

**OFFICE OF THE  
INSPECTOR OF PRISONS  
ANNUAL REPORT  
2010**

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# Office of the Inspector of Prisons Annual Report 2010

Presented to the Minister for Justice, Equality and Defence pursuant to  
Part 5 of the Prisons Act 2007.

Judge Michael Reilly  
Inspector of Prisons

7<sup>th</sup> April 2011

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## **Contents**

Acknowledgements	4
<b><u>Chapter 1</u></b>	
Introduction	5
<b><u>Chapter 2</u></b>	
Brief outline of all 14 prisons	7
<b><u>Chapter 3</u></b>	
Best practice relating to investigation of deaths in prison Custody	14
<b><u>Chapter 4</u></b>	
The way forward	15
<b><u>Chapter 5</u></b>	
Relevant reports	25

## Acknowledgement

As will be seen I visited all fourteen prisons unannounced in the period covered by this Report. I would like to thank all members of prison staff who in one way and another assisted me and my staff when making such visits. I would like to thank all the persons that I spoke to including prison staff, prisoners and those that provide services to prisoners for their forthright and candid views.

I would like to thank Ms. Aoife Watters (Researcher) for her help in researching International best practice which enabled me submit a Report to the Minister on 21<sup>st</sup> December 2010 titled “*Guidance on Best Practice relating to the investigation of Deaths in Prison Custody*”.

I am indebted to my small team without whose assistance I could not fulfil my mandate. They are Ms. Linda Larkin (Office Manager), Ms. Aoife Watters (Researcher), Ms. Michelle Ryan and Mr. John Byrne. They are a dedicated, interested and cohesive team who worked long hours and for that I thank them.

Judge Michael Reilly  
Inspector of Prisons

7<sup>th</sup> April 2011

# Chapter 1

## Introduction

- 1.1 This Report covers the period 11<sup>th</sup> September to 31<sup>st</sup> December 2010.
- 1.2 In the period covered by this Report I visited all fourteen prisons unannounced. I refer in greater detail to these inspections in Chapter 2 of this Report.
- 1.3 On the 21<sup>st</sup> December 2010 I submitted a Report to the Minister for Justice and Law Reform (hereinafter referred to as the “Minister”) titled “*Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody*”. I refer in greater detail to this Report in Chapter 3.
- 1.4 I am taking the opportunity of using this Report to outline my primary role for the future and to make clear the standards that I expect.
- 1.5 Since my appointment as Inspector of Prisons I have given guidance to the Irish Prison Service and local management of prisons on best practice relating to the standards that I expect when inspecting prisons, the minimum cell size for prisoner accommodation, the regimes and services that must be provided in prisons, the use of “special cells”, guidance on best practice relating to prisoners’ complaints and prisoner discipline and the procedures to be followed following deaths of persons in custody. Such guidance is in the form of reports which are set out in Chapter 5.
- 1.6 The Irish Prison Service and local management of prisons should now be aware of what best practice is in the areas that I have given guidance on and of their obligations in this regard. I will expect that, as and from the 1<sup>st</sup> July 2011, all prisons will comply with best practice. If, after that date, I find that best practice is not being followed or that the guidance that I have given has been ignored I will be led to the inescapable conclusion that management is indifferent to their obligations to adhere to best practice.

- 1.7 Chapter 4 of this Report places the guidance that I have given in context and sets out in unambiguous terms how I intend operating as Inspector of Prisons in the coming years.

## Chapter 2

### **Brief outline of all fourteen prisons**

- 2.1 I have visited all fourteen prisons in the period 11<sup>th</sup> September to 31<sup>st</sup> December 2010.
- 2.2 I visited these prisons for the purpose of, *inter alia*, looking at:
- (a) state of cleanliness of the prison,
  - (b) general repair of the prison,
  - (c) population of the prison,
  - (d) regimes and services in the prison.
- 2.3 All of my visits were unannounced. Apart from my, then ongoing, investigation into Mountjoy Prison I only visited each prison once. Therefore, my impressions of each prison are a “birds eye” view of the prison on a specific day. It may be that those deficiencies that I found in various prisons were not representative of those prisons as a whole.
- 2.4 I deal briefly with my findings of each prison in paragraphs 2.5 to 2.53.

