EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CPT)

COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

CPT/Inf (2025) 22

Report

to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

from 21 to 31 May 2024

The Government of Ireland has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2025) 23.

Strasbourg, 24 July 2025

Contents

EXECUTIVE SUMMARY

The eighth periodic visit of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) to Ireland focused on evaluating the treatment of individuals deprived of their liberty and examining progress on recommendations from previous visits. Key areas of review included safety concerns for both prisoners and staff, and incidents of deaths in custody, treatment of prisoners on restricted protection regimes and of women prisoners, and mental healthcare provision in prisons. Additionally, the visit examined the treatment of patients at the Central Mental Hospital and juveniles in detention. During this visit, the CPT inspected five prisons (Castlerea, Cloverhill, Limerick (male and female) Prisons, Mountjoy Female Prison (the Dóchas Centre) and Mountjoy Prison High Support Unit), the Central Mental Hospital, Oberstown Children Detention Campus and Ballydowd Special Care Unit.

Prison establishments

In its 2024 visit to Ireland, the CPT assessed progress on earlier recommendations and evaluated systemic issues affecting Irish prisons.

Progress and Reforms

The CPT acknowledged several positive developments within the Irish prison system. Infrastructural renovations have been undertaken, and reforms in the women's prison estate were evident. The use of Prison Rule 62, which restricts prisoners' regimes for security reasons, has significantly decreased, supported by improved record-keeping and review procedures. Eligibility for temporary release programs has expanded, and the practice of "slopping-out" has been almost entirely eradicated. These measures represent some meaningful progress since the CPT's 2019 visit.

Persistent and Emerging Concerns

Despite these improvements, the CPT found that many longstanding issues persist, with some areas showing clear signs of deterioration. Among these, safety concerns, inadequate mental healthcare provision, overcrowding, and failures in the management of vulnerable populations were highlighted as pressing systemic challenges.

Physical Safety and Ill-Treatment

The CPT expressed deep concern about the deterioration of physical safety in male prisons, where there were some indications of staff ill-treatment, excessive use of force by custodial staff on prisoners, high levels of inter-prisoner violence and some preventable deaths, which illustrate the inadequacies of existing protections. In this context, of particular concern were three areas:

(i) allegations of *ill-treatment* by prison staff have increased since 2019, with reports of abuse - including slaps, kicks, and punches - occurring in Cloverhill Prison, and to a lesser extent, in Limerick Prison. Some incidents reportedly occurred in areas not covered by CCTV, such as reception centres or escort vans, raising questions about oversight and accountability;

(ii) a number of allegations of *excessive use of force* by prison staff during control interventions and planned relocations, several of which were also documented, particularly in Cloverhill and Limerick, with some cases supported by medical findings and external independent investigations; and

(iii) *inter-prisoner violence* and bullying remain pervasive, especially in Cloverhill, where much of the violence is tied to contraband smuggling and drug-related conflicts. The rising number of violent incidents underscores insufficient measures taken to prevent such occurrences.

Deaths in Custody

The CPT noted a deeply troubling pattern of deaths in custody, some of which were, in the Committee's view, preventable. This situation was compounded by inadequate reviews and a lack of systemic learning. In Limerick and Cloverhill Prisons, deaths related to prisoners suspected of internally concealing drugs - so-called "body packers" - highlight deficiencies in care protocols. The absence of detailed or meaningful critical incident reviews means that similar deaths have recurred, reflecting a failure to implement necessary safeguards.

Overcrowding

Chronic overcrowding continues to plague the entire prison estate, with severe consequences for prison life in terms of the adequacy of living conditions and access to a regular regime of purposeful out-of-cell activities. In all facilities visited, the CPT observed overcrowded cells where three or four prisoners were held in cramped, squalid spaces with insufficient ventilation. Many prisoners, including mentally ill individuals, were forced to sleep on mattresses or flimsy camp beds.

Restricted Regimes and Special Observations Cells

Overcrowding has also worsened conditions, treatment and the regime of activities available for prisoners held on restricted regimes under Prison Rule 63 (for protection reasons), who often spend up to 22 or even 23 hours a day locked in their cells, sometimes for extended periods without meaningful activities. Such confinement, in the CPT's view, may amount to inhuman and degrading treatment. The use of Closed Supervision Cells (CSCs) and Safety Observation Cells (SOCs) remains problematic. Practices continued concerning prisoners in need of increased supervision, such as the systematic stripping of prisoners naked and placing them in thin, small ponchos, and the observation of them at 15-minute checks through the cell door spyglass. Such practices were particularly notable in Cloverhill and Limerick Prisons; where, in addition, some falsified monitoring records were discovered following several prisoner deaths in CSCs, yet minimal action had been taken by local prison management to address this. These conditions, along with the lack of therapeutic care for at-risk individuals in special observation cells, were deemed degrading and counterproductive.

Mental Healthcare in prisons

The CPT identified persistent failures in the provision of mental healthcare in prisons, exacerbated by overcrowding and systemic reliance on imprisonment for severely mentally ill individuals. Mentally ill prisoners are often confined in restricted-regime units. In addition, the so-called "High-Support Units" (HSUs) did not offer the same safeguards as in other observation cells and offered only a poor regime, with none of the promised "high support". All these environments lack the therapeutic support required for recovery, rendering many prisoners vulnerable and untreated. The CPT reiterates that prisons are unsuitable for severely mentally ill individuals and urges their transfer to dedicated healthcare facilities.

Women Prisoners

Women prisoners represent a growing population within the Irish prison system, many of whom are incarcerated for non-violent offences. Although reforms have introduced some gender-specific programmes at facilities like the Dóchas Centre and Limerick female Prison, for many women prisoners the regime remains minimal and overcrowding persists, with women often sleeping on mattresses or foldaway camp beds. Vulnerable groups, including mentally ill, addicted, and traumatised women, as well as pregnant women and mothers of young children, are not systematically receiving the specialist care they require. The CPT emphasised the need for legislative reforms to reduce the number of women in custody, particularly those serving short-term

sentences for non-violent offences, and recommends that imprisonment of pregnant women and mothers of young children be only ever used as a last resort and be limited to cases involving serious or violent offences.

Recommendations for Reform

The CPT calls for urgent reforms to address these critical issues. It recommends measures to reduce overcrowding, including expanded use of community-based sentencing. Improvements in mental healthcare provision, particularly for severely ill individuals, were deemed essential, with a clear emphasis on transferring such individuals to appropriate healthcare facilities. Tailored support programmes should be scaled up to meet the needs of vulnerable groups, and legislative changes should aim to significantly reduce the incarceration of women for non-violent offences. Furthermore, the CPT once again urges a review of CSC and SOC policies to ensure dignity and safety, alongside better oversight to prevent abuse and neglect.

The Central Mental Hospital

In 2024, the CPT conducted its first visit to the Central Mental Hospital since its relocation to Portrane in November 2022. While the hospital's increased bed capacity is a positive development, significant systemic challenges remain. The CPT identified delays in transferring prisoners needing psychiatric care, inefficiencies in patient flow, and deficiencies in legal safeguards as areas requiring urgent attention. Further, prisoners with severe mental health conditions continue to face prolonged waits for transfer from prisons to the hospital. Many are held in unsuitable prison environments where their mental health deteriorates further. The CPT emphasized that making the hospital fully operational by opening remaining wards, such as the Intensive Care and Rehabilitation Unit, must be a priority. The unit's activation could reduce waiting times, improve the quality of psychiatric care, and enhance cost-effectiveness.

Barriers to Patient Flow and Discharge

A critical issue undermining the hospital's effectiveness is the retention of long-term patients who, although clinically stable, have no clear discharge pathway. The CPT found that restrictions imposed on these patients often exceeded their clinical needs, which it described as potentially degrading. To address this, the CPT recommended: developing an accelerated discharge program focused on life-skills support and quality of life; and fully implementing the 2022 High-Level Taskforce on Mental Health and Addiction recommendations, including the establishment of decentralised, low-security forensic psychiatric units. These units would provide alternative care options, facilitate the admission of low-security forensic patients, and reduce the burden on the Central Mental Hospital.

Patient Experiences and Facility Conditions

Patients spoke positively of their interactions with staff, and the CPT observed a high level of commitment to care, even in challenging circumstances. Incidents of violence and harassment were handled professionally. The hospital's modern facilities were in excellent condition, with high standards of hygiene and well-designed wards that included individual courtyards and outdoor access, even for visitors. Despite these positive aspects, the hospital's operations remain overly security-focused. For example: patients in the High Security Unit were not allowed to stay in their bedrooms during the day and were confined there at night, regardless of individual risk assessments; and opportunities for therapeutic leave, both within the hospital and in the community, were limited, despite their proven benefits.

