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## Death in Irish Prisons: An Examination of the Causes of Deaths and the Compliance of Investigations with the European Convention on Human Rights

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*Death in Irish Prisons: An Examination of the Causes of Deaths and the Compliance of Investigations with the European Convention on Human Rights*

A thesis submitted to the Dublin Institute of Technology in part fulfilment of the requirements for the award of Masters (MA) in Criminology

by

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September 2011

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**Department of Social Sciences, Dublin Institute of Technology**

## **Declaration**

I hereby certify that the material which is submitted in this thesis towards the award of the Masters (MA) in Criminology is entirely my own work and has not been submitted for any academic assignment other than part fulfilment of the award named above

Signature of Candidate: \_\_\_\_\_

Date: \_\_\_\_\_

Word Count: 13,867 words

## **Abstract**

Death is a tragic and unfortunately unavoidable aspect of life in a prison. The death of a prisoner raises significant questions in relation to the conditions of confinement and the conduct of the prison authorities. Robust investigations into these deaths can enhance accountability by shedding light on deficits in both institutional and systemic practices, as well as providing families of the deceased with a sense of closure. In Ireland, the investigative responses to prison deaths are neither robust, nor do they allow for significant scrutiny of the circumstances surrounding the death. The causes of deaths in custody and the compatibility of the ensuing investigations with international standards have not been subjected to empirical analysis in this jurisdiction. The current study attempts to address this. Using data collected from coronial inquest files in the Dublin City Coroner's district, the causes of prisoners' deaths were subjected to a rigorous thematic analysis. The efficacy of the inquest process and its compliance with Article 2 of the European Convention on Human Rights were also examined. This study exposes a myriad of issues relating to both the causes of deaths and the resulting investigations. The findings highlight issues such as appropriate drug treatment strategies, deficits in medical practices, and the poor provision for family participation at the inquest proceedings. Most importantly, the research findings show that prisoners' deaths are caused by a variety of factors, and as such there can be no 'one size fits all' approach to the problems.

## **Acknowledgements**

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## CHAPTER ONE

### Introduction

#### **1.1 Research Context**

Ninety-five people have died in Irish prisons in the past decade (Irish Prison Service, 2008, 2009, 2010). Twenty of these deaths have occurred in the past two years alone. In spite of these undoubtedly worrying figures, the issue of deaths in custody has been subjected to limited empirical analysis in this jurisdiction. Recent years have seen a number of authors expressing their concerns regarding the current situation in relation to the events surrounding prisoners' deaths and the ensuing investigations. The accountability of the Irish prison system has been acknowledged as greatly lacking in this context, with the absence of robust procedures for internal investigations of deaths being highlighted as particularly troubling (Rogan, 2009). With the right to life under Article 2 of the European Convention on Human Rights assuming increasing importance in the prison environment (Hamilton and Kilkelly, 2008), commentators are becoming progressively sceptical of the compliance of Irish investigations of prison deaths with the jurisprudence of the European Courts. Many elements of the existing mechanisms have been deemed incompatible with the State's obligations under Article 2, and the lack of independent monitoring of the process remains a further problematic issue (Herrick, 2009; Martynowicz, 2011).

While these authors have highlighted their concerns in relation to deaths in custody, there has been a notable lack of robust empirical research in this context. The most recent study examined the years between 1990 and 1997 (Department of Justice, 2000), and the data is now over a decade old. Also, while this study reported on the causes of death, it failed to probe them further to identify emergent themes such as mental health concerns, drug misuse, and violence. Furthermore, there has been no empirical research conducted to examine the compliance of the current investigative structures with Article 2 of the European Convention on Human Rights.



The current study seeks to remedy these deficits. Coronial inquest files will be used to explore the contemporary causes of death in Irish prisons, with a view to examining the compliance of the inquest process with the requirements under Article 2. It is submitted that a study of this nature is both a necessary and worthwhile venture, and being the first of its kind it will also represent an original contribution to both Irish and international research. As Hamilton and Kilkelly (2008: 58) put it, the time is ‘opportune’ to examine accountability in Irish prisons, and to consider the extent to which national and international obligations are met in this context.

## **1.2 Research Questions**

This section outlines the research questions that have served to guide the research. The primary research question was constructed with reference to the exploratory nature of the study. One subsidiary question has been chosen to aid in focusing the research on the Irish State’s particular obligations to protect the life of prisoners under the European Convention on Human Rights.

Primary Question: What are the causative factors in the deaths of individuals in Irish prisons?

Subsidiary Question: To what extent do the circumstances surrounding these deaths and their subsequent investigation raise questions in light of the State’s obligations under Article 2 of the European Convention on Human Rights?

## **1.3 Chapter Overview**

This section sets out the framework for the presentation of the dissertation.

Chapter Two (Policy Framework) will endeavour to outline the key elements of the coronial process in Ireland, and will also provide a summary of the relevance of Article 2 of the European Convention on Human Rights to the current study. It is argued that this chapter is best located before the Literature Review, as it will help the

reader to contextualise the literature while it is being discussed. Chapter Three (Literature Review) contains a comprehensive discussion of both national and international literature relating to the causes of prison deaths, accountability in the context of investigations of deaths in prison, and the importance and role of the coroner. The research strategies utilised in the study are outlined in Chapter Four (Methodology), along with a discussion of ethical considerations and issues relating to data collection and analysis. In Chapter Five (Findings and Analysis) the research findings are presented together with an analysis of their implications. Finally, Chapter Six (Conclusion) will seek to reflect on the findings of the current study, and recommendations arising from the research will be proposed.

## CHAPTER TWO

### Policy Framework

#### **2.1 Introduction**

In light of the importance of both the inquest process and Article 2 of the European Convention on Human Rights (ECHR) to the current study, it was considered both necessary and useful to include an outline of the framework in which each of these processes reside. The first section of this policy framework chapter will be devoted to the Coroner and inquest process, and will seek to outline briefly the procedures currently in place in Ireland. The second part of this chapter will explain the relevance of Article 2 of the ECHR to deaths in custody, and will summarise the jurisprudence in relation to effective investigations of these deaths.

#### **2.2 The Coroner and the Inquest Process**

##### **2.2.1 The Coroner**

In Ireland, the Coroner is an official with legal responsibility for the investigation of certain categories of deaths. A death certificate for sudden, unexplained or violent death can only be issued after the Coroner has concluded an investigation. A Coroner is appointed by the relevant local authority, and must be a barrister or a solicitor or a registered medical practitioner of at least five years standing (Dublin City Coroner Website, 2004). The Coroner is required to be independent in his/her function (Farrell, 2000).

### **2.2.2 Reporting a Death in Prison Custody to the Coroner**

The Rules of Practice currently provide for the types of deaths that must be reported to the Coroner for investigation (Farrell, 2000). Deaths in prison custody are included within these categories of deaths. Rule 47(7) of the *Prison Rules 2007* instructs that it is the duty of the Governor of the prison to report the death of a prisoner to the local Coroner. The current statute governing coronial practice in Ireland, the *Coroners Act 1962*, is silent on this issue. This is remedied in the *Coroners Bill 2007*, with the inclusion of deaths occurring in prisons amongst the categories of reportable deaths outlined in Schedule Three. Unfortunately, this Bill is still awaiting enactment.

Farrell (2000) notes that the investigative role of the Coroner extends to prisoner deaths occurring outside the prison, explaining; ‘the practice is to interpret the word “prison” widely, to include any place where a person may be held in legal custody’ (Farrell, 2000: 130). In practical terms, this means that when a prisoner dies in hospital or while on temporary release, for example, the Coroner still must be informed. It is worth noting that this specific practice is not provided for in any statute or in the rules of practice, and may represent a worrying gap in the current regulations.

### **2.2.3 The Inquest**

Inquests are dealt with in Part 3 of the *Coroners Act 1962*. Section 17 places a duty on the Coroner to hold an inquest in relation to violent or unnatural deaths. There is currently no specific duty to hold an inquest into all deaths occurring in prison custody (Martynowicz, 2011). Section 43(c) of the *Coroners Bill 2007* endeavours to rectify this gap, instructing that the Coroner must hold an inquest in relation to deaths in prison. Inquests can be held with or without a jury, and section 40 of the *1962 Act* outlines a number of circumstances when a jury is required. While deaths in prison are not explicitly referred to in section 40, a jury is required for every inquest relating to the death of a prisoner (Dublin City Coroners Website, 2004). Section 66(2)(b) of the *Coroners Bill 2007* makes this requirement explicit, stipulating that an inquest

relating to a death in prison must be held before a jury. While the Coroner can summon witnesses to appear at an inquest, his powers of investigation have been noted to be quite limited as he is precluded from discovering documents or entering premises (Martynowicz, 2011). An inquest is a purely inquisitorial procedure, and the verdict resulting from an inquest cannot impose any civil or criminal liability. This principle was emphasised by Keane J in *Farrell v Attorney General*<sup>1</sup>.

## **2.3 Article 2 of the ECHR and Effective Investigations of Deaths**

### *2.3.1 Introduction*

Article 2 of the European Convention on Human Rights (ECHR) concerns the right to life. It states,

*Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*

Herrick (2009) simplifies the provisions within Article 2 by explaining that it requires member states to desist from causing unlawful deaths and to prevent unavoidable deaths. As Livingstone (2006) notes, the obligations under Article 2 have been increasingly stressed by the European Court of Human Rights (ECtHR). In recent years the provisions in Article 2 have been applied to the prison environment, and have been described as being 'increasingly relevant to the situation of those in detention' (Hamilton and Kilkelly, 2008: 61). Rogan (2009) explains that Article 2 has been interpreted by the ECtHR as requiring states to take reasonable steps to prevent deaths of prisoners, regardless of whether such deaths are caused by agents of state, state negligence, or a third party such as another prisoner or by the prisoner himself or herself.