#### **Arbour Hill Prison**

- 2.5 The prison was clean and in generally good repair. The regimes and services were adequate. Due to staff shortages the waste management facility has had to close for significant periods.
- 2.6 The prison was not overcrowded.

#### **Castlerea Prison**

- 2.7 Castlerea Prison was and continues to be overcrowded. It does not have adequate services and regimes for prisoners. Parts of the prison were very

dirty and essential maintenance did not appear to have been carried out in certain areas.

2.8 Prisoners were locked in their cells for extended periods for two reasons – (a) approximately 25% of the prison population was on protection, and, (b) at certain times because of staff shortages prisoners were locked in their cells for prolonged periods.

2.9 Castlerea Prison is one of four prisons that I am particularly concerned about. I will expect that management will have due regard to my observations in Chapter 4 of this Report.

### **Cloverhill Prison**

2.10 Cloverhill Prison is a remand prison. It was clean and in good repair.

2.11 The prison on the date of my inspection was overcrowded as it is on all days.

2.12 There are not adequate services and regimes in this prison.

### **Cork Prison**

2.13 Cork Prison is severely overcrowded. I suggested in my Report dated 29<sup>th</sup> July 2010 that the maximum number of prisoners that should be accommodated in the prison was 194 prisoners.

2.14 Management in Cork Prison endeavour to keep the workshops open even when there are staff shortages.

2.15 The main prison was clean and properly painted on my inspection. The area which caused me concern was D Wing. Parts of this area were dirty. A number of the cells were filthy. The temperature in the safety observation cells did not meet acceptable standards.

- 2.16 Prisoners in the main prison have to ‘slop out’. ‘In-cell’ sanitation should be provided in all cells.
- 2.17 Cork Prison is one of the prisons that I am concerned about. I will expect that management will have due regard to my observations in Chapter 4 of this Report.

### **Dóchas Centre**

- 2.18 The Dóchas Centre continually operates way in excess of its capacity.
- 2.19 The fabric of the Centre is in good repair. Some of the areas were dirty. Certain equipment was broken.
- 2.20 Because of the numbers in the Dóchas Centre the existing services and regimes (which would be appropriate for the design capacity of the prison) are not adequate to cater for the increased numbers.
- 2.21 The rooms in the Medical Centre are not used for purpose. They are used for accommodation and management reasons in addition to their specific use. This is understandable because of the chronic overcrowding in the prison.
- 2.22 This prison also causes me concern. I will keep all aspects of the prison under constant review and will refer to same as appropriate. I expect that management will have due regard to my observations in Chapter 4 of this Report.

### **Limerick Prison**

- 2.23 Many areas of Limerick Prison were dirty. The majority of cells in the A and B Divisions were dirty and required painting. Windows in a number of cells were broken. Many areas of the prison required painting.
- 2.24 The prison was and continues to be overcrowded.

- 2.25 The only fresh water taps for drinking water on the A and B Wings were immediately over the 'slop hoppers' on these wings. I had brought this to the attention of management in mid June 2010. I was informed that the situation had been remedied. On my last inspection (7<sup>th</sup> December 2010) I found that the situation was as I had found it in mid June 2010. This suggests indifference on the part of the prison authorities.
- 2.26 Drugs are a major problem in the prison.
- 2.27 There are not sufficient recreational areas in the prison.
- 2.28 The services and regimes in the prison are not adequate.
- 2.29 Prisoners on A and B Wings must 'slop out'. 'In-cell' sanitation should be provided in all cells.
- 2.30 There are not sufficient CCTV cameras in the prison.
- 2.31 Inter-prisoner violence is a problem in the prison.
- 2.32 I am particularly concerned about Limerick Prison. There are many deficiencies in the prison some, if not all, of which should have been obvious to management.
- 2.33 I will keep the situation in Limerick Prison under constant review and will report on same as appropriate. I will expect that management will have due regard to my observations in Chapter 4 of this Report.

### **Loughan House Open Centre**

- 2.34 The Centre was clean and properly painted on my inspection.

- 2.35 There are not adequate services and facilities in the Centre despite the efforts of local management.
- 2.36 The Centre was not overcrowded.
- 2.37 Staff shortages at all levels are a major problem.

### **Midlands Prison**

- 2.38 The prison was clean and in good repair. The prison was overcrowded. There are adequate regimes and services in the prison to accommodate the number that should be accommodated in the prison.