Standards of Care and Treatment

The hospital provides individualised care through pharmacotherapy and comprehensive occupational and psychosocial programmes delivered by multidisciplinary teams. Care plans for patients with intellectual disabilities and somatic healthcare were also commendable. Nevertheless, the CPT recommended expanding the range of therapeutic and recreational activities, particularly for patients in the High Security Unit. Further clarification was sought regarding the frequent use of high-dosage antipsychotic medications and the drugs used for rapid tranquillization. These practices should be accompanied by clear guidelines and safeguards to ensure patient safety.

Staffing and Recruitment Issues

Staffing levels were generally adequate, but the CPT noted persistent vacancies in critical roles, including pharmacists, psychologists, and occupational therapists. The national moratorium on new recruitment exacerbates these shortages. The CPT requested detailed information on the recruitment strategy for the hospital and its integration within the broader National Forensic Mental Health Service.

Seclusion, Restraint, and Safeguards

The CPT found that seclusion was used as a last resort and under the supervision of consultant psychiatrists, which aligns with international standards. However, concerns were raised about the prolonged duration of some seclusion cases and inadequate documentation of the reasons for initiating and continuing these measures. There should, inter alia, be a stricter adherence to best practices and improved regulatory oversight. There is also a need for clear rules and safeguards for the practice of chemical restraint via rapid tranquillization, ensuring it is subject to the same rigorous standards as other forms of restraint.

Legal Safeguards for Legally Incapacitated Patients

The CPT identified serious deficiencies in legal protections for legally incapacitated patients, such as those classified as “wards of court.” Although the Assisted Decision-Making (Capacity) Act 2015 has been enacted, these patients enjoy fewer safeguards than those detained under the Mental Health Act 2001 or the Criminal Law (Insanity) Act 2006. The CPT is critical of cases where patients’ detention orders had been revoked or sentences had expired, yet their detention continued under the inherent jurisdiction of the High Court. It also identified shortcomings in the legal framework for consent to treatment. To address these issues, the CPT calls for comprehensive legislative reforms to strengthen procedural rights and ensure fair treatment.

Recommendations for reform

The Central Mental Hospital demonstrates a strong commitment to patient care, supported by modern facilities and a dedicated staff. However, systemic barriers - such as delays in transfer, inadequate discharge pathways, and deficiencies in legal safeguards - undermine its effectiveness. Addressing these challenges is essential to ensuring the hospital’s role as a cornerstone of Ireland’s forensic mental health services.

Children Detention Establishments

In 2024, the CPT delegation visited Oberstown Children Detention Campus and, for the first time, conducted a targeted visit to Ballydowd Special Care Unit. The Committee identified several critical issues, including insufficient capacity in special care units, the lack of reintegration programmes, and the need for enhanced safeguards and training for staff. Despite these challenges, the delegation observed notable efforts by staff to provide a caring, young-person-centred environment in both establishments.

Capacity Challenges in Special Care Units

The most pressing issue facing the special care units is their insufficient capacity, a problem readily acknowledged by Irish authorities. Prolonged waiting times for admission have significantly worsened compared to previous years, leaving young persons ordered into special care by the High Court exposed to risks in unsuitable facilities for months. Additionally, for those already detained in special care units, the lack of onward placement options unduly extends their detention.

Treatment of Young Persons and Staff Responses

The delegation received no credible allegations of ill-treatment by staff at either Oberstown or Ballydowd. On the contrary, most young persons spoke positively of the staff, highlighting their caring and young-person-centred approach. Episodes of tension, bullying, and occasional violence - both among young persons and against staff - were reported in both establishments. However, staff generally managed these incidents appropriately, particularly at Oberstown.

Efforts to Engage and Reintegrate Young Persons

The CPT welcomed the tangible efforts at Oberstown to engage young persons in structured educational and developmental activities. The Assessment Consultation Therapy Service (ACTS) was particularly commended for its targeted interventions aimed at improving mental health and supporting personal growth. Despite these positive initiatives, the absence of effective step-down arrangements undermines the long-term impact of such efforts. Without reintegration programs and opportunities for gradual re-entry into the community, the benefits of the work done at Oberstown risk being lost. The Irish authorities should prioritise the development of reintegration programs, including temporary leave opportunities within the community, to facilitate young persons' successful transitions post-detention.

Use of Restraint and Disciplinary Practices

The use of means of restraint, such as physical and mechanical restraints and single separation (segregation), is currently governed by policy documents rather than a formal legal framework. The CPT called for the adoption of a comprehensive legal regime to safeguard young persons' rights, including the right to be heard, to receive reasoned decisions, to access legal assistance, and to appeal.

At Oberstown, the use of restraint appeared measured and complied with principles of last resort, proportionality, individual risk assessment, management oversight, and staff training. However, the delegation noted shortcomings in the recording system for single separation, which affected the reliability of separation records. At Ballydowd, while most incidents of agitation or aggression were handled appropriately, staff sometimes called the Gardaí for assistance in situations that should have been managed autonomously. The CPT emphasizes the need for comprehensive staff training in managing aggressive behaviour, de-escalation techniques, and appropriate use of restraint to ensure professional and effective interventions.

Encouraging Compliance with International Standards

Finally, the CPT reiterates, once again, the importance of Ireland ratifying the Optional Protocol to the Convention Against Torture (OPCAT) and establishing a fully resourced National Preventive Mechanism (NPM). This step is crucial to ensure continued oversight and improvement of conditions within the prison estate, psychiatric establishments and children's detention facilities in Ireland.

I. INTRODUCTION

A. The visit, the report and follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a periodic visit to Ireland from 21 to 30 May 2024. It was the Committee's eighth visit to Ireland.[1]

2. The visit was carried out by the following members of the CPT:

- Alan Mitchell, CPT President (Head of Delegation)
- Judith Öhri
- Helena Papa
- Dmytro Yagunov
- Gunda Wössner

3. They were supported by Francesca Gordon and Paolo Lobba of the CPT Secretariat, and assisted by three experts; Birgit Völlm, Professor of Forensic Psychiatry (Germany), Bradley Hillier, Consultant Forensic Psychiatrist (United Kingdom) and Martin Lomas, HM Deputy Chief Inspector of Prisons (United Kingdom).

4. The report on the visit was adopted by the CPT at its 115th meeting, held from 4 to 8 November 2024, and transmitted to the authorities of Ireland on 11 December 2024. The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests that the authorities of Ireland provide, within six months, a response containing a full account of action taken by them to implement the Committee's recommendations, along with replies to the comments and requests for information formulated in this report.

B. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the delegation met Helen McEntee, Minister for Justice and Mary Butler, Minister of State for Mental Health and Older People. It also met with Oonagh McPhillips, Secretary General of the Department of Justice, Caron McCaffrey, Director General of the Irish Prison Service (IPS), Kevin McCarthy, Secretary General of the Department of Children, Equality, Disability, Integration and Youth, as well as senior officials from these Ministries, and from An Garda Síochána, the Health Services Executive, and the IPS, among others.

6. The CPT delegation received excellent cooperation during the visit from the Irish authorities at all levels. The delegation had rapid access to all places of detention it wished to visit, was able to meet in private with those persons with whom it wished to speak and was provided with access to the information required to carry out its task.

The Committee wishes to express its appreciation for the assistance provided to its delegation during the visit by the management and staff in the establishments visited, as well as for the support offered by its liaison officer from the Ministry of Justice, Siobhan Barron.

7. Nevertheless, the CPT must recall once again that the principle of cooperation set out in Article 3 of the Convention is not limited to steps taken to facilitate the task of a visiting delegation. It also requires that decisive action be taken to improve the situation in light of the CPT's recommendations, and that those recommendations are effectively implemented in practice.

---

1. The visit reports and the responses of the Irish authorities on all previous visits are available on the CPT website: https://www.coe.int/en/web/cpt.

In this respect, the CPT remains concerned about the lack of implementation of a number of the CPT's long-standing recommendations, notably regarding chronic overcrowding, widespread use of restricted regimes and segregation in the Irish prison estate, inadequacy of accountability mechanisms, notably the complaints procedures, and issues concerning the provision of mental healthcare for prisoners. Further, the CPT was disappointed to note that it received only a partial response to its Immediate Observations (see below).

