Deaths of Prisoners while in the Custody of the Irish Prison Service

Developing an Irish Database

Oifig An Chigire Príosún
Office Of The Inspector Of Prisons

University of Limerick
School of Law
Foreword

The absence of reliable, comprehensive information on deaths in custody within this jurisdiction has long stuck me as lamentable. This project emerged from a conversation between Prof. Shane Kilcommins and me in 2014 in which we discussed my desire to rectify the information deficit in this regard. Unfortunately, given the limited resources available to my office, this was not work which I could undertake myself. With characteristic enthusiasm, Prof. Kilcommins suggested that the School of Law in the University of Limerick would be in a position to provide academic support to such a project.

Supported by two academic members of staff, Prof. Shane Kilcommins and Dr. Eimear Spain, ten fourth year law students were invited to participate. On meeting the students, Roisin Cahill, Blathnaid Christian O Shea, Maire Ciepierski , Caoilinn Doran, Cillian Flavin, Niall Foley, Michelle Kavanagh, Luke Mulcahy, Rachel O’Carroll and Stephen Strauss Walsh, I was immediately struck by their interest, willingness to participate and their broad knowledge. The students worked diligently and with great enthusiasm and contributed in two important ways: conducting an extensive literature review on deaths in custody and designing a database based on international best practice. This database will be an important resource for my office and the state in the years to come, informing stakeholders and it is hoped, public policy.

As a proud adjunct Professor in the School of Law, I was also delighted to note the very real benefits which accrued to the students who worked on this project. Participation gave them an opportunity to synthesise existing knowledge and apply the analytical and research skills developed during their time in UL in a real world scenario. I hope that this experience is one which the students will long remember, cementing their love of and respect for the law and public service.

This research, which will be presented to the Tánaiste and Minister for Justice and Equality, Frances Fitzgerald, is a concrete example of cooperation between the academic world and a practical Inspectorate such as mine. I am confident that this work which can be expanded in the future will prove a rich source of information in both the academic and practical spheres.

Inspector of Prisons, Judge Michael Reilly
Adjunct Professor of Law, School of Law, University of Limerick
Introduction

In 2014 the Inspector of Prisons in Ireland identified the potential benefits of a comprehensive database on deaths of individuals occurring whilst in the care of the Irish Prison Service. However, given constraints within his own office, he was not in a position to conduct research. Accordingly, in July 2014 he approached the School of Law in the University of Limerick and tasked them with conducting an extensive international literature review on deaths in custody and designing a database based on international best practice.

It was decided in the circumstances to involve undergraduate students and to undertake the work as part of a final year module, entitled Advanced Lawyering (LA4017) offered by the School of Law at the University of Limerick.Introduced in 2008, the purpose of the capstone module is to enhance the analytical and research skills of law students by engaging in various types of end-of-curriculum projects, including those having a service learning and public value orientation.

Students had the choice of a range of projects this academic year on topics such as Contemporary issues in Employment Law (with the Citizens Advice Bureau); Deaths in Custody (with the Inspector of Prisons); the new Child and Family Relationships Act (with Citizen Advice Bureau); and How to Make a Will (an information session for University staff). If such projects are not available, or students do not wish to engage, it is possible to undertake an individual final year research project with a supervisor.

A small teaching grant was secured from the Faculty of Arts, Humanities and Social Sciences to produce the findings in a report format and to support a field trip for the students (£1650). The research was seen as beneficial in that it would permit the Inspector of Prisons to make recommendations as to what data should be collected in Ireland in order to meet best practice and to form a data bank of information.

After the authors had undertaken some background research on deaths in custody, and a call for student participants had gone out, two initial consultations took place in early February with the ten students who agreed to undertake the work. In these consultations, the research project was set out and a report structure agreed; the roles of the academics and the Inspector of Prisons was outlined; relevant jurisdictions were chosen as chapters for the report (Ireland, England and Wales, Northern Ireland, Canada, and Australia); students were allocated in pairs to the selected jurisdictions; research presentations with the Inspector of Prison were scheduled; a progress review was also scheduled at midpoint in the academic term; a visit to Mountjoy Prison was arranged; assessment instruments were outlined; and a deadline for submission of the chapters and findings and conclusions was proposed.