### **Mountjoy Prison**

- 2.39 I have dealt with certain issues relating to Mountjoy Prison in a separate Report dated 24<sup>th</sup> March 2011. I will refer to Mountjoy Prison in future reports as appropriate.

### **Portlaoise Prison**

- 2.40 The prison was clean and the new buildings were in good structural repair.
- 2.41 The new wing in Portlaoise Prison should provide adequate services and regimes for all prisoners accommodated in such wing. Unfortunately, this is not the position as, despite the provision of appropriate workshops, all of these have not been opened due to staff shortages.
- 2.42 The older part of the prison was in reasonable repair.
- 2.43 Many improvements have been made to Portlaoise Prison.
- 2.44 The prison was not overcrowded.

### **Shelton Abbey**

- 2.45 This is an Open Centre. It was clean and in general good repair on my inspection.
- 2.46 The regimes and services in the prison are adequate for the numbers accommodated. The existing school is in an old prefabricated building which should be replaced.
- 2.47 The Centre was not overcrowded.

### **St. Patrick's Institution**

- 2.48 St. Patrick's Institution is in reality two separate entities - one for juveniles between the ages of sixteen and eighteen years and the other for adults between that ages of eighteen and twenty-one years.
- 2.49 The prison was clean on my inspection. The general state of repair was good. The numbers were not over capacity and the regimes and services in the prison were adequate.
- 2.50 Prisoners on protection are a significant problem. Numbers of juveniles and young adults spend much of their time in their cells even if not on protection.
- 2.51 It is not appropriate that juveniles are detained in a prison with adults.

### **The Training Unit**

- 2.52 The Training Unit was clean on my inspection. The general state of repair of the prison was good. The prison was not overcrowded and the regimes and services were adequate.

## **Wheatfield Prison**

2.53 Wheatfield Prison was clean and the general state of repair was good. The regimes and services, while good, would not be adequate for the numbers to be accommodated when the new prison block is fully operational.

## **Chapter 3**

### **Best practice relating to investigation of deaths in prison custody**

- 3.1 Over the three year period since taking up the position of Inspector of Prisons I have examined the investigation procedure employed by prison management when investigating deaths in custody. I found that there was no consistent procedure for the investigation of prisoners' deaths across the Irish Prison System. I also found that such investigations did not meet the requirements of International best practice.
- 3.2 I submitted a Report to the Minister on 21<sup>st</sup> December 2010, titled, "***Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody***".
- 3.3 In my Report I gave an overview of the current investigation process employed in Irish Prisons. I then gave guidance having regard to International best practice. I reached conclusions and made a number of recommendations as to how the current process could be improved to comply with this State's obligations in this regard.

## **Chapter 4**

### **The way forward**

- 4.1 When I was appointed Inspector of Prisons on the 1<sup>st</sup> January 2008, I familiarised myself with all fourteen prisons. I had a comprehensive briefing from the Governors of all prisons and an extensive briefing from the Director General of the Irish Prison Service and his senior management team on the workings of the Irish Penal System.
- 4.2 I spent the first part of my tenure as Inspector of Prisons “reading” myself into the role of Inspector.
- 4.3 I devised operational protocols for my office in order that there would be a consistent approach followed by me and my staff when inspecting prisons. For security and operational reasons I cannot disclose these protocols. Suffice is to say that they cover such aspects as how my staff and I conduct ourselves when inspecting prisons, how we deal with security issues and how we interact with prisoners, prison staff and others in a prison setting.
- 4.4 I do not intend, in this Report, to give details of my inspection process as I have given full details of same in previous Reports.
- 4.5 I discovered that Ireland did not have a set of standards against which I could benchmark prisons. I also found that guidance on ‘best practice’ on numerous important issues relating to prisons was not to be found in a concise form either in this country or elsewhere.
- 4.6 I published general standards for the inspection of prisons on the 24<sup>th</sup> July 2009. I published two supplementary sets of standards relating to juvenile prisoners and women prisoners on the 1<sup>st</sup> September 2009 and the 1<sup>st</sup> February 2011 respectively.