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<sup>1</sup> *Farrell v Attorney General* [1998] 1 ILRM 364

### 2.3.2 Article 2 of the ECHR and Investigations into Deaths in Custody

The obligation to take steps to protect life also requires that an effective investigation must be held in the case of any death that raises questions under Article 2 (Livingstone *et al*, 2008; Martynowicz, 2011). The duty to conduct an investigation was first identified in *McCann v United Kingdom*<sup>2</sup>. As Livingstone *et al* (2008) note, the cases that followed on from the ruling in *McCann* saw the ECtHR placing greater emphasis on this duty. The issue of robust investigations arose again in *Edwards v United Kingdom*<sup>3</sup>. Here, the Court held that Article 2 not only required effective systems to protect prisoners' right to life, but also thorough and effective investigations into deaths in custody. This places on the State a more exacting standard than the law of negligence (Livingstone *et al*, 2008).

The ruling in *Jordan v United Kingdom*<sup>4</sup> sets out the following requirements for an effective investigation under Article 2:

1. The investigation must be undertaken on the State's own initiative;
2. It must be capable of leading to a determination of responsibility and the punishment of those responsible;
3. The investigation has to be independent both institutionally and in practice;
4. It has to be prompt;
5. The investigation has to allow for sufficient public scrutiny to ensure accountability; and
6. The next-of-kin has to be allowed to participate in the process.

While *Jordan* concerned the use of lethal force by a police officer, the language used in the ruling has been interpreted as suggesting that these are essential requirements for any effective investigation where a death in violation of Article 2 has occurred (Livingstone *et al*, 2008).

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<sup>2</sup> *McCann v UK* (1996) 21 EHRR 97

<sup>3</sup> *Edwards v UK* (2002) 35 EHRR 19

<sup>4</sup> *Jordan v UK* (2003) 37 EHRR 2

### 2.3.3 Investigations into Deaths in Custody in Ireland

While the focus of the current study is on the coronial inquest, it is important to briefly outline the other investigative procedures that can take place following a death in custody. In addition to the inquest, two further investigations are also carried out in relation to a prisoner's death; a Garda investigation and an internal investigation conducted by the prison authorities (Inspector of Prisons, 2011a). With regard to the internal investigation, rule 47(8) of the *Prison Rules 2007* requires that the Minister for Justice must receive a report on the investigation from the prison. While the internal investigation can vary from prison to prison, the general practice is that evidence relating to the circumstances of the death is collected from prison staff, with a final report being prepared by the Governor (Inspector of Prisons, 2011a).

In addition to these investigative mechanisms, a Commission of Investigation may be established to enquire into the circumstances of the death. The *Commissions of Investigation Act 2004* provides for the establishment of these Commissions. Section 3(1)(a) of the *2004 Act* instructs that such Commissions are instituted to investigate 'any matter considered by the Government to be of significant public concern'. Section 9 of the *2004 Act* provides that the Commission will be independent in the performance of its functions. While the terms of reference for the Commission are generally specified by the relevant minister, the Commission is enabled by section 10(1) of the *2004 Act* to conduct the investigation in the manner that it deems appropriate (Martynowicz, 2011). Commissions have wide-ranging investigative powers, including the power to direct a person to attend before the Commission to give evidence or to produce documents in their possession (Rogan, 2009).

These current investigative procedures will be examined further in the Literature Review.

## Literature Review

### **3.1 Introduction**

This chapter will be broken into three distinct parts. The first part will seek to examine the literature regarding the causative factors in deaths in prison custody, under the headings of suicide, drugs, violence, and natural causes. The next section will consider the concept of accountability in the context of prison deaths, and will evaluate the current investigative procedures in Ireland, contrasting them with those in other jurisdictions. The chapter will conclude with some discussion on the importance of the inquest, as well as the research value of coronial data.

### **3.2 Causes of and Contributors to Deaths in Custody**

#### **3.2.1 Suicide**

Throughout the literature, suicide is recognised as an enduring cause of death in prisons (Liebling, 1992, 2006, 2007; Livingstone *et al*, 2008). While the problem of suicide is by no means unique to the prison environment, it has been described as having a ‘specific resonance’ in prison populations (Shaw and Senior, 2007: 385). Suicide rates in prisons have been acknowledged as being higher than in the general community (Liebling, 1992, 2007). It is believed that this is due to the nature of prison populations, with a large proportion of prisoners being individuals with multiple risk factors for suicide (Liebling, 1992, 2007; Shaw *et al*, 2004).

A variety of risk factors for prison suicide are considered in the literature. Self-harming is acknowledged as a potential indicator of suicidal intentions, with Liebling explaining, ‘self-injury may be the first overt symptom of a level of distress only steps away from a final act of despair’ (Liebling, 1995: 181). Depressive symptoms and anxiety also frequently arise as risk factors in the literature (Daniel, 2006; Suto and



Arnaut, 2010). Difficulties with coping have also been found to contribute to suicidal ideation (Liebling, 1995; Dear *et al*, 2001), with coping with relationship problems being identified as particularly challenging (Suto and Arnaut, 2010). Interestingly, criminogenic factors have been linked with suicide in prisons, with Hall *et al* (2006) proposing that the risk factors that led prisoners to their offending can also help to explain their self-harming and suicidal behaviour while in prison.

### *3.2.1.1 Suicide in Irish Prisons*

The overall numbers of deaths in Irish prisons began to rise in the 1980s (Rogan, 2011), with a great number of these deaths being suicides (Dáil Debates, 23 June 1988). Moreover, the prevalence of suicide continued to grow, with a ‘marked increase’ in self-inflicted deaths since 1988 (Dooley, 1997: 186). Suicide remained an enduring problem throughout the 1990s, with a study by the National Steering Group on Deaths in Prison reporting that 56% of all deaths in prison custody between 1990 and 1997 were suicides (Department of Justice, 2000). Suicide was also highlighted as a problem of ‘major concern’ for the Irish prison system in Paul O’Mahony’s sociological profile of prisoners in Mountjoy Prison (O’Mahony, 1997: 112). O’Mahony’s study further found that suicidal behaviour amongst prisoners was linked with previous psychiatric inpatient treatment. In 2008, the Irish Prison Service reported that there had been 18 suicides in Irish prisons between 2000 and 2008 (Irish Prison Service, 2008). Inquests were also pending in relation to a number of deaths at the time of the report. In February 2010 the Minister for Justice, Dermot Ahern, confirmed that 7 suicides had taken place in Irish prisons in 2007 and 11 in 2008 (Dáil Debates, 9<sup>th</sup> February 2010). In an attempt to address the issue of prisoner suicide the Irish Prison Service Steering Group on Prevention of Self-harm and Death in the Prisoner Population has been established, with the aim of promoting the prevention of self-inflicted deaths in Irish prisons (Irish Prison Service, 2009).

### *3.2.1.2 International Perspective*

The Irish experience of prison suicide appears to be largely in line with the international situation. Prisons in England and Wales also report a high prevalence of suicides; with the Prisons and Probation Ombudsman reporting that their office undertook 206 investigations into self-inflicted deaths between 2007-2009 (Prisons and Probation Ombudsman for England and Wales, 2011a). Suicide is also one of the leading causes of death in prisons in the United States (Suto and Arnaut, 2010) and Finland (Joukamaa, 1997). Internationally, remand prisoners have been found to be at particular risk of suicide (Morgan and Liebling, 2007), but this risk can perhaps be mitigated with appropriate staff to prisoner ratios (Wooldredge and Winfree, 1992). International research also suggests that prisoner suicides can often deeply distress both prisoners and prison staff (Liebling, 2007).

### **3.2.2 Drugs**

It is now accepted that drug use has become a dominant aspect of prison culture, both in Ireland and internationally (O'Mahony, 1997, 2008; Wheatley, 2007). There may be a number of explanations for the increase in drug use in prisons, with Liebling and Maruna (2005) arguing that the vulnerabilities that individuals bring with them into prison, such as poor coping skills, can promote drug misuse. Others have found through interviews with prisoners that the problem may stem from the boredom and monotony of prison life (Dillon, 2001; Crewe, 2006, 2009). Drug users in prison tend to favour drugs that have a sedative effect, with heroin being preferred for the 'sanctuary, diversion and relief' that it offers (Crewe, 2006: 241). While prevention and effective treatment are necessary to tackle the problem of drugs in prison, Wheatley (2007) stresses that there is no universal solution. In Ireland, the Irish Prison Service has taken steps to deal with this issue, developing a drugs policy that emphasises their commitment to eliminating the supply of drugs in Irish prisons (Irish Prison Service, 2006a). This strategy has been subject to some criticism however, with the Inspector of Prisons describing it as 'still an ambitious aspiration' (Inspector of Prisons, 2009: 37)

### *3.2.2.1 Drug-related Deaths in Irish Prisons*

It is difficult to ascertain the full extent of the influence of drugs on deaths in Irish prisons. As well as being the causative factor in overdoses, drugs are often indirectly involved in other deaths, such as suicides and homicides (O'Mahony, 2008). These deaths are usually counted separately from overdoses. While deaths from suicide and natural causes remain most prominent, drug-related deaths appear to be increasing in frequency. The National Steering Group on Deaths in Prisons reported a 'noticeable increase' in deaths caused by overdoses and choking on vomit, with this category making up 27% of deaths in prisons between 1990 and 1997 (Department of Justice, 2000: 3). A study by Lyons *et al* (2010) shows that there were 25 drug-related deaths in Irish prisons between 1998 and 2005. Five prisoners are reported to have died from suspected drug overdoses in 2006 (Irish Prison Service, 2006b). Nine prisoners died from 'other causes' in 2007 and 2008, in which drug overdoses are included (Irish Prison Service, 2008: 34). As demonstrated, Irish data relating to drug-related deaths in prisons must often be gathered from different sources, making it difficult to determine the true impact of drug misuse on death in Irish prisons.