This report is the result of the research conducted by students in the academic year 2014/2015 and represents data available as at 1st April, 2015.
There has been a significant increase in the Irish prison population over the past several decades. For example, since the 1970s there has been an increase of over 400% (Rogan 2014: 2). As of the 2nd April 2015 there were 4,472 prisoners under the care of the Irish Prison System; this includes prisoners in custody, on temporary release and on remand (Irish Prison Service 2015). In the period from the 1st Jan 2012 to 11th June 2014, 34 deaths occurred of prisoners in the custody of the Irish Prison Service. Of the 34 deaths, 15 occurred in prison or when the prisoner was admitted to hospital following a serious life threatening incident in prison and 19 while prisoners were on temporary release (Inspector of Prisons 2014). There are five types of investigation that can occur when a death occurs in custody in Ireland.

The Coroner

The role of the Coroner is to enquire into the circumstances of sudden, unexplained, violent and unnatural deaths. The types of deaths which must be reported to the Coroner for investigation are outlined in the Rules of Practice (Farrell 2000; Barry 2011). Specifically, Rule 47(7) of the Prison Rules 2007 provides that it is the duty of the Governor of the prison to report the death of a prisoner to the local Coroner. Section 17 of the Coroners Act 1962 places a duty on the Coroner to hold an inquest in relation to violent or unnatural deaths. When a death in custody occurs the Coroner is notified and an inquest is held.

The purpose of the inquest is to:

a) Establish the facts surrounding the death,

b) Place those facts on the public record, and

c) Make findings on:

1. the identification of the deceased,

2. the date and place of death, and

3. the cause of death.

When an inquest is held as a result of a death in custody, a jury is required. The law that deals with Coroners’ inquests states that no criminal or civil liability can be determined by an inquest (Farrell v Attorney General [1998] 1 ILRM 364). The inquest is designed to find out what caused the death, rather than to make determinations in relation to culpability. The verdicts available to the jury at the end of the inquest are limited to the following: accidental death, misadventure, suicide, an open verdict, natural causes and unlawful killing.
If the jury at the inquest fails to agree on the cause of death, the Coroner can either accept the majority decision of the jury or if the decision is tied, discharge the jury and hold a new inquest. The jury may also make a recommendation about how such deaths can be prevented in future. Typically, an inquest file will contain a post mortem, medical reports, a Garda Síochána investigation report, toxicology reports, depositions, and any correspondence relevant to the inquest process (Bennewith et al. 2005: 607-614).

**An Garda Síochána**

In all cases when a death in custody occurs, the Gardaí carry out an investigation to ascertain whether or not a full criminal investigation should be carried out. If necessary, such an investigation is carried out and, where relevant, a prosecution would follow. Therefore, the Garda Síochána fulfils two roles: conducting a criminal investigation if warranted and the collection of evidence on behalf of the Coroner (Inspector of Prisons 2010).

**The Inspector of Prisons**

The Office of the Inspector of Prisons is a statutory, independent office established under the Prisons Act, 2007. The Inspector's main role is to carry out regular inspections of prisons, submit an Annual Report to the Minister and as of 2012 to investigate deaths in prison custody.

The aims of these investigations are to:

- Establish the circumstances surrounding the death.
- Examine whether any change in operational methods, policy and practice, or management arrangements would help prevent recurrence of a similar death or serious event.
- Address any concerns of the family.

The reports completed by the Inspector of Prisons provide very comprehensive information on any death in custody. They include *inter alia* general background information on the deceased; any examination of relevant CCTV footage; circumstances relating to the finding of the deceased prisoner; the Inspector's contact with the family and findings and recommendations. Section 31(4) of the Prisons Act 2007 allows the Minister to omit any matter from any report where he or she is of opinion that its disclosure may be prejudicial to the security of the prison or the State, would be contrary to the public interest, or that it may infringe the constitutional rights of any person.