C. Immediate observations under Article 8, paragraph 5, of the Convention

8. During the end-of-visit talks with the Irish authorities, on 30 May 2024, the CPT delegation made three immediate observations under Article 8, paragraph 5, of the Convention. The Irish authorities were requested to ensure that:

- the IPS immediately establish a system of meaningful critical incident reviews at local prison level into the circumstances regarding deaths in custody. These reviews should be initiated within a maximum of one week of the person's death, to identify any lessons to be learned, contribute to safeguards and, as appropriate, the prevention of any further deaths;
- at Limerick male Prison's D1 Unit, the female transgender Rule 63 prisoner, who was living in squalid conditions, with minimal access to natural light and ventilation and under an inappropriate regime, held in 23-hour lock-up, be offered a meaningful regime of activities and sufficient out-of-cell time and be transferred to another adequate cell. Steps should be taken to immediately refurbish this cell and others on D1 Unit at Limerick Men's Prison; and
- at the Dóchas Centre, to ensure the transfer of two mentally ill women prisoners held for several weeks in designated Healthcare Observation Units ("HCU" (cell 6) and in cell 5, situated on the Committals Unit) to a location providing a more therapeutic environment with appropriate care for their needs. These women were held in inappropriate conditions, under an impoverished regime, with limited access to a shower, without care plans and with limited meaningful human contact. Cell 5 and the HCU/cell 6 should be taken out of use.

These observations were confirmed by letter of 14 June 2024 when transmitting the delegation's preliminary observations to the Irish authorities.

On 12 July 2024, the Irish authorities informed the CPT of the actions taken in response to these immediate observations and on other matters raised by the delegation at the end-of-visit talks. This response has been taken into account in the relevant sections of the present report.

D. National Preventive Mechanism

9. On 2 October 2007, Ireland signed the Optional Protocol to the United Nations Convention against Torture (OPCAT). However, the Irish authorities took the decision that they would not ratify the OPCAT until after they had made provision in law for the establishment of a National Preventive Mechanism (NPM). The CPT has over the years repeatedly been informed by the Ministry of Justice that an Inspection of Places of Detention Bill, the legal basis for establishing the NPM, would soon be finalised and be submitted to the Oireachtas (Parliament). While this Bill had progressed and the bodies to run and coordinate the NPM, including by the Office of the Inspector of Prisons (OIP) and the Irish Human Rights and Equalities Commission (IREC) had been proposed, at the time of the CPT's visit, it was clear that it had not yet been finalised and a date for OPCAT ratification had not yet been set.

10. More generally, **the CPT recommends that the Irish authorities ratify the OPCAT and designate a fully resourced NPM as soon as possible; all the more pressing in light of the issues raised in this report. Notably, it recommends that the Irish authorities ensure rapid progress in the legislative scrutiny of the Bill and its passage to finalisation, and that additional funding or other resourcing be made available to the designated bodies to enable them to carry out the NPM mandate effectively.**

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Prison establishments

1. Prison establishments visited

11. The CPT visited the following places of deprivation of liberty: Castlerea Prison, Cloverhill Prison, Limerick Female Prison, Limerick Male Prison, Mountjoy Female Prison (Dóchas Centre), and paid a targeted visit to Mountjoy Prison High Support Unit. Overall, the purpose of the visit was to assess the progress of the implementation of the CPT's previous recommendations made following its 2014 and 2019 visits[2] to these establishments.

12. **Castlerea Prison**, built in 1998, is a closed, medium security prison for adult male prisoners. It is the committal prison for remand and sentenced prisoners in Connacht and also takes committals from counties Cavan, Donegal and Longford. With an operational capacity of 340, it was holding 388 prisoners (that is, an occupancy rate of 114%) at the time of the CPT visit. The general layout of the prison was described in the previous CPT visit reports.

13. **Cloverhill Prison,** built in 1999 is a closed, medium security prison for adult males, which primarily caters for remand prisoners committed from the Leinster area. With an operational bed capacity of 431, at the time of the visit it was holding 485 prisoners (an occupancy rate of 112%), of whom 77 were sentenced. The general layout of the prison was described in the previous CPT visit reports.

14. **Limerick Prison**, built in approximately 1820, is a closed, medium security prison for adult men and women prisoners. It is the committal prison for male prisoners for counties Clare, Limerick and Tipperary and for female prisoners for all six Munster counties. With an operational capacity of 210 (men's prison) and 28 (women's prison), it was holding 316 and 73 prisoners respectively (occupancy rates of 150% and 260% respectively) at the time of the CPT visit. The women's prison unit was moved in the summer of 2023 from the main prison building to a separate annex within the overall prison facility, when it became a standalone and entirely refurbished women's prison facility.

15. **Mountjoy female Prison's Dóchas Centre**, built in 1999, is a closed, medium security prison for adult women prisoners. It is the committal prison for women committed on remand or sentenced from all Courts outside the Munster area. With an operational capacity of 146, it was holding 180 prisoners (an occupancy rate of 123%) at the time of the CPT visit. The general layout of the prison was described in the previous CPT visit reports.

16. **Mountjoy male Prison,** built in 1850, is a closed, medium security prison for adult males. It is the main committal prison for Dublin city and county. With an operational capacity of 755, it was holding 887 prisoners (an occupancy rate of 117%) at the time of the CPT visit. Here, the CPT delegation paid a targeted visit to its nine-bed High Support Unit (HSU) only.

2. Preliminary remarks

17. The CPT delegation came to Ireland not only to undertake a detailed examination of the status of the implementation of its previous visit reports' recommendations, but also to assess the key issues overall related to its mandate facing the Irish penal estate in 2024.

18. The CPT found that some measures had been undertaken by the Irish authorities to reform the Irish prison estate.[3] These included infrastructural changes at Limerick prisons,[4] improved recording and review procedures concerning restricted regimes across the prison estate and,

2. CPT/Inf (2015) 38 and CPT/Inf (2020) 37.
3. IPS acknowledges, in its recent Strategy 2023-2027, that the reform process is a work in progress which includes upgrading, modernising and digitalising the prison estate and recruiting staff for the future, as well as the development of a new anti-drugs strategy and a new Code of Ethics for all prison staff.
4. The Limerick Prison Build Project was completed in 2022 when the male prisoner cohort migrated to the new B Wing; the new Limerick female prison opened in summer 2023.

notably, a reduction in the use of Prison Rule 62 (prisoners placed on a restricted regime as a security measure) and the near eradication of the use of "slopping-out" in Irish prisons.[5] Indeed, notwithstanding the blight of overcrowding in the Irish prison estate, the number of prisoners qualifying for temporary release has increased from 398 to 541 in the year to 31 May 2024. Equally, the Limerick female Prison and its overall trauma-informed approach towards the treatment and conditions of women prisoners was positive (see *Women prisoners* section).

19. During its previous visit in 2019, the CPT noted that the IPS recognised, in its Strategic Plan, that the reform process was a work in progress, ranging from upgrading parts of the prison estate and recruiting staff to developing a robust prisoner complaints system as well as addressing the challenge of caring for prisoners with severe mental illness. In 2019, the CPT acknowledged that "this was a prison service moving in the right direction".[6] It was therefore disappointing that the CPT found during this 2024 visit that many of the issues raised by the CPT in its previous visit reports had not tangibly changed.

20. Overall, the CPT found that there remained many key aspects which showed little concrete change since its previous visit. Indeed, in some areas, there was even some deterioration. Of greatest concern to the Committee was the notable deterioration in the core issue of physical safety (for prisoners and staff alike) in male prisons. The Committee was deeply concerned by the findings outlined in this report's sections 3 on *Ill-treatment* and 4 on *Deaths in custody*, which presented a worse situation than had been seen in 2019.

21. The problem of overcrowding pervaded the entire prison estate, resulting in all aspects of prison life being negatively impacted, from the provision of meaningful regimes to the quality of healthcare and specialist support. The CPT found that the IPS was being stretched to its limit. There were high levels of inter-prisoner violence and, worse, the deaths of some prisoners, which in the CPT's view, might have been preventable.

22. At the time of the visit, prisoner numbers had been steadily increasing[7] and as of 31 May 2024, the prison population stood at 4 950, a new all-time high for Ireland, with a population increase of over a 1 000 prisoners since the CPT's 2019 visit, for an official capacity of 4 514 beds.

23. In all six of the prisons visited by the delegation, there was chronic overcrowding. Limerick's newly-opened female prison was the most overcrowded prison in the country.[8] Overcrowding put significant strain on the material conditions and negatively influenced the sufficiency of the provision of regimes.