### *3.2.2.2 International Perspective*

The Irish situation is somewhat similar to that of prisons in England and Wales and Northern Ireland. Drugs appear to be among the most prevalent causes of death in prisons in Northern Ireland, with drug overdoses ranking third behind natural deaths and suicides in prison deaths occurring between September 2005 and March 2011 (Prisoner Ombudsman for Northern Ireland, 2011). In England and Wales the problem of an increase in drug-related deaths from combined toxicity of prescription and illicit drugs has been acknowledged, but overall rates of drug-related deaths appear to be falling since 2004 (Prisons and Probations Ombudsman for England and Wales, 2011b). While deaths caused by drugs may be falling in prisons in England and Wales, illicit drug use remains a huge problem with the prison system accommodating more drug users than the healthcare system (Wheatley, 2007). A study of deaths in Swiss prisons shows that drug-related deaths are more common,

with overdoses representing 28.6% of all deaths in custody between 1984 and 2000 (Sattar and Killas, 2005). The authors recognise that the incidence of drug-related deaths can vary across jurisdictions, contrasting the Swiss experience with a comparably lower incidence of drug-related deaths in prisons in the UK. These variations, they propose, may be caused by differences in the overall national drug problem as well as the incidence of drug-related offences in each jurisdiction (Sattar and Killas, 2005).

### **3.2.3 Violence**

The problem of violence in prisons is widespread. As Edgar *et al* (2003) note, violence in prisons cannot be explained by a single causative factor. Assaults in prison can arise over ‘the nature of a prisoner’s offence, following arguments about material goods, for self defence in response to assaults or armed robberies, as a means of resolving differences or to relieve boredom’ (Edgar *et al*, 2003: 46). The authors recognise, however, that the issue of drugs commonly arises in violent disputes regarding possessions. Gender has been found to have an impact on prison violence, with Harer and Langan (2001) explaining that male prisoners are responsible for most violence in prisons. Overcrowding and a greater percentage of younger prisoners can also be predictors of violence in prisons (Lahm, 2008). The equitable use of formal controls in prisons has also been suggested as having an effect on levels of violence (Steiner, 2009).

#### *3.2.3.1 Violence in Irish Prisons*

The rise in violence in Irish prisons in recent years is highlighted frequently in the literature as a cause for concern (O’Donnell, 2003, 2008; Hamilton and Kilkelly, 2008; Herrick, 2009; Martynowicz, 2011). McDermott (2000) believes that a fear of reporting violent attacks has allowed a culture of violence to grow. The levels of violence in Irish prisons have been subject to international scrutiny and criticism, with the Council of Europe Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT) condemning the culture of inter-prisoner

violence in their recent reports on Ireland (CPT, 2007; 2011). Martynowicz (2011) notes that the findings of the 2007 CPT report had little impact on levels of violence. The CPT recently found that violence in Irish prisons appeared to be linked with a variety of other institutional problems such as drugs, feuding gangs, a lack of space, and boredom (CPT, 2011). Drugs are often connected in some way with violent attacks on prisoners, with O'Mahony (2008) identifying strong links between drugs and three homicides in Irish prisons in the past decade

### **3.2.4 Natural Causes**

While the unnatural causes of death in prisons discussed above often receive more attention in the literature, it must be remembered that a significant proportion of prisoners die as a result of natural causes. Often, deaths from natural causes represent the largest category of prisoner deaths, and recent Irish and international data demonstrates this. Natural deaths accounted for 32% of all deaths in Irish prisons between 2000 and 2008 (Irish Prison Service, 2008). In Northern Ireland 41% of deaths between September 2005 and March 2011 were as a result of natural causes and illness (Prisoner Ombudsman for Northern Ireland, 2011), while in England and Wales, 61% of prisoner deaths between 2010 and 2011 were natural deaths (Prisons and Probation Ombudsman for England and Wales, 2011b). Research from Swiss prisons shows that 34.6% of Swiss prisoners died natural deaths between 1984 and 2000 (Sattar and Killas, 2005). Heart disease has been acknowledged as the single largest cause of natural death in prisons, with cancer closely following (Prisons and Probation Ombudsman for England and Wales, 2010).

#### *3.2.4.1 Prisoners with Chronic or Long-term Illnesses*

In recent years there has been growing concern about the needs of chronically ill prisoners (Steiner, 2003). Steiner (2003) explains that problems such as overcrowding, shortages of medical staff, and inadequate facilities for palliative care mean that the prison environment is inappropriate for seriously or terminally ill prisoners. Questions have also been raised about the amount of time doctors in Irish

prisons dedicate to clinical contact with prisoners with long-term illnesses. In their study of medical care across the prison estate, Barry et al (2010) found that prison doctors spend approximately half of their time on committals and transfers of prisoners, devoting much less time to routine clinical reviews. The recent CPT report also indicates that the attendance times of doctors in some prisons are insufficient for the provision of appropriate healthcare (CPT, 2011).

#### *3.2.4.2 Elderly Prisoners*

Elderly prisoners present significant challenges for prison authorities, particularly in the context of the adequate provision of healthcare (Wright and Bronstein, 2007). The proportion of elderly prisoners is rising across the western world, with the United States' aging prison population more than tripling since the early 1990s (Phillips *et al*, 2009). Prison systems with a significant population of elderly inmates have been found to have a high incidence of natural deaths (Aday, 2005). Particular concern has also been expressed in relation to the rising numbers of aging female prisoners in recent years (Deaton *et al*, 2009). Recent Irish figures show that there are currently 102 prisoners aged 60 years and above in Irish prisons (Dáil Debates, 31<sup>st</sup> May 2011).

### **3.3 Deaths in Prisons: Accountability and Investigations**

#### **3.3.1 Importance of Accountability**

Cavadino and Dignan (2007) define accountability as the process of ensuring that individuals or organisations in positions of power are answerable for their actions. The authors further explain that for prisons this will involve 'ensuring a degree of answerability' for the conduct and decisions of the prison authorities (Cavadino and Dignan, 2007: 230). Establishing accountability in prisons can be a challenging task, due to their closed nature (Harding, 2007). However, as Vagg *et al* (1985) maintain, it is this closed nature that strengthens the need for effective systems of accountability. Independent monitoring has been highlighted as an important feature of

accountability by van Zyl Smit and Snacken (2009: 118), with the authors advising that effective monitoring ‘must be conducted independently of the bureaucratic operation of the prison system’.

Effective accountability in the Irish prison system has been criticised, with Rogan (2009: 298) acknowledging the ‘disturbing lack of data regarding the way in which decisions, procedures and regulations within the prison system are made and enforced’. The response to deaths in custody is an important issue in this context, with both Rogan (2009) and Martynowicz (2011) sceptical about the compliance of the current procedures with Article 2 of the ECHR. In light of the gap in accountability in this context, a call for strengthened monitoring mechanisms has been made on a number of occasions (Irish Penal Reform Trust, 2007, 2009a, 2009b; Herrick, 2009; Rogan, 2009; Martynowicz, 2011).

### **3.3.2 Deaths in Irish Prisons: Current Investigative Procedures**

The requirements for an effective investigation into a death in custody under Article 2 are set out in the previous chapter. In Ireland, as many as three concurrent investigations may be carried out when a prisoner dies in custody; a Garda investigation, a Coroner’s inquest, and an internal investigation by the prison authorities (Inspector of Prisons, 2011a). While the first two processes are largely deemed to be effective (Inspector of Prisons, 2011a), the internal investigation attracts considerable criticism in the existing literature. The overall consensus appears to be that these investigations are certainly at odds with the requirements of international best practice. Martynowicz (2011) remains sceptical about the potential for such internal investigations to fulfil the requirements of Article 2, citing numerous problems with compatibility with the requirements set out in *Jordan v United Kingdom*. The Inspector of Prisons has also highlighted concerns about the prison authorities’ investigations, believing them to be ‘neither robust, independent nor transparent’ (Inspector of Prisons, 2011a: 19). Concerns have also been raised regarding the consistency of these investigations (Rogan, 2009), and the adequacy of the detail contained within the reports (Inspector of Prisons, 2011a).

As outlined in Chapter Two, a Commission of Investigation may be established to enquire into the circumstances of the death of a prisoner. While their wide-ranging powers of investigation have been praised (Rogan, 2009), a number of concerns relating to the Commissions have been highlighted also. Martynowicz (2011) maintains that the lack of any statutory provision for free legal representation for families is troubling. The level of ministerial control of the Commission's function has also been subject to criticism (Martynowicz, 2011), and Rogan (2009) remains concerned regarding the fact that the decision to publish the report of the Commission rests with the Minister and not the Commission itself.