- 4.7 I found that, despite publishing the standards referred to in paragraph 4.6, I had to give further guidance to the Irish Prison Service and local management of prisons on a number of important issues. These included the size of prison cells, the regimes and services in prisons, the use of special cells, guidance on best practice relating to prisoners' complaints and prisoner discipline and guidance on best practice relating to the investigation of deaths in prison. This guidance is to be found in the Reports referred to in Chapter 5. I will submit a report on the healthcare standards that should be available in prisons within the coming weeks.
- 4.8 All of the Reports mentioned in paragraph 4.7 are the result of extensive research which my office has done in order that guidance on best practice could be given to the Irish Prison Service and local prison management.
- 4.9 This research is informed by various International Instruments, both from the United Nations and the Council of Europe that Ireland is a party to, non-binding Instruments and Recommendations from the United Nations and the Council of Europe which possess great persuasive authority, the Decisions of the European Court of Human Rights and the Irish Courts, the Reports of the Committee for the Prevention of Torture, Inhuman and Degrading Treatment or Punishment (CPT), our National Laws and relevant Irish National Authority Standards.
- 4.10 The Reports referred to at paragraph 4.7 taken with the standards for the inspection of prisons (incorporating the supplements on juvenile prisoners and women prisoners) give adequate guidance to the Irish Prison Service and local management of prisons on what is expected of them to comply with best practice.
- 4.11 I can only set out what is International best practice. If Ireland is to adhere to its obligations there must be an acceptance by all sections of Irish Society and particularly by the Irish Prison Service and local management of prisons that such best practice should be observed in all prisons.

- 4.12 I consider that I have now given sufficient guidance to the Irish Prison Service and to senior management on best practice in the important areas where guidance was required. I will give further guidance, if and when necessary, if I find other issues that require clarification.
- 4.13 The Reports from my office are intended to give guidance, not alone to the Irish Prison Service and local management, but also to prisoners, their families and the general public. Families of prisoners and the general public have access to such reports as they are all published. Prisoners do not. It is therefore essential that all of my reports are in a prominent place in all libraries and sub-libraries of each prison. I am disappointed to report that, despite my requests, this is not the case in all prisons.
- 4.14 There is an obligation on senior management of all grades to appraise themselves of best practice and in particular to study my reports on best practice. I am disappointed to report that not all members of senior management have appraised themselves of the contents of all my Reports.
- 4.15 I consider that my role, going forward, should be that of a “regulator” in ensuring that Ireland meets its obligations to its prisoners.
- 4.16 As and from the 1<sup>st</sup> July 2011 all Governors should ensure that their prisons comply with best practice.
- 4.17 As and from the 1<sup>st</sup> July 2011, I will be monitoring all prisons to ensure that they do comply with best practice.
- 4.18 I will be particularly vigilant to ensure that a proper, robust and transparent complaints procedure is followed in all prisons. I will be equally vigilant in ensuring that best practice is followed when prisoners are being disciplined.
- 4.19 I wish to point out that under Section 31(6) of the Prisons Act 2007, I am not entitled to investigate individual complaints. I have stated in earlier reports

that there is a lacuna in the law in this regard. Consideration should be given at a political level to remedying this.

- 4.20 While I cannot investigate individual complaints it does form part of my mandate to ensure that best practice is followed when complaints are made by prisoners.
- 4.21 Prisoners, their families, prison staff and the public at large must have confidence in both the prisoner complaints procedure and the disciplinary procedure in all prisons.
- 4.22 The way prisoners' complaints and prison discipline is handled is a good barometer as to how individual prisons are run.
- 4.23 The way prisoners with mental health issues or other medical issues are dealt with is important in defining how a prison system and society treats such people in prison. I will be vigilant in ensuring that best practice in this regard is followed.
- 4.24 I appreciate that in certain areas prisons will not, in the short term, be able to comply with best practice. These areas cover 'slopping out', overcrowding, the provision of certain services and regimes and certain aspects of healthcare.

#### **Deficiencies to be remedied by 1<sup>st</sup> July 2011**

- 4.25 I have given guidance in the following areas:
- (a) Appropriate use to be made of safety observation and close supervision cells. Proper records should be maintained.
  - (b) Proper complaints' procedures to be followed with supporting records.
  - (c) Proper disciplinary procedures to be followed supported by appropriate records.

- (d) Appropriate procedures to be in place when deaths occur in custody. Protocols for the holding of enquiries should be in place. Proper records should be maintained.
- (e) Certain aspects of appropriate healthcare must be in place by the 1<sup>st</sup> July 2011. Proper records must be maintained.