24. One of the most evident signs of local overcrowding was that many prisoners had to sleep on mattresses or fragile foldaway camp beds on the floor of cells. In its previous visit report, the CPT criticised the policy of creating additional capacity by placing a second bed in a single-occupancy designed cell, which then increased strain on the existing IPS resources to ensure regular access to activities, ready access to specialist services, and supervision and proper support by prison and specialist staff.

25. During this visit, not only were some cells which had been designed for single-occupancy doubled up with bunk beds, but often a third mattress or camp bed, and sometimes even a fourth mattress were squashed onto cell floors. This necessitated an informal arrangement whereby the mattresses or camp beds were stashed on the floor under the cell's bunkbeds during the day in double, triple or even quadruple-occupancy cells. As a consequence, the last person into the cell having nowhere to sit or put their belongings. In some instances cells measuring 11.5 m^2 (including

5. Prisoners who did not have direct access to toilets in their cells used bottles or buckets for their toilet needs. The percentage of prisoners having to "slop out" was 1.9% in 2019 and this had been reduced to 0.1% in 2023.
6. See CPT's 2019 Visit to Ireland, paragraph 27, CPT/Inf (2020) 37.
7. According to information shared with the CPT, in 2022, there were 7 043 committals to prison in 2022, a 14.8% (+910) increase on the number of committals in 2021 (6,133). The overall daily average number of prisoners in custody in 2022 was 4 122, compared to 3 792 in 2021, an increase of 8.7% (+330). The number of committals for the non-payment of fines for 2022 is 205, decreasing from 234 in 2021. Of the 4 162 committals under sentence, 2 259 were for sentences of six months or less.
8. With an occupancy rate of 260%.

the toilet), were holding up to four prisoners, resulting in some 2.8 m^2 of living space per person. In the prisons visited, over 100 prisoners did not have their own beds at the time of this CPT visit.[9]

26. The overcrowding was acutely felt in units where there were prisoners held on restricted regimes, notably for protection reasons. Here, prisoners could be locked in their cells for between 21 and 22 (and, occasionally, even 23) hours per day and this could last for considerable lengths of time.[10] This affected a significant portion of the Irish prison population. Indeed, the number of prisoners held on restricted regimes for protection reasons (Rule 63) had increased since 2019 and involved hundreds of prisoners locked in their cells (see *Restricted Regimes* section).

27. **The cumulative effect of such conditions may well, in the CPT's view, amount to inhuman and degrading treatment.**

28. The number of prisoners placed in pre-trial detention had increased since the CPT's previous visit by 15% and, at the time of the visit, stood at 944 persons, some 20% of the prison population. Equally, the number of persons being given sentences of less than six months has steadily increased by some 10% each year over the past few years.

29. The CPT acknowledges that there have been some steps taken to reduce the prison population, notably with an increase in the use of temporary release orders.[11] However, given the swell in prisoner numbers from September 2019 (3 869) to 4 950 on 31 May 2024, the increase of releases is marginal in proportion. Indeed, many more measures are additionally needed in order to effectively address the issue of chronic overcrowding. While the numbers on alternatives to detention and release conditions were increasing somewhat, they still concern a small fraction of the overall prison population.[12] Despite legislation aimed at reducing the number of persons sent to prison for short term sentences (of 12 months or less), the number of committals to prison has continued to increase annually since the CPT's previous visit in 2019.

Moreover, while legislation now enables the judiciary to impose alternative sanctions for short and medium-term custodial sanctions, such as a Community Return Service Order, these still are not, in the CPT's view, used as fully as they could be.[13]

30. The Irish authorities informed the CPT of the measures and efforts underway to try to alleviate the strain on the Irish prison estate caused by the steady increase in prisoners committed year on year. The measures envisaged included the promise made by the Minister of Justice to increase prison capacity[14] and the recourse to the use of temporary release.

31. The CPT considers that overcrowding can turn a prison into a human warehouse and undermines any efforts to give practical meaning to the prohibition of torture and other forms of ill-treatment. The resultant lack of personal space and privacy puts all prisoners at risk, especially the most vulnerable. Prison overcrowding is not primarily a reflection of rising crime levels; indeed, it is mainly the result of stricter penal policies with increased criminalisation, more frequent and longer use of remand detention, lengthier prison sentences and limited recourse to non-custodial alternatives to deprivation of liberty.

---

9. For example, at Cloverhill Prison, 52 prisoners were sleeping on mattresses on the floor at the time of the CPT visit when the prison was accommodating 485 prisoners for a capacity of 435. This was by no means an issue that only affected a fast turnover remand facility; at Mountjoy Men's Prison, 132 prisoners did not have their own bed, but had foldaway mattresses or camp beds.
10. Many of these prisoners had been held for several weeks, some for months and a few, occasionally, for up to a year or more (see *Restricted Regime* section for more details).
11. In 2019, during the CPT's previous visit, there were 250 prisoners (some 7% of prisoners) on temporary release; in 2024 this had increased to 541 (some 10%).
12. As of 31 May 2024, IPS Statistics show that out of a prisoner population of 4 950, some 541 (11%) were on alternative measures to custody (temporary release).
13. The number of persons benefitting from Community Return schemes had in fact decreased since 2021 (according to IPS information, in 2021 there had been 218 persons offered community return, 175 in 2022 and 213 in 2023).
14. In the spring of 2024, regarding infrastructural works in onsite developments and the promise to create 670 additional places.

32. The Committee considers that, for every prison, there should be an absolute upper limit for the number of prisoners that can be held, in order to guarantee the minimum standard in terms of living space,[15] namely 6 m^2 per person in single cells and 4 m^2 per person in multiple-occupancy cells (excluding the sanitary annexe). **Thus, whenever a prison in the Irish prison estate has reached that limit, no further persons should be admitted to that establishment.**

33. In 2019, the CPT recommended that the Irish authorities take steps to tackle the phenomenon of local overcrowding in prisons through promoting greater use of alternatives to imprisonment and remand detention, notably as regards short sentences. In 2024, the Committee is not convinced that sufficient steps have been taken in this regard.

34. The Committee considers that the development of community service, for example, or the use of effective electronic monitoring systems, coupled with supervisors (probation officers) and reintegration programmes remains insufficient. The CPT wishes to recall that prison overcrowding is neither just a problem for prison governors and prison administrations to solve, nor one that the Irish Government can tackle alone. Instead, the CPT's experience has shown that combating prison overcrowding requires a systemic approach and concerted action by all relevant stakeholders. As stated in the Council of Europe's White Paper on prison overcrowding: "there should be constant dialogue and common understanding and action involving policy makers, legislators, judges, prosecutors and prison and probation managers in each member State". It is also important to effectively implement the precepts set out in Committee of Ministers Recommendation No. R (99) 22 on prison overcrowding and prison population inflation. In light of this, in order to effect urgent change, **the Committee recommends that the Irish authorities adopt more measures for the execution of sentences in the community, alongside the adoption of a systemic approach, involving dialogue and action taken with all relevant stakeholders in Ireland (including with the judiciary).**

3. Ill-treatment

35. The majority of the prisoners met by the CPT delegation stated that prison officers treated them correctly. Relations between staff and prisoners could be categorised as respectful in most of the prisons visited. In the women's prison estate, in **Limerick female Prison** and the **Dóchas Centre**, there were some positive and dynamic interactions between staff and prisoners in evidence, as well as in **Castlerea Prison**, in the men's prison estate.

36. Nevertheless, compared to the CPT's previous visit to Ireland in 2019, the delegation received an increased number of (i) allegations of deliberate ill-treatment by staff, (ii) allegations of excessive use of force by staff and (iii) insufficient management of inter-prisoner violence. It appeared that some core aspects of safety for prisoners had deteriorated since the CPT's previous visit.

37. More specifically, turning first to allegations of prison officer ill-treatment of prisoners. The delegation received and analysed documentation relating to several allegations of deliberate and severe abuse against prisoners by prison officers in both **Cloverhill Prison** and, albeit to a lesser extent, **Limerick male Prison**. These included slaps, kicks and punches to the face, head and torso, including while prisoners were prone on the floor. These allegedly happened either in prisoners' cells, in areas not covered by CCTV in the reception centre (Limerick Prison) and/or in escort prison vans (Cloverhill Prison).

15. "Living space per prisoner in prison establishments: CPT standards" (CPT/Inf (2015) 44) and 31st General Report of the CPT 2021 (https://rm.coe.int/1680a63c72).

38. An illustrative example of the *severity* of alleged ill-treatment encountered by the delegation includes an incident, dated 3 November 2023, involving **Prisoner 1**, held at **Cloverhill Prison**.