Delays in recent years in the publication of the reports of the Inspector of Prisons by the Minister for Justice, as well as the existence of ministerial powers to redact parts of any report, have caused concern (Irish Penal Reform Trust 2009).
Commission of Investigation

The Commissions of Investigation Act 2004 provides for the establishment of Commissions. Under section 3 of the Act, the Commissions are instituted to investigate 'any matter considered by the Government to be of significant public concern'. 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. One such commission of investigation was set up after the death of prisoner Gary Douch in 2006 but has not been used since. The report of the findings of Grainne McMorrow SC was not published until May 2014, seven years after the commission was established.

Internal Prison Investigation

The prison itself is obligated to hold an internal investigation and present a report to the Minister for Justice under the Irish Prison Rules. This report aims to set out what they know of the circumstances surrounding the death of the prisoner. The Inspector of Prisons (2010) has noted that the 'internal investigation is neither robust, independent nor transparent' and may not meet the criteria for an independent investigation which would satisfy the elements of Article 2 of the European Convention on Human Rights and judgments such as *Jordan v United Kingdom* ([2003] 37 EHRR 2).

Concerns have also been raised regarding the consistency of these investigations, and the adequacy of the detail contained within the reports (Rogan 2009: 298-324).

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The main causes of death in Irish prisons include drugs, suicide, natural causes, accident and third party violence. In relation to the first of these, there is evidence from a number of sources which highlights the role played by drugs in prisoner deaths. For example, the National Steering Group on Deaths in Prisons (Department of Justice and Equality 1997) reported a ‘noticeable increase’ in deaths caused by drug overdoses, with the category of drug overdoses and choking on vomit making up 27% of all deaths in prisons between 1990 and 1997.

Of all deaths in Mountjoy Prison between 2009 and 2014, 13 out of 15 had a history of heroin abuse and 6 out of 15 died following suspected illicit drug use (Mullaney et al., 2015). A review of all available Inspector of Prison reports demonstrates that four of the 29 deaths in custody were drug related; all four prisoners had previous drug problems prior to entry into prison (Inspector of Prisons 2013/14). Of the deaths analysed by the Inspector of Prisons which remain unpublished, four deaths were classed as ‘overdoses’ in 2014 and two at the time of writing in 2015. Four of these six were on temporary release at the time of their deaths.

Similarly, suicide is a significant cause of death amongst prisoners while in the custody of the Irish Prison Service. The national steering group on deaths in prison found that 56% of all deaths in custody between 1990 and 1997 were suicides (Department of Justice and Equality 1997). Between the years 2000-2008 there were 18 suicides in Irish prisons (Barry 2011). A study by the Central Mental Hospital which focused solely on deaths in Mountjoy between the years 2009-2014 found that there were 15 deaths during this period, seven of which were suicides, with six of the 15 having histories of previous suicide attempts (Mullaney et al., 2015).

Nine of the 15 deaths had a lifetime history of mental disorder (Mullaney et al., 2015). Between the years 2012-2014, the Inspector of Prisons published 10 reports which found the cause of death to be suicide. Four out of the 10 suicides in custody occurred when the prisoner was on temporary release.

1 As at 1st April 2015
2 As at 1st April 2015
3 The authors would like to thank the Office of the Inspector of Prisons for providing us with this information.
Of the six that occurred in prison, in all cases the prisoners were alone at the time, either on special observation list, ‘on protection’, in a single cell, or awaiting a new cell mate. (Inspector of Prisons 2012; Inspector of Prisons 2013; Inspector of Prisons 2014). From unpublished Inspector of Prisons reports there were three deaths in 2014 classed as ‘Suicide’ or ‘Hanging’ and one in 2015 classed as ‘Hanging’.  

Not surprisingly, a significant number of prisoner deaths result from natural causes. For example, in nine of the 29 reports of the Inspector of Prison which are publically available, the prisoner died from natural causes.

Six of this nine were suffering some degree of medical problems upon entry into prison - many of which were classified as ‘serious’ medical problems (Inspector of Prisons 2012). In 2012, four out of 16 deaths were classed as arising from natural causes; all four prisoners were over the age of 55 (Inspector of Prisons 2012 for Prisoners C, J, M, O).