### **3.3.3 International Comparisons**

In stark contrast with the somewhat chaotic Irish process, the procedures for investigating deaths in custody in both England and Wales and Northern Ireland are largely robust, independent and effective. In both of these jurisdictions, deaths in custody are investigated by a prisoner ombudsman. Prior to the introduction of the Prisons and Probation Ombudsman in England and Wales, there was a perception that internal investigations conducted by the prison authorities were lacking in rigour and independence (Livingstone *et al*, 2008). The introduction of a Prisoner Ombudsman in England and Wales has been an undeniably successful venture, with Newburn (2007) noting that the prison authorities have adopted 90 per cent of the Ombudsman's recommendations. The office has also been praised for its significant contribution to prisoners' rights (Eady, 2007). In the context of deaths in custody, Livingstone *et al* (2008) note that the establishment of the Ombudsman has greatly improved transparency in the process, with the publishing of investigations making it easier to access information about deaths in custody. The success of the Ombudsmen has not gone unnoticed in Ireland, with both Herrick (2009) and Rogan (2009) suggesting the establishment of a similar office here. Martynowicz (2011) recognises the potential of such an office to become a catalyst for change, praising the work of both bodies in Northern Ireland and England and Wales for contributing significantly to accountability and the protection of prisoners' rights.



### 3.4 The Inquest Process and Coronial Data

#### 3.4.1 The Inquest

As the inquest is usually the only public hearing where facts can be established about a prisoner's death, the process is therefore of 'crucial importance in the quest for the truth' (Shaw and Coles, 2007: 89). In practice, however, the process is not without problems. In Ireland, while general duty to hold an inquest currently exists under the *Coroners Act 1962*, there is no specific duty to hold an inquest into all deaths occurring in prisons (Martynowicz, 2011). This 'lack of an automatic trigger' is of concern, and will remain so until the passage of the *Coroners Bill 2007* (Martynowicz, 2011: 93). In the UK the inquest process has been criticised as often presenting 'official and sanitised' versions of deaths in favour of providing the family of the deceased with an opportunity to discover the full circumstances surrounding the death of their loved one (INQUEST, 2002: 2).

The inquest assumes particular importance for the family of the deceased prisoner. As Beckett (1999) notes, the family are dependent on the actions and decisions of the Coroner to provide them with information that will allow them to fully mourn their loss. In reality however, the process can often be 'confusing and unsatisfactory' for family members, with little information provided to the family in advance of the proceedings (Shaw and Coles, 2007: 76). Family members can often find themselves 'alienated and unsupported' by the process (Beckett, 1999: 279).

A number of practical elements of the inquest can affect families' poor experience of the process. As Beckett (1999) notes, the inquest will take place in the coronial jurisdiction in which the prison is located, and families will sometimes have to travel long distances to attend the proceedings. The provision of funding for legal representation for families at the inquest is another problematic issue, both in Ireland (Martynowicz, 2011) and the UK (Beckett, 1999; Shaw and Coles, 2007), and can inhibit their participation in proceedings. Families can be further disadvantaged by limitations on the disclosure of certain categories of documents that are available to the Coroner (Martynowicz, 2011).

### **3.4.2 Research Value of Coronial Data**

For certain categories of death which are reportable to the Coroner, the potential for the inquest files to provide useful data for research is quite broad (Conroy and Russell, 1990). As outlined in the previous chapter, all deaths of Irish prisoners must be reported to the Coroner. Typically, an inquest file will contain a post mortem, medical reports, a Garda Síochána investigation report (if required), toxicology reports, depositions, and any correspondence relevant to the inquest process. Therefore, ideally there should be a wealth of information relating to a variety of aspects of prison life contained within inquest files. While the quality and breadth of the data can sometimes vary across cases and districts (Bennewith et al, 2005), the usefulness of inquest files in providing valuable information not available elsewhere must be recognised (Conroy and Russell, 1990).

## CHAPTER FOUR

### Methodology

#### **4.1 Introduction**

The following chapter will outline the research strategies utilised in the study. It will include a discussion of the data collection processes undertaken, as well as the chosen data analysis methods and justification for the same. Ethical issues will also be considered, along with the practical limitations of the research. The chapter will conclude with some proposals for future research.

#### **4.2 Research Strategy and Design**

A qualitative research strategy was selected for the study. The exploratory aims of the research questions served to guide the selection of the qualitative strategy. The exploratory focus of the research questions mean that the data required will need to be rich in both depth and quality. As qualitative methodologies are acknowledged as best suited to produce data of this kind (Hoepfl, 1997), this research strategy was chosen.

The research design follows the case study method from within the qualitative research framework. In simple terms, a case study involves one or a number of cases being studied in detail (Punch, 2005). It was decided to undertake a collective case study; whereby several cases are studied in order to gain insight into a particular issue (Stake, 1994, cited in Punch, 2005). Coroner's inquest files were selected for inclusion in the research study, with each inquest file representing a single case. Coroner's files were chosen with regard to their research value, as discussed in the previous chapter. The Dublin City coronial district was selected as it contains five prisons and would therefore offer a broad sample from a number of institutions. These prisons also accommodate a diverse range of offenders, including older males, females, and juvenile prisoners (Irish Prison Service, 2010). The collective case study

method was chosen as it facilitates a broader understanding than would be possible with a single case study (O’Leary, 2010). In the context of the present research, it was decided that studying a number of cases of deaths in custody would provide more robust data than a single case study approach

#### **4.2.1 Documentary research**

As the collection of documentary sources is the central focus of this study, it is worthwhile to consider the relevance and importance of documents within the overall context of social research. The significance of documents as a resource for researchers within criminology is recognised by Noaks and Wincup (2004), with the authors advising that documents can provide valuable insights into the activities of the typically closed institutions of the criminal justice system, such as prisons. State documents in particular have been recognised as a useful source for social researchers (Bryman, 2004; Silverman, 1993), and have been described as a ‘potential goldmine for sociological investigation’ (Silverman, 1993: 68).

Working with documents is not without challenges however, with researchers sometimes having to ‘think innovatively’ (Noaks and Wincup, 2004: 118) to overcome possible difficulties. Data collection can be time consuming (Silverman, 1993), and a variety of problems such as accessibility and obscure cataloguing can often plague documentary research (May, 2001). The most enduring challenge with working with documents is that they are very often not compiled for the purposes of the research study, and accordingly some data contained within them can be insufficient or irrelevant (Bowen, 2009; O’Leary, 2010). Bowen (2009) notes however that it is this characteristic that makes documents quite a stable source of data, unaffected by the presence of the researcher.

## **4.3 Data Collection**

### **4.3.1 Access**

Accessibility of texts can often be an issue when conducting documentary research, with negotiating access being a priority for any researcher (Scott, 1990). Accordingly, Scott (1990) divides documents into four categories depending on their accessibility; closed, restricted, open-archival, open-published. In the context of the current study, access to the inquest files was restricted, meaning that permission had to be sought from the Dublin City Coroner to access the files. This involved sending an initial email to the Dublin City Coroner's office in early March, outlining the study and requesting a meeting to discuss negotiating access to the files. By mid-May, no reply had been received. After several follow-up telephone calls, a meeting was arranged with the Coroner for early June. The rationale for study was discussed at length with the Coroner. Upon the Coroner granting access to the files, informed consent was sought and assurances of confidentiality were made. This will be discussed further in the section dealing with ethical issues below.

### **4.3.2 Data Collection Process**

It was agreed that data collection would commence in early August, as this is typically a quiet period for the Dublin City Coroner's Court. It was planned to subject each file to the same critical questions, and for this purpose a Data Sheet was constructed. The Data Sheet was intended to be semi-structured, with plenty of space for the recording of the facts and events that would be unique to each case. This approach was intended to be in harmony with the practice of conducting semi-structured or unstructured interviews in qualitative research.

Data collection in documentary research can very often be a lengthy and protracted process (Bryman, 2004; May, 2001), and the current study was no exception. Every inquest is documented in a handwritten ledger, and given a corresponding reference number. The ledger contains the name and address of the deceased, the Coroner's

verdict on the cause of death, and whether or not the inquest was held with a jury. As there is seldom an indication in the ledger that the death has occurred in a prison, all jury inquests had to be noted and the files pulled out and examined. As indicated by Bryman (2004) and May (2001), this was quite a laborious process. Once files were identified as prison deaths, they were set aside. A total of fifteen files were gathered, with six excluded either because the inquest had not been closed (typically because criminal proceedings were still pending in relation to the death), or the file contained a large volume of illegible handwritten information. The remaining nine files were then reviewed using the Data Sheet.

### **4.3.3 Sampling**

Nine cases of deaths in custody were analysed in the course of this study. This number was chosen with reference to the scale and the time constraints of the research project, as well as the nature of qualitative research. This small sample size is in accordance with the practice of using smaller samples in qualitative research, achieving a ‘rich understanding that may come from the few rather than the many’ (O’Leary, 2010: 165).

The sampling strategy used in the study can be identified as ‘criterion sampling’, in accordance with the framework outlined by Miles and Huberman (1994: 28). This strategy instructs that all participants must display certain characteristics in order to be included in the research. For this study, the inquest files must conform to a number of specifications before they were utilised. These specifications were: the death of an individual in prison custody; prisons located within the Dublin City Coroners District; and deaths that have occurred after the year 2004. The decision to limit the sample to deaths after 2004 was made with reference to the subsidiary question, as the ECHR has had effect in Irish law since the *ECHR Act 2003* (Hamilton and Kilkelly, 2008). It was also hoped that it would facilitate an analysis of the contemporary factors that contribute to deaths in custody.

## 4.4 Data Analysis

### 4.4.1 Documentary Data Analysis

The inquest files were analysed using the method of documentary data analysis. Documentary data analysis involves ‘finding, selecting, appraising, and synthesising data contained in documents’ (Bowen, 2009: 28). The analytical procedure involves organising data into categories and themes (Labuschagne, 2003). Noting the ‘few pronouncements on methodology’ that exist for researchers seeking to analyse documents, Prior (2003: ix) laments the limited information on strategies to adopt when approaching the data analysis stage of a study. While Bowen (2009) also acknowledges this dearth of information, he advises that researchers should not be apprehensive about undertaking analysis of documents. Document analysis can be useful as a stand-alone method, with Bowen (2009: 29) noting that it is of ‘immense value’ in case study research.