4.26 The Irish Prison Service must be proactive in ensuring a common approach to the issues raised in paragraph 4.25. Direction should be given by the Irish Prison Service to local management as to what is required in this regard to comply with best practice.

4.27 Best practice covering all aspects of penal policy is constantly evolving worldwide. The Irish Prison Service should be aware of such developments and in this regard should ensure that information on such developments is disseminated throughout the Prison System. The Irish Prison Service should be proactive in this regard and should, where International best practice dictates, bring forward policy changes to reflect such changing circumstances.

4.28 I have drawn attention in previous reports to shortcomings in all prisons. I will also expect that, as and from the 1<sup>st</sup> July 2011, I will not have to comment on the following issues:

- (a) Dirty prisons or areas of prisons.
- (b) Unpainted areas of prisons.
- (c) Unacceptable conditions of cells.
- (d) Broken, out of commission or leaking equipment.
- (e) Broken windows.

4.29 If, by the 1<sup>st</sup> July 2011, all of the issues identified in paragraph 4.28 have not been attended to, such as the painting of the prison, each prison should have a published timescale for completion of such works.

4.30 I will expect that all prison personnel of all grades will treat all prisoners, their families and visitors with respect.

## **Initiatives that may not be achieved by 1<sup>st</sup> July 2011**

4.31 It may not be possible for a variety of reasons to achieve the following initiatives by the 1<sup>st</sup> July 2011:

- (a) 'Slopping out'. The elimination of 'slopping out' has commenced in Mountjoy Prison. All areas of Mountjoy Prison should have 'in-cell' sanitation in all cells by the end of 2011. This should be rolled out in all relevant prisons and a timeframe for same (which must be adhered to) must be given.
- (b) Elimination of overcrowding. If society as a whole and the Irish Prison Service in particular accepts that Ireland is obliged to adhere to best practice a realistic timescale (which must be adhered to) should be given for the elimination of this overcrowding. I refer in paragraphs 4.32 to 4.34 to the published statistics detailing the bed capacity of each prison. These statistics could be misleading if relied on as the basis for commenting on the overcrowding or otherwise of Irish prisons.
- (c) Services and regimes. A timeframe (which should be adhered to) should be agreed between the Irish Prison Service and local management in order that adequate regimes and services are provided in all prisons.
- (d) Healthcare, appropriate to that enjoyed by members of the public, must be available to all prisoners. It should be appreciated that the health requirements of prisoners is different to the health requirements of persons in the community. This is an important aspect when healthcare regimes are being put in place. A timescale for the provision of such healthcare (which should be adhered to) should be provided.

4.32 I have, in many reports, referred to the term 'bed capacity'. This is a misleading term in that its use in the published daily statistics of the Irish Prison Population could be taken to suggest that the Irish Prisons are operating

at or just above capacity. The term is no more than a statement that either bunks or beds to accommodate those numbers are in place in the particular prison. It ignores the size of the cells, International best practice, Rulings of the European Court of Human Rights and Reports of the Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT).

- 4.33 The daily statistics, in addition to giving the stated bed capacity for each prison, should specify the maximum number of prisoners that should be accommodated in each prison having regard to best practice as set out in my Report dated 29<sup>th</sup> July 2010. The statistics should also refer to the actual numbers in custody as a percentage of this figure.
- 4.34 If my recommendations referred to in paragraph 4.33 were followed it would mean that those with an interest in prison regimes or those agencies that collect statistics on prison populations worldwide would have an accurate picture as to the extent of overcrowding in the Irish Prisons at any particular time.
- 4.35 If, after the 1<sup>st</sup> July 2011, I find it necessary to comment adversely on those issues that I have identified in paragraphs 4.25 and 4.28, I will be led to the inescapable conclusion that local management is indifferent to both their obligations to adhere to best practice and to maintaining their prisons to acceptable norms.
- 4.36 In my Report on Mountjoy Prison dated 24<sup>th</sup> March 2011, I referred to three initiatives in that prison, namely, - a dedicated committal area, a vulnerable persons/high support unit and a drug free support unit. All relevant prisons should have these areas/units. The reasons for having such areas/units are compelling and are set out hereunder in paragraphs 4.37 to 4.50.