In 2013, five of 10 deaths were classed as arising from ‘natural causes’, ranging between the ages of 34 and 50 (Inspector of Prisons 2013 for Prisoner N, L, G, D, C). From unpublished Inspector of Prisons reports there were 2 deaths in 2014 classed as arising from natural causes with one of the individuals having underlying medical issues.

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6 The authors would like to thank the Office of the Inspector of Prisons for providing us with this information.
There is currently no database in Ireland recording information on individual deaths in prison custody with individuals seeking information on deaths reliant on the mechanisms outlined above, particularly reports of the Inspector of Prisons and inquest reports. In contrast, Australia maintains a database recording deaths in prison custody and while this is not publicly accessible the Australian Institute of Criminology publishes monitoring reports periodically containing information on deaths in custody.

In England and Wales, the National Offender Management Service (NOMS) maintains a database on Deaths in Custody and the Ministry of Justice publishes a quarterly statistical bulletin on deaths, self-harm and assaults in prison custody (Ministry of Justice, 2015b). The Prisons and Probation Ombudsman also publishes a ‘Fatal Incident Report’ on each death while INQUEST, a voluntary organization, also gathers and analyses data on deaths in custody.

In Northern Ireland, data is collected by the Prison Ombudsman who produces reports on individual deaths in prison custody. In Canada, the Office of the Correctional Investigator independently reviews the Canadian Correction Services investigations into fatal incidents and publishes statistics in annual reports.

A database in Ireland would provide transparency within the prison system regarding deaths in prison custody, allowing for comprehensive information gathering. It would also encourage evidence based policy with an aim to reduce the number of prisoners dying in prison custody. Based on our findings, we recommend that the Irish Prison Service/Inspector of Prisons should produce a database to record relevant information regarding deaths in prison custody.

This should follow the format outlined below.

### 1. Basic Demographics and Characteristics

#### Basic Demographics

**i) Overall Numbers:** Each jurisdiction studied within this report records the overall number of deaths in prison custody on an annual basis (Ministry of Justice, 1978-2012; Northern Ireland Prison Service, 2015; Inspector of Prisons 2014; Australian Institute of Criminology, 2013; Office of the Correctional Investigator of Canada, 2014a).

**ii) Gender:** The gender of each person who dies in prison custody is recorded in each jurisdiction studied (Ministry of Justice, 1978-2012; Inspector of Prisons, 2014; Office of the Correctional Investigator of Canada, 2014a; Northern Ireland Prison Service, 2015; Australian Institute of Criminology, 2010).
iii) Age: The age of the deceased is recorded in each jurisdiction studied with average ages varying in the different areas (Office of the Correctional Investigator of Canada, 2014a; Department of Justice and Equality 1997; Australian Institute of Criminology, 2013; Northern Ireland Prison Service, 2015, Ministry of Justice, 1978-2012).

iv) Ethnicity: The Inspectorate of Prisons in England and Wales records the ethnicity of those who die in prison custody (HM Inspectorate of Prisoners, 2008). Similarly in Australia, the NDICP records whether the deceased is of indigenous or non-indigenous status (Australian Institute of Criminology, 2013). Including information as to the ethnicity of a prisoner who dies in prison custody enables the authorities to monitor the position of ethnic minorities and avoids the invisibility of race or discrimination issues (Roach, 1999). It is therefore recommended that such a field be included in the database and the categories utilised by the Central Statistics Office of Ireland in the census be adopted (Central Statistics Office, 2012).

v) Home Region: The Inspector of Prisons in Ireland records ‘Home Region’ in his reports on deaths in custody. It is suggested that the last known address of the deceased, if available, be recorded in the database.

vi) Prison: Details of the place of incarceration are recorded in many jurisdictions including Australia and in England and Wales, (Australian Institute of Criminology, 2013; Prison and Probation Ombudsman for England and Wales, 2013).