Following the collection of the data contained in the inquest files in the Data Sheet, the information was then transcribed from the Data Sheet to a Microsoft Word document, creating a ‘case profile’ for each file. These case profiles were first examined using content analysis as suggested by Bowen (2009). This process entailed an initial review of each of the cases, in which meaningful and relevant data were identified. A thematic analysis followed this, involving a ‘careful, more focused re-reading and review of the data’ (Bowen, 2009: 32). Patterns were recognised and extracted, resulting in emerging themes becoming categories for analysis (Fereday and Muir-Cochrane, 2006). Themes relating to the causes of death were broadly anticipated and informed by the literature review, and the structure of the analysis in relation to Article 2 was constructed in accordance with the requirements set out in chapter two above.

Noaks and Wincup (2004) advise that the amount of data collected will influence the choice between manual and electronic coding and analysis. The authors state a particular preference for the manual approach in smaller scale studies. Coffey and Atkinson (1996) echo this approach, cautioning against the potential for software

packages to stifle the researcher's own analytic skills. Bearing this in mind, it was decided that a manual approach to data analysis would be best suited to the present study.

#### **4.5 Ethical Issues**

Miles and Huberman (1994) stress the importance of ethical issues in qualitative research, stating, 'Any qualitative researcher who is not asleep ponders moral and ethical questions' (Miles and Huberman, 1994: 288). The Dublin Institute of Technology (DIT) Guidelines for Ethical Research (DIT, 2010) were at the heart of the ethical considerations in this study. There were no human participants used in the study, and the impact of the researcher on the coronial data was limited. In spite of the unobtrusive nature of the study, ethical issues were still given great consideration.

Confidentiality is the most pertinent of these ethical issues. DIT's ethical guidelines stress the importance of confidentiality, instructing that the researcher is responsible for ensuring confidentiality is maintained (DIT, 2010). A researcher can face significant challenges in relation to safeguarding confidentiality (Wiles *et al*, 2008). Confidentiality was the primary concern expressed by the Coroner, and was the sole condition put on the access agreement. Due to the sensitive nature of the research, any personal details contained within the inquest files have been presented in a manner that ensures anonymity. During the data collection process the Coroner's reference number and the dates of death and inquest were recorded in the Data Sheet to facilitate the Researcher in returning to examine an inquest file if necessary. Once data collection had concluded and the case profiles were complete, this information was blacked out on each Data Sheet, ensuring that the cases used in this study could not be traced back to the original inquest file.

Data storage is another area for consideration in this context. Electronic data collected in the course of this study is currently stored in a password-protected database to which the Researcher has sole right of access. Data generated in the course of this study will be securely held for two years, in accordance DIT ethical practice (DIT, 2010).



Connected with the issue of confidentiality was that of informed consent. Informed consent was sought from the Coroner during the initial meeting. The Researcher supplied the Coroner with a typed information sheet about the study, a letter from the supervisor, and a consent form.

Ethical concerns about integrity and bias must be considered also. Maintaining integrity is an important challenge for every researcher (Punch, 2005). Bowen (2009) recognises the particular problem of bias in documentary research. Subjecting all data used in analysis to the same critical questions mitigated these issues.

#### **4.6 Limitations and Future Research**

The scale and time frame for the proposed study was the main limitation. This mostly affected the achievable sample size, and it is therefore proposed that future research in this area could take the form of a larger study, enabling the collection of a larger volume of data. Future studies could also be broadened beyond the Dublin City Coronial District, and a comparative or national level study could be undertaken.

Another limitation relates to the content of the reports. Inquest files are produced on foot of a legal requirement, and not for the purposes of research. This is a common challenge for most documentary researchers (O'Leary, 2010). They contain legal and medical language also. At times these limitations made data collection somewhat difficult, but this was largely minimised by an undertaking to gain familiarity with any challenging language prior to examining the files.

This study was very much focused on the causes of deaths in custody and the factors preceding them. The investigative process and outcomes in the context of prison deaths in Ireland is a largely under-researched area. Further research could take the form of an examination of the Irish Prison Service internal investigations and their outcomes. It is also submitted that a study focused on a particular cause of death in Irish prisons would represent a valuable contribution to existing research.

## CHAPTER FIVE

### Findings and Analysis

#### **5.1 Introduction**

As this study has a strong qualitative focus, it was deemed appropriate to combine the research findings and subsequent analysis into a single chapter. This chapter will be divided into two distinct sections, with the causes and contributory factors in the deaths being presented and discussed first. Analysis in relation to the subsidiary research question regarding Article 2 of the ECHR will then follow.

#### **5.2 Causes and Circumstances of the Deaths**

##### **5.2.1 Introduction**

The following section will deal with the causes and circumstances of the deaths. Initial data pertaining to the causes of death and Coroner's verdicts will be presented and analysed first, with some basic demographic information detailed also. Results from the in-depth thematic analysis of the files will then be introduced and discussed.

##### **5.2.2 Demographics and Coroner's Verdicts**

As can be seen from the Data Sheet, a certain amount of demographic information was recorded during data collection. Acknowledging the importance of confidentiality for a study of such sensitive nature, a decision was made to present the data in manner that best respects this.

The following table gives the age range of the nine prisoners included in the study.

**Table 5.1 Age at Time of Death**

<b>Age</b>	<b>Number</b>
16-24 years	2
25-34 years	3
35-44 years	2
45-54 years	2
55+ years	0

The age at death ranged from 21 to 48 years, with a mean age of 33.77 years. The 25-34 year olds accounted for one third of the deaths, and this is largely in line with previous domestic (Department of Justice, 2000) and international (Sattar, 2001; Sattar and Killas, 2005) research.

**Table 5.2 Prisoner Deaths by Institution**

<b>Prison</b>	<b>Number</b>
Arbour Hill	2
Dóchas Centre	0
Mountjoy	6
St. Patricks Institution	0
Training Unit	1

Table 5.2 shows a breakdown of the deaths by institution. All of the deaths occurred in prisons that exclusively accommodate male prisoners. There are therefore no female prisoners included in the study. This result was somewhat surprising, given that the Dóchas Centre accommodates the majority of the female prisoners in Ireland. Furthermore, the Dochas Centre would hold roughly around the same number of prisoners as Arbour Hill Prison, where two of the deaths occurred. In 2010 the daily average number in custody for the Dochas Centre was 131, while for Arbour Hill this number was 148 (Irish Prison Service, 2010).

As can be seen above, two thirds of the cases concerned prisoners who were being held in Mountjoy Prison. This is most likely due to the fact that Mountjoy accommodates a much larger population in comparison to the other institutions. Recent figures from the Irish Prison Service show that the daily average number in custody for Mountjoy was 667 in 2010 (Irish Prison Service, 2010). The sum of the daily averages of the remaining four institutions for the same period falls short of this figure. Mountjoy also faces significant challenges such as ‘slopping out’, overcrowding, and a transient population (Inspector of Prisons, 2011b). These issues

have all been acknowledged to impact significantly on prisoners' health and quality of life (Inspector of Prisons, 2011c).

**Table 5.3 Coroner's Verdict in Each Case**

<b>Verdict</b>	<b>Number</b>
Natural Causes	1
Accidental Death	0
Suicide	2
Open Verdict	1
Misadventure	4
Narrative	1
Unlawful Killing	0

**Table 5.4 Prisoner Deaths by Cause**

<b>Cause of Death</b>	<b>Number</b>
Accidental	0
Drug-related death	3
Homicide/other violence	0
Natural	3
Suicide	3

Table 5.3 shows a breakdown of the Coroner's verdict for each case, while table 5.4 lists the cause of death for each case. Information on the cause of death was collected from the post mortem report in each inquest file, and then classified according to the categories above. Presenting these tables together shows the differences that can sometimes occur between the actual cause of death and the eventual verdict returned at inquest. As can be seen above, not all cases of suicide were given such a verdict. Coroners have been noted to have quite high standards for suicide verdicts, as well as an overall attitude of caution in relation to them (Madge and Harvey, 1999). As a result the real rate of suicide is often underestimated, thus having an eventual effect on the provision for suicide prevention (Gosney and Hawton, 2007). The misadventure and narrative verdicts were also reclassified into drug-related and natural deaths. Misadventure is described as the unintended outcome of an intentional act (Gosney and Hawton, 2007), while a narrative verdict is delivered when the Coroner or jury wish to forgo a short-form verdict in favour of a more comprehensive account of the cause of death (Hill and Cook, 2011).

### **5.2.3 Thematic Analysis**

#### *5.2.3.1 Drugs*

The most prominent theme to emerge from the inquest files was that of illicit drug use. This is perhaps unsurprising given the prevalence of drug abuse in prisons, both domestically (O'Mahony, 1997, 2008; Inspector of Prisons, 2009) and internationally (Crewe, 2006; Wheatley, 2007). Three of the nine deaths examined in the present study were directly related to drug use, with deaths occurring due to intoxication/poisoning or from a drug-related illness. While only three prisoners' deaths were directly related to drugs, seven were reported as having a history of drug abuse, either prior to their committal or whilst in prison. Clinical and toxicology reports found within the inquest files suggest that six of these seven prisoners were using illicit drugs in the prison prior to their death. It is interesting to further note that the two prisoners who did not have a history of drug misuse were noted to have relatively quiet, untroublesome day-to-day lives whilst in custody. Both were praised as being well behaved, with one of them being described as a 'model prisoner' who had achieved a number of privileges.