> **Prisoner 1** was taken out of Cloverhill Prison for a court hearing in an IPS escort van by custody staff on 3 November 2023. From the CCTV footage available from the van and analysed by the CPT, throughout the journey from Criminal Court of Justice, Prisoner 1 appeared dazed and tired but not agitated or violent.
>
> On return back at Cloverhill Prison, several more prison officers got into the escort van and a control and restraint (C&R) procedure was conducted. One of the Cloverhill prison officers (**Officer A**) held a 4-foot standard-issue PPE (Personal Protective Equipment) shield and was the first to enter the cubicle of the prison van, accompanied by two other officers, who were standing behind him. Seen from the CCTV footage (which was newly installed, and of which Officer A was unaware (see below)), after the cubical door was opened, Officer A pushed the shield against Prisoner 1. He then continued by striking Prisoner 1 with the shield in a downward motion, with force, three times in a row, and then struck hard again at the Prisoner 1's head with the shield in a slicing sideways motion. After throwing the shield back, Officer A is seen on the van's CCTV to punch Prisoner 1 with a closed fist, albeit that at that point Prisoner 1 was already motionless crumpled on the floor and posed no threat to the Officer. He then grabbed Prisoner 1 by the neck, shaking him violently. Prisoner 1 was then carried out from the prison van and is seen on CCTV to have a severe wound to the right upper side of his face and was bleeding significantly from large open wounds on his head.
>
> Cloverhill Prison doctor's notes, in Prisoner 1's medical files, state that Prisoner 1 had "a large laceration of nose, forehead and significant blood loss, wound back of head. Ambulance called". Prisoner 1 was transferred to hospital and spent several weeks there. The hospital records set out the result from a CT scan and MRI and show that Prisoner 1 had "an acute subdural haematoma" (bleed on the brain). He later suffered from significant disabilities commensurate with a head and brain injury[16] including memory loss, according to prison records and the following investigation findings.
>
> The prison management confirmed to the CPT that they had recently installed CCTV in all escort vans to ensure transparency and accountability.
>
> The Committee also notes that the prison officers involved originally stated officially that the injuries were a result of prisoner self-inflicted injury. Even the prison doctor's notes of 3 November 2023 state "*self-injury* at the back of the transport van". Cloverhill Prison management, however, on 21 November 2023 (that is, 19 days later) opened a Category A complaint (CAT A)[17] and an external investigator was appointed.
>
> The investigation, including analysis of CCTV, gathering of evidence and interviewing of witnesses was completed on 14 February 2024. The investigation concluded that the C&R removal from the escort van was carried out by prison staff (Cloverhill C&R team) who did not have the experience or the relevant training for C&R removal from escort vans specifically, but only from standard cells. While it was positive that there was an external investigation, nonetheless, the CPT was disappointed to find that the investigation was, in its view, deficient in a number of aspects (see *Complaints* section).
>
> As of the date of the visit (May 2024), this case was with the Gardi for criminal investigation and Officer A had been suspended, pending the conclusion of the criminal investigation.

16. Prisoner 1 spent over 10 days in hospital, had 22 stiches to his forehead, four stiches to his nose and suffered memory loss for months afterwards.
17. A Category A Complaint is defined in section 57B (1) of the Prison Rules 2007 as "Assault or use of excessive force against a prisoner or ill treatment, racial abuse, discrimination, intimidation, threats or other conduct against a prisoner of a nature and gravity likely to bring discredit on the Irish Prison Service".

39. Upon analysis of the relevant documentation and evidence, the Committee finds that this incident is deeply troubling in a number of respects.

40. First, it considers that the severity and nature of the incident may amount to, at least, physical ill-treatment by a prison officer, and may even, in its view, amount to torture. It considers that this conduct indicates a level of individual cruel abusive treatment on the part of Officer A, who abused a position of responsibility and power, causing severe and as yet immeasurable life consequences due to the brain injuries to a person to whom the prison had a protective responsibility. Officer A, and the other prison officers, then attempted to hide the truth of the incident.

41. Moreover, five months previously, on 17 July 2023, a separate CAT A complaint had been submitted by another Cloverhill prisoner, **Prisoner 2** (see also below), against the same **Officer A** and another officer **(Officer B)**, in a different and unrelated incident of alleged ill-treatment, involving the inappropriate and excessive "headlock" technique during a use of force against Prisoner 2 by Officer A. Here, the external investigator was only appointed in December 2023 and their report was issued only in February 2024 (some seven months after the alleged incident), finding Officer B's behaviour in breach of his duties (see *Investigations* and the issue of delays). Meanwhile, as the investigation was pending, the same Officer A and Officer B were kept in direct contact with prisoners and one (Officer A) went on to seriously and deliberately abuse another prisoner (Prisoner 1) in November 2023 (see above), even before the investigator had been appointed for Prisoner's 2's case.

42. While the CPT acknowledges that Cloverhill Prison management initiated the CAT A complaint regarding Prisoner 1 proactively, and had installed CCTV in escort vans due to previous suspicions about Officers A and B; nevertheless, *delays in the complaints and external investigation procedures* (see *Complaints* section) resulted in the officers in question being placed in direct front-line operational contact with prisoners for *far longer than necessary*. Prisoner 1's life and safety was put at risk and the CPT considers that this may amount to a violation of Article 3 of the ECHR.

43. While these cases have been subject to investigation by external investigators and, in some cases, the Gardi, the lengths of time that these investigations took (see *Complaints and Investigations* section) meant that prisoners continued to be exposed to the risk of ill-treatment, and remained in contact with the same officers allegedly involved in their assaults, for far longer than necessary.

44. The CPT recalls that any form of ill-treatment is totally unacceptable and must be subject to appropriate sanctions. This demands that all senior and middle managers pay special attention to the actions of staff under their responsibility, notably prison officers, and take immediate steps to address any indication that staff are abusing prisoners. Failure on the part of supervisory staff to fulfil this role is, in itself, a serious dereliction of duty.

The CPT requests that the Irish authorities provide a copy of the outcome of the criminal investigation into Officer A, once concluded.

It recommends that the Irish prison authorities ensure that, if there is a reasonable suspicion of illegal and/or abusive behaviour, the prison officer(s) suspected is/are immediately removed from front-line direct contact with prisoners, until the investigation and/or criminal proceedings, are concluded.

Further, given that other prison officers were aware of these incidents, the CPT recommends that the Irish authorities strengthen the secure whistleblowing avenues available and raise awareness of these with prison staff.

Lastly, prison management should demonstrate increased vigilance by ensuring the regular presence of prison managers in detention areas, their direct contact with prisoners, effective investigation of complaints made by prisoners, and improved prison staff training, including a transparent selection procedure and ongoing control and restraint training.

45. Turning to the issue of (ii) excessive use of force by prison staff, there remains a small number of officers who seem inclined to use more physical force than is necessary. During this visit, the CPT delegation received a number of allegations of excessive use of force by staff, notably at **Cloverhill Prison** but also at **Limerick (male) Prison**, as well as a few at the **Dóchas Centre**. These allegations concerned the "disproportionate" and/or "unreasonable" amount of force applied to prisoners during control and restraint interventions or "planned relocations"[18] by prison staff. Many of these allegations were supported by medical findings and/or the outcomes of external investigations. Some of these had been investigated through the CAT A complaints system (see below), but by no means all of them.

46. Two illustrative examples of allegations of excessive use of force by prison staff were received at **Cloverhill Prison**. These involved incidents dated 17 July 2023, involving **Prisoner 2** (as mentioned above) and dated 15 May 2024, involving **Prisoner 3**. They are, in the CPT's view, indicative of a potential pattern of excessive force applied during a relocation or C&R procedure at Cloverhill Prison. The first case (of Prisoner 2) has been found by the relevant external Category A complaint investigator to comprise "grounds which may indicate that in his removal […] unnecessary force was used."[19] The second case (of Prisoner 3) had its investigation "pending", as of the date of the CPT visit (May 2024).