Characteristics

i) History of Illness:

a. Mental illness: The mental health of deceased prisoners is recorded to varying degrees in the jurisdictions examined (Shaw et al, 2013; Australian Institute of Criminology, 2013; Wobeser et al 2002; Prison and Probation Ombudsman for England and Wales, 2013; Office of the Correctional Investigator of Canada, 2014b). A forthcoming study conducted by staff of the Central Mental Health Hospital also highlights the prevalence of a history of mental illness in prisoners who died while in the custody of the prison service in Ireland (Mullaney et al., 2015). As a result, it is recommended that if the deceased had a history of mental illness, it should be recorded in an Irish database.

b. Physical illness: The existence of pre-existing physical conditions is also an important factor to be considered in this context and is recorded in a variety of jurisdictions including Canada and England and Wales (Office of the Correctional Investigator of Canada, 2013; Prison and Probation Ombudsman for England and Wales, 2014). It is therefore suggested that the database should include a record of pre-existing physical illnesses.

ii) History of Drug and Alcohol Addiction:

It is clear that current or former drug and alcohol abuse is a common characteristic amongst deceased prisoners in this jurisdiction. Whether the deceased had a history of drug and alcohol abuse is also recorded in the various jurisdictions examined (Department of Justice and Equality, 1997; Criminal Justice Inspection Northern Ireland and the Regulation and Quality Improvement Authority, 2014; Australian Institute of Criminology, 2013; Office of the Correctional Investigator of Canada, 2014b; Coles et al, 2008).
2. Status

**Legal status**

The legal status of the prisoner refers to the stage the prisoner is at within the legal process. Each jurisdiction examined records this information, with the manner in which it is recorded varying between jurisdictions. In both Australia (Australian Institute of Criminology, 2008) and Northern Ireland (Northern Ireland Prison Service, 2015) the legal status of the prisoner is specifically noted.

It is suggested this should be categorised as sentenced, un-sentenced and on remand with the intention of gaining a clearer understanding of which stages pose more of a risk to prisoners.

3. Location

**In Prison**

In Northern Ireland and in Australia the general location of the deceased at the time of his/her death is recorded (Australian Institute of Criminology, 2008; Northern Ireland Prison Service, 2015), although neither appear to record information as to whether the prisoner was in a single or shared cell at the time of his/her death. In Ireland, the Inspector of Prisons will note this within a report where available and relevant. It is therefore recommended that information as to the general location of the deceased and whether the deceased died in a shared or single cell should be recorded in the Irish database.

**Outside of Prison**

In England and Wales, Northern Ireland and Australia records are also kept when the death of a prisoner in prison custody occurs outside the prison (Inspector of Prisons 2014; Northern Ireland Prison Service, 2014; Australian Institute of Criminology, 2008). It is recommended that this should be recorded under the headings of ‘receiving medical care, offsite or other’.
4. Time

Length of Sentence

The length of sentence is recorded in both England and Wales as well as in Northern Ireland (Shaw et al., 2013; Northern Ireland Prison Service, 2014). It is submitted that this is useful information to record in order to ascertain whether prisoners serving particular sentences are more at risk.

Length of Time in Prison

This refers to the length of time the prisoner has spent in prison custody at the time of his or her death. This data is recorded in some of the jurisdictions discussed in this report and it illustrates different periods of vulnerability throughout their prison term (Prison Reform Trust, 2014; Northern Ireland Prison Service, 2014).

Time of Death

The time of death is recorded in England and Wales in Coroner’s Inquest Reports and in Prison and Probation Ombudsman Fatal Incident Reports (Meadows, 2002; Prison and Probation Ombudsman for England and Wales, 2013). Though it is not readily available in the other jurisdictions, it is recommended that this be included in an Irish database as it could indicate specific time periods in the day when prisoners are more at risk.

5. Offence and Offender History

Type of Offence for which the Prisoner has been Incarcerated

The majority of the jurisdictions under consideration have documented the type of offence for which the prisoner was incarcerated (Australian Institute of Criminology, 2010; Prison and Probation Ombudsman for England and Wales, 2013). It is important to record this type of data as it has been observed that prisoners serving sentences for particular offences are most at risk (Kariminia et al., 2007).