The issue of the provision of appropriate and adequate drug treatment was quite evident when analysing each of the cases. Five of the nine inquest files gave information of the prisoner's engagement with a drug treatment programme; four prisoners were taking methadone and one was engaged in what was described as an 'abstinence drug free course'. All five of these prisoners were using illicit drugs whilst on their treatment programmes. The problem of prisoners engaging in drug use whilst on treatments such as methadone maintenance programmes is unfortunately not uncommon. During their visit to Irish prisons in 2010 the CPT expressed serious concerns over the manner in which methadone prescribing is carried out across the prison estate (CPT, 2011). The Committee found inadequate monitoring of the frequency of illicit drug use for those on methadone, and highlighted concerns that a number of prisoners had been offered a methadone maintenance prescription upon committal without appropriate follow-up review. The number of prisoners on methadone programmes has increased hugely in the past decade, from 65 in 2000 to 2,424 in 2010 (Irish Prison Service, 2010). In spite of the expansion in the provision

of methadone treatment over the past ten years, the findings of both the current study and the CPT report demonstrate that that Irish Prison Service is struggling to deliver robust drug treatment to all prisoners. Indeed this sentiment is expressed by the Inspector of Prisons, who has described the Irish Prison Service's commitment to providing a drug free prison service as proclaimed in their drug policy document (Irish Prison Service, 2006a) as 'still an ambitious aspiration' (Inspector of Prisons, 2009: 37).

The drugs problem in Irish prisons has also been highlighted as a significant public health issue (Hamilton and Kilkelly, 2008; Herrick, 2009). The CPT have previously expressed concerns regarding the high risk of transmission of blood-borne viruses between prisoners through practices such as sharing needles (CPT, 2007). Turning to the current study, prisoners were found to have contracted blood-borne viruses from intravenous drug use in two cases. One individual was HIV positive while the other had contracted hepatitis C.

#### *5.2.3.2 Suicide*

Suicide emerged as another notable theme during analysis. As acknowledged in the literature review, suicide remains an enduring problem for prisons all over the world. Three of the nine cases in the current study were self-inflicted deaths. These men were aged between thirty and fifty years, with two of the deaths taking place in Mountjoy and the other in Arbour Hill.

In each of the three cases the prisoner committed suicide by hanging. A report from the Garda scene examiner in each file confirms that shoelaces were used in all deaths, with the prisoner using them to suspend himself from the window of the cell. This appears to have been the typical method for some time, with Dooley (1997) noting that almost all suicides between 1980 and 1996 were by hanging from a cell fixture. This issue was highlighted by the Advisory Group on Prison Deaths in their report in 1991. The Group recommended that fixtures in all cells should be designed with reference to limiting the possibility of self-injury, and raised particular concern regarding the design of windows (Advisory Group on Prison Deaths, 1991). The later

report of the National Steering Group on Deaths in Prisons also recognised the problem of hanging from cell windows, but acknowledged that it was ‘almost impossible to manufacture a window which will allow ventilation and at the same time be made absolutely suicide proof’ (Department of Justice, 2000: 14). It is clear from the findings of this study that the design of cell windows remains an enduring issue for the Irish Prison Service in terms of suicide prevention.

Another area of interest within this theme relates to the response of the prison authorities to self-inflicted deaths. Provisions to help prisoners to cope with the suicide of a fellow inmate appear to have been made in only one of the three cases of suicide. In this case, the Chief Officer told the inquest that he had made counselling and psychological services available to all prisoners in the division after the death. Borrill and Hall (2006) emphasise the need to respond appropriately after a self-inflicted death to minimise the distress for other prisoners. Freyne and O’Connor (1992) further acknowledge this, explaining that the effect of a prisoner suicide on other prisoners can be intensified because of the nature of the confined environment of prisons. Suicides can also deeply distress prison staff (Liebling, 2007), and in two cases prison officers mention feelings of shock and upset in their depositions in the files.

Unfortunately, only one of the inquest files contained detailed information of the events that may have contributed to the prisoner’s suicide. The prisoner was noted as having been involved in an altercation with other prisoners on the day before his death. Although it was described in a Garda report contained within the file as ‘nothing serious and among friends’, the prisoner sought to be moved to the protection area of the prison after the incident. He mentioned being fearful of another altercation. Feelings of fear and a lack of safety have been noted as frequently arising in cases of self-harm and suicide (Liebling, 2007).

### *5.2.3.3 Medical Treatment*

Owing to the medical-legal nature of the inquest process, each of the inquest files contained information regarding the prisoner’s medical treatment and history.

Although the consistency in the information provided varied largely across the nine files examined in the study, it became clear that medical treatment was a prominent theme. The cohort presented with a myriad of medical conditions, ranging from long-term illnesses such as diabetes, HIV, and serious cardiac conditions, to minor problems such as headaches.

Two prisoners suffered with diabetes mellitus, and were receiving medical treatment for this while in prison. A further two prisoners required cardiac care, with one of these prisoners being admitted to hospital during his time in prison to undergo serious cardiothoracic surgery. Transmittable diseases were also a problem, as mentioned in the preceding section, with two prisoners having contracted blood-borne viruses from intravenous drug use. One prisoner had asthma, and another was noted to frequently visit the medical orderly complaining of headaches. In eight cases the prisoner had been in receipt of a prescription from a prison doctor. All eight of these prisoners were taking prescribed medications prior to their death.

In three of the nine cases the prisoner was noted as having contact with healthcare services outside of the prison. This number may have been higher, but regrettably a number of the inquest files contained no mention of the prisoner attending for outside medical review. Common to each of these three cases was the issue of the prisoner's difficulty to arrange and maintain their medical appointments whilst in custody. In each case this difficulty seemed to stem from the poor organisation of the prison healthcare services. In one case a prisoner requested a referral to an outpatient service in the Mater Hospital. He had previously attended an outpatient clinic in a different hospital whilst he was on remand in Cloverhill Prison, but since his transfer he found that the long journey to this facility made him unwell. This request was made one month prior to his death. The inquest found that in that one-month period the prison had not taken steps to arrange this, and no referral letter was written.

Recording practices for medical charts was another issue in this context. A number of cases demonstrate alarming inconsistencies in medical record keeping. In one case, a prisoner in Mountjoy was alleged to have been refusing his medication before his death, while the prisoner himself was noted as accusing the prison of denying him his medication. The prisoner was noted to have refused medication previously while in



another prison. In this instance the prisoner's refusal to take his medication was documented on a treatment refusal form and this was inserted into his medical chart. This practice was not followed in Mountjoy, and a letter from the Governor to the Coroner contained in the inquest file explains that no written record is kept of treatment refusals because it was 'not uncommon amongst prisoners'. At the inquest the jury highlighted concern over this inconsistency in practice, attaching a rider to their verdict recommending that a common refusal form be introduced across the prison estate. In another case involving a prisoner with a long-term illness, the prison doctor never had access to a medical chart. It transpired that the prisoner's chart was sent with him when he was transferred between institutions, but that it was simply filed away and never taken out for writing up of attendances.

Unfortunately, it appears that the circumstances described above are not uncommon. Instances of poor practice in relation to medical records have been previously acknowledged by the CPT during their visits to Ireland (CPT, 2007, 2011). Inadequate recording in charts was among the 'important structural deficiencies' noted by the CPT as undermining the provision of healthcare to prisoners (CPT, 2011: para 58). The Committee found in their 2011 report that the quality of medical records was inadequate in too many cases, highlighting particularly the scant clinical notes kept by doctors. They further noted an 'absence of rigour' by prison doctors in acknowledging and following recommendations made in hospital letters (CPT, 2011: para 63).

In a wide-ranging report published earlier this year, the Inspector of Prisons declared that Irish prisoners have a right to healthcare and are entitled to the same standard of medical treatment as is available in the community (Inspector of Prisons, 2011c). The CPT have also acknowledged the State's responsibility to provide healthcare to prisoners, explaining,

*[T]he act of depriving a person of his liberty always entailed a duty of care which calls for effective methods of prevention, screening, and treatment.*  
(CPT, 2001: para 31)

It was clear when analysing each of the cases that there are startling inconsistencies in relation to the standard of medical care. Adequate healthcare is a crucial issue in a

custodial setting, and if delivered properly it can help to counteract some of the negative features of imprisonment such as ‘slopping out’ and overcrowding (Inspector of Prisons, 2011c). High standards of medical treatment are also important due to the nature of the prison environment. Lines (2006) notes that transmittable diseases such as Tuberculosis and Hepatitis B and C spread faster in prisons than in the general community, due mostly to their closed and overcrowded setting.

#### *5.2.3.4 Mental Illness*

Mental illness emerged from the files as another notable theme. In five cases the prisoner was recorded as suffering from depression, with three of these prisoners also noted to have an anxiety disorder and one noted to have obsessive-compulsive disorder. No information was provided in the files regarding the prisoner’s mental health in the remaining four cases.