> **Prisoner 2,** on 17 July 2023, was required by prison officers to return into the prison building from the yard. Upon refusal, a "P19" (disciplinary procedure) was issued against him and he was forcibly removed by prison officers. Prisoner 2 alleges[20] that unnecessary and unreasonable force was used to bring him into the prison and that he was put into a "guillotine" hold and that, whilst held in this position, he was struck on his torso and back, more particularly, to the upper part of his spine close to his neck. He also alleges that he was taken by the C&R removal team into the Reception corridor and placed in a cell in Reception, where he was also beaten by prison officers (including Officer A (see above)).
>
> According to the CCTV and prison records analysed by the delegation, Prisoner 2 can clearly be seen with three prison officers outside in the yard, holding him by the left and right hands (hand lock), in a relatively peaceful manner until Officer A arrives. Officer A then is seen to jump on the head of Prisoner 2, pulling the head down and holding it down. The CCTV then shows that Prisoner 2 becomes non-compliant, trying to move and escape. One of the officers (**Officer B**) gives one single punch with closed fist to Prisoner 2's back.[21]
>
> Turning to the outcome of the Category A investigation opened on 1 December 2023 and concluded on 14 February 2024, the investigator rejected three out of four allegations of Prisoner 2. However, the investigator did uphold one allegation and found that Prisoner 2 had been subject to unnecessary and unreasonable force to remove him from B yard at Cloverhill Prison.[22]

47. Prisoner 2's case was by no means an isolated incident; another example can be seen with the case of **Prisoner 3**.

> **Prisoner 3**, held at Cloverhill Prison, submitted a CAT A complaint about an incident in May 2024 and was interviewed by the CPT shortly afterwards. Prisoner 3 alleged that, on 15 May 2024, during a forcible relocation operation, a prison officer entered his cell and kicked him in the stomach. Allegedly, the officers involved in the relocation then kicked him and punched his body, while he was prone on the ground. The officers relocated him by restraining both his hands and head, and dragged him into the corridor of the D1 Unit landing. Prisoner 3 then alleged that he was beaten again in the landing and that one of the officers

18. The planned moving of prisoners to a different cell or part of the prison by way of control and restraint.
19. The investigator based their findings on CCTV footage and analysis of the evidence submitted in this CAT A complaint.
20. Through his solicitors and the CAT A procedure.
21. This last act, which is not criticised in the subsequent investigation report, was justified as an act of use of force in order to get hold of Prisoner 2's hand.
22. Regarding the incident dated 17 July 2023.

tried to strangle him and drag him by his hair. Prisoner 3 states that as a result he started bleeding from his mouth and nose, a situation which was corroborated by IPS prison documentation of the incident.[23] Once relocated to the Close Supervision Cell, Prisoner 3 alleges that officers punched him again and verbally abused him.

Prisoner 3 requested to see a doctor and stated in his complaint that he had sustained several bruises in the back, the eye and other parts of the body. He also alleged that the officers sexually assaulted him during the relocation. He was visited by a doctor the next day but the medical notes merely state that Prisoner 3 had his head covered by his poncho/gown. He was visited again by the prison doctor the following day and the allegation of sexual assault by the C&R team was noted in his medical file, but no mention was made of the injuries.

48. The investigation was pending at the time of the CPT visit. However, the CPT delegation itself reviewed the evidence, which appeared to suggest that unnecessary and disproportionate force may well have been applied during the C&R operation. CCTV coverage shows that a prison officer jumps on the head of the prisoner (Prisoner 3) pulling his head down and puts the prisoner on the floor.

49. Moreover, the CPT's concerns about the potential for excessive use of force during C&R operations is not limited to Cloverhill Prison alone, albeit that appeared the most severe, but also as regards the **Dóchas Centre**.

50. By way of illustration, follows an incident at the **Dóchas Centre's Laurel House**, dated 21 January 2024 involving **Prisoner 4**, a woman prisoner, who had a row with a prison officer. The C&R operation began with at least seven prison staff, then four more male and female staff joined in the intervention, totalling 11 staff, on one prisoner. From the CCTV footage, staff appear to burst into Laurel House and their whole approach was uncompromising, there appeared no attempt at initial de-escalation and the behaviour of staff came across as extremely aggressive.

51. Use of force is authorised under IPS Prison Rule 93 and the relevant standard operating procedure regulations (SOP) is comprehensive.[24] Nevertheless, local management and use of force coordinators at most of the prisons visited (apart from **Cloverhill Prison**) appeared unaware of the SOP guidance.

52. The CPT notes that the overall *recording* of the use of force by IPS staff at all prisons visited had somewhat improved since the CPT's 2019 visit. Nonetheless, the keeping of records was disorganised, most notably at **Limerick Prison (male and female)** and the **Dóchas Centre,** and the records lacked detail and the relevant context. For example at the **Dóchas Centre**, as regards the use of force forms[25] examined by the delegation, none of the descriptions were more than a few sentences in length, nothing was included about context, the demeanour of the prisoner or initial attempts at de-escalation.

53. In all of the prisons visited the *review, oversight and accountability* systems for the use of force remained underdeveloped and was found to lack any detailed scrutiny or analysis.

For example, at **Limerick Prison**, despite safeguards clearly in place for planned relocations, during discussions with those responsible for use of force at the prison, it became evident that they did not know where records should be kept or for how long.[26] This was despite the guidance set out in the

23. National Incident Management System (NIMS) documents.
24. Un-named/untitled SOP dated 01/03/18. The SOP is, however, comprehensive and addresses: statutory limitations and risk assessments; guidance with respect to legitimacy; procedural guidance; technical guidance with respect to mechanical restraint, batons, video evidence and reporting.
25. These were templates that listed basic information, time, date, place, names of those persons who had applied the force, the supervisor, followed by a description of the incident.
26. Planned relocations at Limerick Prison were relatively infrequent (indeed, the camera for the planned relocations had not been used for the previous two years, at the time of the CPT visit). From 01/01/22 to 01/05/24, there were 25 recorded uses of force involving C&R restraint for men in Limerick, and eight recorded uses for women. There was no disaggregation of planned or spontaneous uses and no *per capita* measure.

relevant SOP. There was no evidence to indicate this material was being used to improve practice, either nationally or locally. For example, prison management held no oversight meeting, and there was no routine review of incidents.

54. Equally, at the **Dóchas Centre**, while an IT database for use of force incidents has been established, this did not accurately correlate with paper-based systems. Incidents were not uploaded on to the Prisoner Information Management System (PIMS) (the electronic national prison management database) other than as a record with respect to the conduct of an individual. Use of force incidents were not disaggregated or reviewed in any meaningful way.

55. The governance and accountability structures overseeing the use of force were more systematic at **Cloverhill Prison**, and were also under review to improve them further. However, here too a learning approach was lacking, notably as regards the headlock technique during C & R, but also more generally to prevent an environment where C&R techniques become an informal punishment or abusive mechanism (see *Ill-treatment* sub-section (a)).

56. The Committee considers that a more detailed analysis, review and a lessons-learned approach from restraint operations, at all the Irish prisons, is crucial to preventing any abuse or informal punishment system arising out of lawful C&R procedures. Of significant concern to the Committee was the use of the headlock technique applied to prisoners during C&R operations.

Further, the delegation received some allegations of verbal abuse of a discriminatory nature at the **Dóchas Centre** and at **Castlerea Prison.** At the **Dóchas Centre**, for example, prisoners on protection did inform the delegation that they were called names when they crossed communal areas. Traveller women also reported that they felt discriminated against by the staff who, allegedly, were more positively-minded towards non-Traveller prisoners.

57. **The CPT recommends that the Irish authorities reiterate to prison officers that no more force than is strictly necessary should be used in bringing an agitated /aggressive prisoner under control.**

Further, the CPT recommends that the Irish authorities ensure that custodial staff receive the clear message that excessive use of force, verbal abuse, and threats, as well as other forms of disrespectful or provocative or discriminatory behaviour vis-à-vis prisoners, are not acceptable and will be dealt with commensurate to the gravity of the act.

To this end, it is essential that all prison officers receive regular refresher training in the use of control and restraint techniques and that communication skills and de-escalation techniques be promoted among all prison officers.

The CPT also recommends that the IPS ensure that local prison managers improve oversight and accountability structures governing the use of force, including planned relocations, to establish regular oversight meetings, routine reviews of incidents and the use of local and global data to improve oversight and prevent abuse. It also recommends an increased use of CCTV.

58. Turning to (iii) inter-prisoner violence and its prevention. Frequent low-level, and some severe, inter-prisoner violence and bullying was noted at all prisons visited, with the highest levels evident at **Cloverhill Prison**. Often this was related to contraband smuggled into the prisons, in particular drugs, and their overall adverse effect on the level of safety within the prison system. The CPT was not convinced that sufficient measures were in place to prevent and stem the frequency of the violence. The number of violent incidents across all the prisons visited had also been steadily rising.[27]

59. At **the Dóchas Centre**, inter-prisoner violence appeared to be manged well, if more reactively.

27. IPS-provided statistics indicate that the annual number of prisoner-on-prisoner physical assaults increased from 2022 to 2023, including at Cloverhill Prison (from 125 to 182), Castlerea Prison (from 16 to 20), Limerick Prison (from 11 to 90), Mountjoy Men's Prison (from 20 to 62) and the Dóchas Centre (up from five to 17).

