benefit of hindsight, can the steps taken to achieve these goals be made more efficient?
- What things would you do differently?

Appendix 8 Acknowledgments

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Grainne McMorrow SC

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