### **Dedicated Committal Area**

- 4.37 Each prison that accepts **new** committals/remands should have a dedicated committal area which should be used for no other purpose. Such committal areas should be adequate to accommodate all new committals/remands. Local management should be consulted in this regard.
- 4.38 All new committals/remands to the prison should be assessed in the dedicated committal area. They should be seen by, *inter alia*, a doctor, a nurse, a governor, a chief officer, a chaplain and an industrial manager. Only after an appropriate assessment should such prisoners be accommodated either on a landing in the prison, in a specialist unit or transferred to another prison as appropriate. This assessment should not take longer than 24 hours.
- 4.39 The compelling reason for the provision of such an area is that it would, in so far as is humanly possible, eliminate the potential for an incident such as that which gave rise to the Commission of Enquiry set up after a death in Mountjoy Prison.
- 4.40 A study should be carried out to ascertain if such a dedicated area should be provided in Cloverhill Prison which is a remand prison.

### **Vulnerable persons/high support unit**

- 4.41 All prisons, other than open centres, should have a separate dedicated stand alone unit for this category of prisoner.
- 4.42 These units should be properly staffed and have the benefit of either the Inreach Team from the Central Mental Hospital or a similar team. Such a team should be under the direction of a consultant psychiatrist.
- 4.43 Prisoners in these units should be assessed on a daily basis by the relevant medical team and when and where appropriate should be transferred to the

Central Mental Hospital, to another appropriate medical facility, back to the main prison or to another prison.

- 4.44 The establishment of these high support units should not be used as an excuse for not transferring prisoners to the Central Mental Hospital or other medical facility where such prisoners need medical and other care that can only be provided in such hospital or facility.
- 4.45 These high support units should not be used as a long term facility, neither, should they be used for accommodation, management or any other purpose.
- 4.46 The size of such units would differ from prison to prison. The criteria as to size should be dictated by the experience of each prison.

#### **Drug free support unit**

- 4.47 Each prison has a number of prisoners who would wish to be separated from active drug users.
- 4.48 A dedicated area in each prison should be available to accommodate such prisoners. Prisoners should 'earn' the right to be accommodated in such an area.
- 4.49 The Irish Prison Service and local management in each prison should dedicate themselves to the provision of the three types of areas/units as referred to in paragraphs 4.37 to 4.48. I would expect that an announcement signalling the dedication of such areas/units in all relevant prisons should be made within six months of the date of this Report. Such an announcement should be accompanied by a timescale for the opening of these areas/units.
- 4.50 The provision of a dedicated committal area, a vulnerable persons/high support unit and a drug free support unit would not necessarily entail the construction of additional cells as the experience in Mountjoy Prison would

suggest that such units could be accommodated within the present structure of each prison.

### **Search procedures**

4.51 The searching of prisons and prisoners is an integral part of prison life. However, any such searches must be carried out in accordance with accepted best practice and human rights norms. I intend looking at the searching procedure adopted and if necessary will address this issue either within the prison system or in a stand alone report as appropriate.

### **Conclusion**

4.52 My role as a “regulator” will have resource implications for my office. Despite the financial difficulties that this country faces I am confident that any resource issues can be addressed in order that I can fulfill my mandate and ensure that best practice is followed in all Irish prisons.

4.53 I intend submitting periodic reports to the Minister throughout the year and will follow this with an Annual Report. I will bring any urgent matter to the immediate attention of the relevant authority. I will also carry out any investigations required by the Minister.

## **Chapter 5**

### **Relevant reports**

- 1 'Standards for the Inspection of Prisons' published 24<sup>th</sup> July 2009.
- 2 'Standards for the Inspection of Prisons – Juvenile Supplement' published 1<sup>st</sup> September 2009.
- 3 The Irish Prison Population – an examination of duties and obligations owed to prisoners dated 29<sup>th</sup> July 2010.
- 4 Report of an Investigation on the use of 'Special Cells' in Irish Prisons dated 26<sup>th</sup> August 2010.
- 5 'Guidance on Best Practice relating to Prisoners' Complaints and Prison Discipline' dated 10<sup>th</sup> September 2010.
- 6 'Guidance on Best Practice relating to the Investigation of Deaths in Prison Custody' dated 21<sup>st</sup> December 2010.
- 7 'Standards for the Inspection of Prisons – Women Prisoners' Supplement' published 1<sup>st</sup> February 2011.