60. At **Cloverhill Prison**, inter-prisoner violence was pervasive. This was not helped by the remand facility having a high turnover of short-term prisoners and the severe overcrowding. It was also exacerbated by the increase in the amount of drugs entering the prison system according to prison management, despite measures in place to counter this. Prisoners interviewed confirmed that drugs were prevalent in the prison and were regularly available (see *Substance use* section).

61. The CPT was not convinced that sufficient work was being undertaken at **Cloverhill, Castlerea** and **Limerick Prisons** to address and prevent inter-prisoner violence, other than merely relocating the prisoners to different locations and resorting to the use of Close Supervision Cells (CSCs) (see below).

62. At **Limerick Female Prison** the delegation received no allegations of staff on prisoner abuse and very few allegations of inter-prisoner violence. Indeed, there appeared generally to be positive relations between staff and the women in prison.

63. At the **Dóchas Centre***,* while it was clear that, in the main, there were good prisoner-staff relations, the delegation received a few allegations of excessive, disproportionate and/or unnecessary force applied by staff during control and restraint interventions (see above). There remained a high number of bullying incidents and some low-level incidents, which created an atmosphere of tension among the women in prison. The staff were fully aware of these concerns and had taken proactive steps to reduce and tackle inter-prisoner violence. Nevertheless, the control and restraint used, on occasion, appeared disproportionate (see *Ill-treatment* section).

64. The CPT considers that addressing the phenomenon of inter-prisoner violence requires a multi-faceted approach which includes enhanced ongoing monitoring of the prisoners' behaviour (including the identification of potential perpetrators and victims), with a particular focus on the situation in the cells in the evening/at night (for example, by more frequent and irregular visits by staff), the proper reporting of suspected and confirmed cases of inter-prisoner intimidation/violence, the thorough investigation of all incidents and, where appropriate, the adoption of suitable sanctions or other measures, as well as the development of effective violence reduction interventions. The management and staff should pay increased attention to the risk and needs assessment, classification and allocation of individual prisoners with a view to ensuring that prisoners are not exposed to other inmates who may cause them harm. In light of this, **the Committee recommends that the Irish authorities ensure that improved strategies and concrete measures are put in place to better prevent inter-prisoner violence and intimidation and ensure the safety of prisoners. Any injuries displayed by prisoners (on admission or following a violent incident) should be recorded in a detailed and comprehensive manner** (see *Healthcare* section, *Recording of injuries*). **The CPT requests an update on the measures taken**.

65. Turning to the regulatory and legal framework underpinning the prisoner complaints system, notably the Category A complaint procedure and external investigation procedure, these were outlined in detail in the CPT's previous visit report of 2019.[28] While a review of the complaints policy was ongoing at the time of this visit (and had not yet been finalised at the time of the visit, and existed in two draft models), the Committee noted that the actual situation in prisons had not changed, despite longstanding CPT recommendations in this regard.

66. In the prisons visited, the delegation found that not all incidents of inter-prisoner violence were properly recorded and investigated in a timely fashion. Crucially, Category A complaints relating to alleged staff abuse were still not being investigated sufficiently *promptly*. The CPT noted that external investigators often only initiated the investigation three or often several more months after a complaint was made, even in the case of the most extreme Category A complaints. Further, some investigations seen by the delegation were noted as *pending* many months after the date of the incident, which was all the more concerning as this was evident even in the most severe cases (see above).[29]

28. See the CPT's 2019 Visit Report on *Complaints*, Section B; CPT/Inf (2020) 37.
29. Out of the 10 Category A prisoner complaints made in 2023 at Cloverhill Prison, four were still pending at the date of the CPT visit in May 2024.

67. By way of illustration, **Prisoner 5**, a prisoner held at **Cloverhill Prison**, submitted a Category A complaint on 6 August 2023 concerning an allegation of a prison officer meting out severe physical abuse against him (shoe placed on Prisoner 5's neck to choke him) and kicks made to Prisoner 5's head. As of the date of the CPT's visit in May 2024 (nine months later), the investigation was still pending.

68. The Committee was also not convinced that the *quality of investigations* of the external investigators (many of whom had professional and institutional links to the IPS) was sufficiently robust. By way of example, is the case of the investigation of **Prisoner 1** (see above), an investigation into alleged severe violence meted out against Prisoner 1 on 3 November 2023 at **Cloverhill Prison**, the investigation only concluded on 14 February 2024 that the C&R removal from the escort van was carried out by prison staff who did not have the requisite experience or the relevant training for C&R removal from escort vans. However, upon analysis of the same files and evidence concerning Prisoner 1's case, the CPT delegation noted that the investigation stopped short of establishing any causal links drawn between the actions/facts and the consequences for the victim. Also, the type or level of responsibility for the alleged perpetrator was not determined, nor the necessary measures to be taken to avoid such cases of excessive use of force or even torture of prisoners happening again in the future. The report did not draw any conclusion regarding the other members of the C&R team and the use of force in question, their involvement (or non-involvement) in this operation and the relevant responsibilities.

69. Generally, prisoners did not systematically receive *feedback* on their complaints, and thus did not know what the outcome was. It was unsurprising therefore that the delegation found that most prisoners interviewed, across all the prisons visited, had no faith in the complaints system. Many also feared reprisals for complaining.

70. Despite the existence of complaint boxes on the wings, it was often the case that complaint forms had to be sought from prison officers, which *per se* was a significant deterrent to any prisoner raising a complaint.

71. Moreover, as was the situation in 2019, it remains at the ultimate discretion of a prison governor to disagree with the investigator's findings and decide themselves whether to proceed or not with disciplinary proceedings against staff implicated (as evident in the documentation analysed at **Cloverhill Prison**).

72. Further, the CPT notes that Category A complaint investigations could (and sometimes did) terminate early, without conclusion or follow-up, if the relevant prisoner had moved out of the respective prison or was non-contactable. **The CPT recommends that, in the interest of justice, once a Category A investigation has been opened it should be continued even if the prisoner has moved out of the prison or has become non-contactable.**

73. In sum, the deficiencies in the complaints system regarding allegations pertaining to core issues of safety, notably ill-treatment and abuse of prisoners by prison staff, have not been addressed since the CPT's recommendations set out in its 2019 report.

74. As mentioned above, the CPT acknowledges that a new model of complaints was, at the time of this visit, in the process of being drawn up by the IPS. **The Committee requests a detailed update from the Irish authorities on the finalisation of the complaints system review process and its outcome. The Committee trusts that the basic principles surrounding complaints mechanisms as laid out in the 27th General Report of the CPT[30] have been taken into account in the designing of the new system.**

75. **The CPT reiterates its recommendation that the Irish authorities invest in the necessary resources to ensure that the new prisoner complaints system is fair, efficient and effective. To this end, sufficient training must be provided to all the actors concerned and clear information about the system provided to prisoners.**

30. 27th General Report of the CPT: CPT/Inf (2018) 4.

4. Deaths in custody

76. The CPT's mandate is not limited to assessing the ill-treatment of persons deprived of their liberty which may have been inflicted by prison staff. The Committee is also concerned with examining the discharge of the duty of care that is owed by the prison authorities to prisoners in their charge, which includes the responsibility not only to keep them safe, but also to proactively protect their lives, as required under the positive obligation enshrined in Article 2 of the ECHR. Seriously ill prisoners who die while being held in prison custody and who may have otherwise been saved also fall into this safety category.

77. The Committee is deeply concerned about a number of recent deaths in Irish prisons and the *insufficiently prompt reviews*, as well as the *lack of lessons learned* procedures at local prison level.

78. At **Limerick** and **Cloverhill Prisons**, several deaths had occurred in recent years, a number of which were, in the Committee's medical experts' view, preventable.

79. At both these prisons, no meaningful review, in particular no *detailed* critical incident review, had been undertaken at prison level in respect of the circumstances leading up to the persons' deaths. In some cases, deaths occurred subsequently in similar circumstances, which might have been prevented had lessons been learnt sooner. This was notably the case regarding the deaths of prisoners who were suspected of concealing drugs internally either through ingestion or secretion ("body packers") and the systemic lack of immediate formal management or care plans provided for these prisoners.