It is recommended that this category be further categorised into the following subheadings:
1. Homicide Offences
2. Sexual Offences
3. Threats to kill, Assaults, Harassments & Related offences
4. Dangerous or negligent Acts
5. Kidnapping and Related Offences
6. Robbery, Extortion & Hijacking Offences
7. Burglary and Related Offences
8. Theft and Related Offences
9. Fraud, Deception & Related Offences
10. Controlled Drug Offences
11. Weapons & Explosives Offences
12. Damage to Property & to the Environment
13. Public Order & Other Social Code offences
14. Road and Traffic Offences
16. Offences Not Elsewhere Classified

The above categories are utilised by the Irish Prison Service and the Central Statistics Office (Irish Prison Service, 2013). It is recommended that these categorisations be retained for consistency.

### Number of Convictions

In England and Wales, the number of convictions is noted in the ‘Fatal Incident Reports’ (Prison and Probation Ombudsman for England and Wales, 2013). Although this information does not appear to have been recorded in other jurisdictions, it is recommended that the Irish database does so in order to assess whether the rates of death differs among recidivistic or first time offenders (Green et al., 1993; Blaauw et al., 2005).

### 6. Cause of Death

The headings under which the cause of death can be classified differ in each jurisdiction (Ministry of Justice, 2015; Ministry of Justice, Dept. of Health, and Home Office, 2011; Barry, 2011; Australian Institute of Criminology, 2013). natural causes, suicide, caused by others and other.
From an analysis of each of the jurisdiction’s respective approaches, it is recommended that the cause of death is categorised under the following headings: drug related, natural causes, suicide, caused by others and other.

i) **Drug related:** The prevalence of drug related incidents in the Irish penal system warrants the inclusion of this section in the database (Department of Justice and Equality 1997; McClelland, 2014).

ii) **Natural Causes:** A high portion of prisoners die of natural causes and, as such, this categorisation should be included in an Irish database (Ministry of Justice, 2014; Inspector of Prisons, 2013; Inspector of Prisons, 2012; Barry, 2011; Australian Institute of Criminology, 2013).

iii) **Suicide:** In each jurisdiction studied, suicide is a prevalent issue (Prison Reform Trust, 2012; Australian Institute of Criminology, 2013; Department of Justice and Equality 1997; McClelland, 2014).

iv) **Homicide:** This section would include any deaths resulting from homicide (Ministry of Justice, 2015; Aebi, *et al.* 2013).

v) **Other:** This category includes deaths waiting further classification, or those of an unclassifiable nature (Ministry of Justice, 2015).

**Manner of Death**

Australia is the only jurisdiction studied which records the manner of death (Australian Institute of Criminology, 2013). The manner of death refers to the circumstances in which the person died. In some cases, cause and manner of death will correspond. For example, where a person dies as a result of natural causes, their death will be recorded as natural causes for both cause and manner of death. In other cases, cause and manner of death will differ. In addition, where a person dies from acute drug toxicity, cause of death will be recorded as drug-related and manner of death will be recorded as either intentionally self-administered or as an accidental overdose (Australian Institute of Criminology, 2013).

**7. Proposed Database**

The analysis outlined above was utilised to design a database reflective of international best practice for use by the Office of the Inspector of Prisons to collate information on deaths of individuals which occur while in the custody of the Irish Prison Service. Microsoft Access, a database management system, was used as it permits the secure storage of data and enables complex queries or analysis across large datasets.

This database should be populated retrospectively with data from all relevant deaths from January 2012 and should be updated regularly to include all future deaths in prison custody. A sample of the form created for each individual prisoner is contained in Appendix 1.


<table>
<thead>
<tr>
<th>ID</th>
<th>History of Drug Use</th>
<th>Legal Status</th>
<th>Location at time of death in prison</th>
<th>Location at time of death outside of prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>On remand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td>Eimear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>Spain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID Number</td>
<td>9919678</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White, Irish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Region</td>
<td>Limerick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison</td>
<td>Limerick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of Mental Illness</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of Physical Illness</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of offence incarcerated for (see list)</td>
<td>Homicide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of convictions</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cause of Death (see list)</td>
<td>Drug related</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manner of Death</td>
<td>Accidental overdose</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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Inspector of Prisons, Judge Michael Reilly
Adjunct Professor of Law, School of Law, University of Limerick