One prominent issue to emerge in this context was the pharmacological treatment of mental illnesses. In all five cases the prisoner was prescribed medication for his mental illness. Four of the five prisoners did not appear to receive any counselling or psychiatric services in the prison, with the medication being the only treatment for the prisoners’ depression and anxiety disorders. Undue reliance on medication for the treatment of mental illness has been signposted as a problem across the Irish prison system, with both the CPT and the Irish Penal Reform Trust (IPRT) previously highlighting their concerns in this context. Following their visit to Ireland in 2006 the CPT observed that not only was there an acute over-reliance on pharmacological treatment for mental illness, there was also a concerning underdevelopment of therapeutic interventions (CPT, 2007). The Committee further noted that many prisoners were being prescribed anti-psychotic drugs without adequate supervision or follow-up interventions. Revisiting the issue on their next visit, the CPT outlined the concerns of psychiatrists that the nature of the prison environment meant that the possible side effects of such medication could not be adequately monitored (CPT, 2011). The IPRT have also highlighted this issue, calling for the focus to shift from medication to non-pharmacological treatment (IPRT, 2009c).

In two cases there was record of the prisoner receiving psychiatric contact from outside the prison. In one case this simply involved the prisoner being seen once by a psychiatric team while admitted to hospital for surgery. In the other case the prisoner was routinely transferred between the Central Mental Hospital and the prison, staying in the Central Mental Hospital for as long as five months on one occasion. While he was in the prison however, the only treatment he appeared to receive for his mental condition was medication, which was administered to him routinely by a nurse officer attending his cell. A letter from the Deputy Governor to the Coroner explains that while the prisoner was known to have mental health issues, the prison authorities were unaware of their exact nature.

The suitability of the Irish prison system for accommodating the prisoner in the above case must be questioned. The issue of the ability of Irish prisons to provide adequate care for vulnerable individuals such these has been raised previously. The Inspector of Prisons acknowledges that the mental health of prisoners is a ‘complex matter’, declaring,

*Evidence from mental health experts, those working in the prisons, anecdotal evidence and my observations suggest that there are many prisoners who suffer from mental illness, many of which are vulnerable and should not be accommodated in our prisons.*

(Inspector of Prisons, 2011c: 6)

The IPRT takes the same stance as the Inspector, expressing concerns about the suitability and the impact of the prison environment for mentally ill prisoners (IPRT, 2009c). Recent findings of a high prevalence of mental illness among the male prison population (Duffy *et al*, 2006), as well as the admissions of the Inspector in the final chapter of his report on healthcare (Inspector of Prisons, 2011c), demonstrate that the case outlined above is unfortunately not unique. Prisoners of this nature should undoubtedly be diverted from the prison system and cared for in a more appropriate setting.

#### 5.2.3.5 Violence

As discussed in the literature review, violence is an enduring problem for prisons around the world. It was therefore surprising that violence was only indirectly linked to one of the deaths in the sample. In this case, the prisoner committed suicide following a violent altercation that took place between him and three other prisoners. The argument was over a mobile phone that had gone missing, with the three prisoners believing that the deceased had stolen it. A physical fight ensued, and the deceased received a number of injuries as a result. Disputes over property such as this are commonplace in prisons, largely because prisoners will go to great lengths to guard their personal items (Edgar *et al*, 2003).

As noted above, there were no homicides in the sample, and this most likely explains the absence of any element of violence among the remaining eight cases. In five of these cases, the prisoners were noted in the inquest files to be well behaved and not involved in any physical assaults while in the prison. In two of these cases depositions were taken from the deceased's fellow prisoners, where attributes such as kindness and sociability were highlighted.

### **5.3 Article 2 of the ECHR**

#### **5.3.1 Introduction**

In this section findings relating to the subsidiary research question will be presented and analysed. This section will be somewhat shorter than the preceding section, owing to the subsidiary nature of the research question pertaining to Article 2.

#### **5.3.2 Circumstances of the Death**

In two cases the response of the prison authorities can be interpreted as concerning in the context of their obligations under Article 2. The first case concerned the standard

of care and maintenance afforded to a prisoner with a long-term illness. One month prior to his death, the prisoner became ill and collapsed. He was not taken to hospital, and instead he was given his medication slightly later than usual as a precaution. He passed away a month later from an underlying heart condition which, as his family maintained at the inquest, may have been discovered had he been transferred to hospital following his initial collapse.

In the second case the deceased prisoner worked as a cleaner on the landing. On the day of his death he did not get up to commence work as usual, but instead lay motionless in bed making strange noises. His cellmate complained to a prison officer, who looked in on the prisoner and decided that he was simply sleeping. At the inquest a fellow prisoner noted that this behaviour was out of character, and that the deceased was 'usually out and about'. Later in the day a prison officer, who was visiting the cell to discuss removing the prisoner from his cleaning job, realised that the prisoner had passed away.

The three cases of suicide do not appear to raise questions under Article 2. As Herrick (2009) notes, Article 2 will be breached only in circumstances where the authorities knew or ought to have known that the prisoner posed a real risk of suicide. In two of the cases the prisoner did not display any irregular behaviour prior to his death, with both of the men not noted to have any mental health concerns. The other prisoner, while suffering with mental health problems, was described by a prison officer in a deposition as having been coping very well in months prior to his death.

In one case the prisoner committed suicide shortly after being placed on protection. It must be noted that the prisoner was moved to the protection area of the prison immediately after expressing fears regarding a threatened attack. A prison officer visited his cell on the protection landing and spoke with him for a considerable amount of time about his feelings of safety and overall wellbeing. The prison officer noted him to be 'in fine spirits' and he was checked periodically throughout the night in accordance with regulations. He was found dead within minutes of his last check. The response of the prison authorities is to be commended in this case. Staff acted swiftly once the prisoner told them that he felt unsafe, and he was monitored regularly after he arrived on the protection landing.

### **5.3.3 Time between Death and Inquest**

As set out in *Jordan v United Kingdom*, the promptness of an investigation is an important element of its compliance with Article 2. Turning to the current study, the time between the death and inquest ranged from 10 months to 20 months. The mean time was 15.1 months. While a period of 20 months may appear at first to be excessive, these times are actually well below what the European Court of Human Rights (ECtHR) has deemed to be an acceptable delay. Herrick (2009) notes that in *Jordan v United Kingdom* a delay of four years between the death and the investigation was held as acceptable by the ECtHR, while in *Edwards v United Kingdom* a delay of three and a half years was deemed adequate. These rulings, Herrick (2009) maintains, may be taken as indicating where the ECtHR sees the limit of promptness to lie.

### **5.3.4 Next-of-Kin**

#### *5.3.4.1 Next-of-Kin Participation at the Inquest*

Family members attended the inquest in seven of the nine cases. The degree of their participation in the process varied greatly. In four of these cases, a family member gave a short deposition outlining that they had formally identified the body of the deceased. In a further two cases family members gave very brief evidence regarding the age, occupation and marital status of the deceased. In the final of these seven cases the deceased's sister queried evidence being given by another party during the inquest, leading to its eventual adjournment.

Families were not in attendance at the inquest in two of the cases. One deceased's family were unable to attend because they were living in England. In the other case the family were never informed about the inquest. A letter from the mother of the deceased to the Coroner dated five months after the inquest was found in the file. In

this letter the mother explained that none of the deceased's family were informed about the inquest, expressing her distress and disappointment at having to find out about the proceedings from reading an article in the local newspaper. Two weeks later a photocopy of the entire inquest file was sent to the family, along with a letter of apology.

This compliance of this inquest with Article 2 must be questioned. The case of *Jordan v United Kingdom* instructs that next-of-kin participation is one of six requirements for an effective investigation into a death under Article 2. The recent recommendation of the Inspector of Prisons that the relatives of a deceased prisoner should have appropriate access to all investigative procedures regarding the death must also be considered in this context (Inspector of Prisons, 2011a). Putting aside legal issues, the inquest process has been noted to have a therapeutic effect for many families (Shaw and Coles, 2007). Beckett (1999) explains that it is usually an important forum for the family, as it provides them with the information about the circumstances surrounding the death that will allow them to fully mourn their loss.

#### *5.3.4.2 Legal Representation for Next-of-Kin at the Inquest*

The case of *McCann v United Kingdom* instructs that legal representation for the family of the deceased is one of the requirements for an effective investigation. Legal representation for the family can often be a problematic issue at the inquest however, and more often than not the family find themselves without a legal advocate (Beckett, 1999). The family of the deceased had legal representation at the inquest in three of the nine cases. In one case the family of the deceased had made an application to the Department of Justice for funding for a solicitor and a barrister to appear on their behalf at the inquest. They appeared to have significant problems in relation to this, and a quite a large volume of correspondence between the Coroner, the family's legal team, and the Department of Justice were found in the file. The Department of Justice agreed to pay for a solicitor for the family, but would not fund a barrister. The family's solicitors replied to the Department, imploring them to reconsider their decision. The inquest commenced during this dispute, with the family still unclear regarding the issue of legal representation. The family's solicitors then wrote to the

Coroner, declaring that the absence of a barrister acting on behalf of the family meant that the inquest was not fully compliant with Article 2, and should be adjourned. This struggle to get legal aid is often an unfortunate reality for families at the inquest (Shaw and Coles, 2007; Martynowicz, 2011). Again, the degree of compliance with Article 2 in this case is certainly questionable. The circumstances of the prisoner's death were particularly complicated, and the family should have been enabled to instruct a legal team to question witnesses.



## CHAPTER SIX

### Conclusion and Recommendations

#### **6.1 Introduction**

In this chapter a number of recommendations arising from the study will be proposed. Concluding remarks and reflections on the research findings will follow. The recommendations have been informed by both the existing literature and the findings of the study.

#### **6.2 Recommendations**

It is clear from the research findings in the preceding chapter that there is no universal approach that could be adopted by the prison authorities in the context of deaths in custody. Prisoners' deaths are caused by a variety of factors, and as such there is no 'one size fits all' solution. The findings of the study suggest a number of recommendations in relation to certain healthcare and drug treatment practices across the prison service, the provision for families at inquests, and the adequate recording and storage of the inquest files.

The first recommendation relates to medical treatment. As can be seen from the research findings, the provision of healthcare in prisons is well below the standards dictated by best practice. The Irish Prison Service has evoked repeated criticism from both national (Inspector of Prisons, 2011c) and international (CPT, 2007, 2011) bodies in relation to the standards of physical healthcare across the prison estate. Particular issues arising from this study relate to adequate care for prisoners with long-term illness, recording practices for medical charts, and provisions for prisoners who need to attend outside medical services. It is therefore recommended that reforms be made in relation to these findings.

Following on from physical healthcare, it must also be questioned whether a prison is the most suitable place to accommodate individuals with acute mental health needs. The preference for pharmacological treatment of mental health problems to the exclusion of all other treatment seemed to be as a result of poor resources at a service-wide level. The high incidence of conditions such as depression and anxiety amongst the nine prisoners included in this study was unsurprising in light of previous research regarding the prevalence of mental illness in Irish prisons (Duffy *et al*, 2006). It is therefore submitted that adequate resources should be directed towards the provision of a broad spectrum of appropriate therapeutic interventions for prisoners with mental health concerns. Particularly vulnerable prisoners in this context should be diverted from the prison environment to more suitable accommodation.

It is also proposed that the current practices in relation to methadone maintenance programmes need to be reviewed. As was clear from the findings, routine monitoring of those engaged in methadone treatment is far from adequate, with prisoners still engaging in illicit drug abuse whilst receiving methadone. This appears to be a problem across institutions, with the CPT reporting that for many Irish prisoners a methadone prescription was simply ‘free petrol’ (CPT, 2011: para 74). As the numbers on methadone continue to rise, it is advised that this problem is tackled sooner rather than later.

Two further recommendations are also proposed in relation to the inquest process. The first of these relates to the involvement of next-of-kin. The research findings show that the participation of family members at the inquest was quite varied. There was little evidence of contact between the Coroner’s Court and the family prior to the inquest. In line with similar recommendations made by Shaw and Coles (2007) in relation to the UK inquest system, it is recommended that a casework approach should be taken in relation to each inquest, with the family of the deceased prisoner receiving regular contact from a liaison worker in the Coroner’s Court. It is also submitted that a right to legal aid for families at the inquest should be enshrined in legislation, further ensuring their effective participation in the proceedings. These recommendations will have the benefit of not only improving the experience of the process for families, but also ensuring that the inquest process is completely

compliant with the provisions for effective investigations of death under Article 2 of the ECHR, as set out in *Jordan v United Kingdom*.

Finally, in relation to the inquest files it is submitted that the current system of recording and filing is in dire need of updating. As outlined in chapter four, the process of identifying and locating prison deaths was somewhat laborious. A number of files gathered for the study had to be excluded from the final sample after an initial examination, as they contained a large volume of handwritten material that was often completely illegible. A number of the records were also in poor condition. It is therefore a recommendation of this study that the record keeping practices in the Coroner's Court be updated, ideally computerised. Furthermore, the recording and filing practices should be maintained at a high standard across all coronial districts in Ireland, as this will facilitate comparative and national level research.

### **6.3 Conclusion**

This study set out to explore the contemporary causes of death in Irish prisons, with a unique subsidiary focus on the State's obligations under Article 2 of the ECHR. The research findings have exposed a number of issues in relation to the causative factors in Irish prisoners' deaths, highlighting particular problems in the context of healthcare and drug treatment.

It is clear from the findings of this study that, as in the community, the causative factors of deaths in prisons are varied. Every death of a prisoner will present a unique set of facts and circumstances. This is not to say however that the prison environment and the experience of detention are without culpability. The thematic analysis in the previous chapter exposes a number of institutional and service-wide issues that can contribute to a prisoner's eventual passing. The results of the present study certainly raise questions about certain policies and practices currently in place across the Irish prison system. Regrettably, in a number of cases the causative factors in the prisoner's death appeared to be affected in some way by the prison authorities. Issues such as the

inadequate management of methadone programmes, inappropriate responses to medical conditions, and poor treatment for mental health problems all seem to be problematic challenges in the context of deaths in Irish prisons. The findings of this study therefore raise significant questions regarding the Irish Prison Service's compliance with the requirement to protect prisoners' lives under Article 2.

This study questioned whether any of the deaths and their subsequent investigations raised questions in relation to compliance with Article 2 of the ECHR. As outlined in chapter two, the *Jordan* case instructs that an effective investigation of a death must be subject to sufficient public scrutiny before it will be compliant with Article 2. Currently, none of the three investigative mechanisms (the inquest, the Garda investigation, and the internal inquiry) allow for adequate public appraisal, as they are all closed processes. The results of these investigations never become available in the public domain, and this suggests an alarming lack of transparency in the entire process. Sufficient public scrutiny of the investigative process for prison deaths is significantly curtailed as a result. This current position is unfortunate, and Ireland would do well to follow the example of both Northern Ireland and England and Wales, where investigation reports into individual fatal incidents in prisons are published online.

The research findings of the current study clearly demonstrate that poor accountability in relation to prison deaths is a regrettable reality of the Irish prison system. Until significant steps are taken to rectify both the institutional and policy level problems, accountability in the context of deaths in custody is unfortunately lacking.

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## APPENDIX A

### Consent Form

Dear Dr Farrell,

My name is Colette Barry and I am currently undertaking an MA in Criminology in Dublin Institute of Technology. As part of my studies I am required to complete a research study. For this research I have chosen to conduct a study of deaths in Irish prisons.

I respectfully seek your assistance in conducting this study. The research will involve a small-scale qualitative study of coroner's records pertaining to deaths of prisoners in Irish prisons. In order to carry out this research I require formal consent to access these records.

If you decide to participate in the study and grant access to the relevant records I request that you read the following statements and sign below.

- The purpose of the study has been explained to me
- I understand that any information that is provided by the Office of the Dublin City Coroner in the course of this study is confidential and will be anonymised.
- I understand that participation in this study is voluntary
- I understand that consent can be withdrawn at any time
- I have had the opportunity to ask questions and discuss the study

Please feel free to contact me at any time regarding the study. I can be reached by email or telephone at [colette.barry@student.dit.ie](mailto:colette.barry@student.dit.ie) or 0874101965.

I understand the information contained in this letter:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I give consent to the researcher to access the relevant records as agreed:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX B

### Information Letter

Dear Dr Farrell,

My name is Colette Barry. I am currently in the process of completing an MA in Criminology at Dublin Institute of Technology. As part of my studies I am required to complete a dissertation. For this research I have chosen to conduct a study of deaths in Irish prisons. This research will be carried out under the supervision of Dr Mary Rogan.

I am writing to you to respectfully seek your support in conducting this research. The primary purpose of my study is to explore the factors involved in the deaths of prisoners in Irish prisons. This research will also be guided by a subsidiary focus on Article 2 of the European Convention of Human Rights, with a view to examining if any of the deaths included in the study raise questions in this regard. My aim is to conduct a small-scale qualitative study using coroner's records. Data analysis will be conducted in the form of document analysis. This process will involve exploring the coronial data using interview techniques, treating each record as a respondent. A set of standard questions will be devised, and each of the records included in the study will be interviewed using these questions. This will ensure uniformity and integrity in the research. It is also proposed to include some demographic characteristics in the study.

Confidentiality and anonymity is assured in this study. Any personal details contained within the records will be anonymised. Electronic data will be stored in a password-protected database, to which I will have the sole right of access. Any physical data will be stored safely in Dublin Institute of Technology, Mountjoy Square.

I strongly believe that a study of this nature is both timely and necessary, particularly given that the most recent research conducted by the National Steering Group on Deaths in Prisons is over a decade old now. Through this study I am also seeking to raise awareness of the provisions contained in Article 2 of the European Convention of Human Rights, both generally and in the context of prisons. Additionally, it is envisaged that the use of coroner's records in the study will serve to highlight the role and the functions of the Coroner.

I hope that you can assist me in this research.

Kind regards,

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Colette Barry

Email: [colette.barry@student.dit.ie](mailto:colette.barry@student.dit.ie)  
Telephone: 0874101965

## **APPENDIX C**

### **Data Sheet**

DATA SHEET

**The information contained in this sheet is private and confidential**

*Admin: (For Researcher's Use Only)*

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Case Number: \_\_\_\_\_

Coroner's Reference Number: \_\_\_\_\_

Date of Inquest: \_\_\_\_\_ Date of Death: \_\_\_\_\_

*Demographics:*

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Gender:      Male    Female

Age: \_\_\_\_\_

Prison: \_\_\_\_\_

*Cause and Circumstances:*

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Coroner's Verdict:

\_\_\_\_\_

Brief description of circumstances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Location of death: \_\_\_\_\_

Was the deceased alone at the time of death?      Yes    No    Unknown





Did the deceased have an underlying medical condition(s) at the time of death?

Yes No Unknown

Specify:

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History of mental health issues/illness?

Yes No Unknown

Describe:

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History of self-harm (or similar behaviour)?

Yes No Unknown

Describe:

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**Additional Comments:**

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*Article 2 Questions:*

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Time between date of death and inquest: \_\_\_\_\_

Did the next-of-kin have legal representation at the inquest?

Yes   No   Unknown

Describe the nature of next-of-kin involvement in the inquest:

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Were criminal proceedings pending at the time of the inquest?

Yes   No   Unknown

Is there evidence of separate investigation/inquiry into the death within the case file?

Yes   No   Unknown

If yes, describe the nature of the investigation:

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Additional Comments

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