80. The CPT considers that persons entering prison suspected of having ingested or secreted drugs within their body should not be placed in an observation or special regime cell (such as a Close Supervision Cell in the Irish context) under the observation of prison officers. As there is always a risk that the receptacle in which the drugs are placed may burst with potentially life-threatening consequences, it is good practice for the persons concerned to be placed under medical observation in hospital rather than being kept in prison.

81. Further, the CPT considers that where a prisoner is suspected of having ingested drugs, diagnostic imaging is the most effective means of determining whether this is indeed the case.

82. The Committee wishes to share several cases, which it considers are illustrative of its key concerns. These may well be indicative of systemic issues affecting a range of prisons visited by the CPT.

First are the cases of **Prisoners A.A.** and **B.B.**, who died in 2020 and 2023 respectively. Both men died in, or just after, being held in the CSC cells at **Limerick Prison**. Second, are the cases of **Prisoners C.C.** and **D.D.**, who died in 2021 and 2022 respectively. Both these men died in the CSC cells at **Cloverhill Prison**. Three of these men had been held on suspicion of concealing drugs in their bodies.

83. **Prisoner A.A.** was found dead in his cell in the morning of 19 July 2020 at **Limerick Prison**. He had been placed in the **CSC** from 2 July to 5 July on suspicion of concealing drugs internally. He was reviewed by the prison doctor daily while in the CSC cell and was noted to be "drowsy".

He was then transferred out of the CSC to a separation cell on D wing and was next reviewed by the prison doctor on 10 July, when the doctor wrote that he was still under the influence of drugs. Thereafter, he was reviewed on 16 and on 18 July by the doctor. He was found dead at 07:18 on 19 July 2020.

A review of the medical file by the delegation's medical experts showed that the prison doctor noted that, on 16 July 2020, Prisoner A.A. remained very drowsy and unsteady. On 18 July, the prison doctor noted that he was alert but mumbling and advised nursing staff that if he deteriorated he should be transferred to the closest hospital's Accident & Emergency (A&E) Unit . Later that same day, nursing staff noted that A.A. had been incontinent of urine and that he appeared to be having visual hallucinations, was not drinking, was lying in his bed and was talking to himself. He was not

engaging with staff. Nursing staff noted that the skin turgor was poor, which corresponded with dehydration, and he was talking nonsensically. Although Prisoner A.A. was seen by nursing staff on at least five occasions on 18 July (because he was seriously ill), he was not taken to hospital.

Further, the statement of prison officers concerned stated that, on the evening of 18 July, officers had "checked" Prisoner A.A. However, on no occasion between 19:15 and 07:00 had they engaged with him verbally. Indeed, one officer stated that while initially he had been lying across the head of his bed with his two legs on the floor, thereafter he had been found lying on the floor, but again the CPT notes that the prison officer on duty did not attempt to speak with him.

Prisoner A.A. died in the early hours of 19 July and, when seen by the nurse on the morning of 19 July, "rigor mortis of the jaw and facial area and mottled skin together with pooling of blood to the body" was noted, indicating that Prisoner A.A. had been dead for some hours prior to being discovered by prison staff.

The oral report of the autopsy included that two packages of drugs and a mobile phone had been recovered from Prisoner A.A.'s body.

84. Of concern to the Committee is that Prisoner A.A. was suspected of concealing drugs internally when he was admitted to Limerick Prison, but there was no management plan put in place for him other than a relocation to a CSC, where he was observed for a few days, and thereafter was placed in a normal cell on D1 Wing. Advice had been given by the doctor, on 18 July, that if Prisoner A.A.'s health deteriorated then he should be sent to A&E, and although his health did deteriorate, he was not transferred to hospital.

85. The CPT delegation was surprised to find that, at the time of the delegation's visit in May 2024, the Limerick Prison management had made no effort to read and be informed by the contents of the local relevant Death in Custody file,[31] given that they considered that the investigation of deaths was the joint responsibility of only the OIP and the Coroner.

86. Moreover, the CPT takes note that, while Prisoner A.A. died in July 2020, the report of the OIP was published only on 31 May 2024. The CPT found that no opportunity, at local prison level, had been taken over four years to identify any learning points subsequent to his death. Indeed had there been such, then lessons could have readily been learned in 2020 concerning persons suspected of concealing drugs internally, which might have contributed to preventing further deaths in Irish prisons. Such delays in review and learnings at local prison level are, in the Committee's view, unacceptable.

87. **Prisoner B.B.** was found dead at 06:15 in a **CSC** in **Limerick Prison** on 12 January 2023. He too had been placed in a CSC on account of being suspected of concealing contraband. While he had been placed in a CSC, on 9 January, he was not seen by a doctor until 11 January (although he was reviewed by a nurse on a daily basis).

In the relevant records and documentation, there is a statement of one of the prison officers, which included that she had checked Prisoner B.B. at 06:00 and 06:15 on 12 January 2023 and found him dead at 06:15. However, the CPT delegation's review of the CSC book showed that the observations had also been ticked for 06:30 and 06:45 on the same day and then attempts had been made to delete these entries.

The entries in the CSC books (and the Safety Observation Cell (SOC) books) require staff to tick "asleep, awake, agitated or passive". A criticism by the CPT during previous visits to Ireland was that prison staff were ticking a series of nightly checks in advance, stating (falsely) that observations had been made, when they had not been. A prison officer had ticked that Prisoner B.B. had been observed asleep at both 06:30 and 06:45 while he had in fact been found dead at 06:15. Attempts had been made to delete the 06:30 and 06:45 entries. The CPT considers that this falsification of records brings into question the whole integrity of the system of observing and recording vulnerable prisoners placed either in a CSC or a SOC.

31. Despite a meeting with the OIP inspectors reviewing this case. The case of "Mr. I" - Date of death: 19 July 2020; OIP investigation report publication on 31 May 2024.

88. Again, the CPT delegation was surprised to find that, at the time of the delegation's visit in May 2024, the Limerick Prison management was also not aware of the contents of the "death in custody" file and no investigation had been concluded regarding this death. The CPT considers that no opportunity, at local prison level, had been taken to identify any learning points subsequent to this death and, given the delays in the investigation into the death of Prisoner B.B., lessons could have readily been learned in 2020 concerning persons suspected of concealing drugs internally, which might have contributed to preventing his death.

89. **Prisoner C.C.** was found dead at in his **CSC** cell at **Cloverhill Prison** in the early morning of 27 April 2021, where he had been placed the day before on the suspicion of internally concealing contraband. He had not been reviewed by healthcare staff.

Here again, the Committee had serious reservations as to the integrity of the prison's records. A review of the CSC logbook shows that the "asleep" box was ticked for Prisoner C.C. on the 15-minute checks between 21:10 on 26 April 2021 and 08:30 on 27 April 2021. There is a statement, however, from another prison officer stating that between 21:00 and 02:00 he had attended Prisoner C.C.'s cell due to several activations of Prisoner C.C.'s call-bell.

The Committee finds it incongruous that one prison officer can set out that he attended a cell several times during the night and yet another prison officer records in the CSC book that every 15 minutes during the night the prisoner was checked and was asleep.

Prisoner C.C. was found dead in his cell during the unlock in the morning (as was the case with Prisoners A.A. and B.B.) and rigor mortis was noted to be established, clearly indicating that he had been dead for some time before he was found.

The CPT notes that, in the local Critical Incident Review, the prison doctor suggested the possibility of a policy being developed for persons suspected of concealing drugs internally. In response, the Cloverhill Prison Director had indeed developed a local policy to regulate how persons suspected of concealing drugs internally should be treated, including being placed in the CSC, but that they should be checked by a nurse every hour. This, however, was not complied with systematically in practice, as seen in later cases.

90. **Prisoner D.D.** was found dead on 10 August 2022 in a **CSC** cell at **Cloverhill Prison**. D.D. had a history of mental health problems and was seen by the psychiatrist and the mental health nurse the day after his admission (five days before he died). The delegation's review of the relevant registers indicates that that he was, in all likelihood, placed in a CSC because he was mentally ill, rather than because he had been disruptive in the prison.

On arrival on 5 August 2022, the prison doctor observed that he was psychotic. He was checked by the doctor and nurse over the next few days and was often sleeping and appeared reluctant to engage with them. On 9 August 2022, the nurse noted that Prisoner D.D. had refrained from eating for one day and that prison staff were unaware whether he was drinking any fluids. She requested a review by the prison doctor. The CSC register sets out that Prisoner D.D. ate breakfast on 8 August but had nothing to eat or drink thereafter (that is, he had not consumed any food or water in the 48 hours prior to his death on 10 August).

<u>The Committee is deeply concerned that a man, who was clearly mentally ill, was placed in a CSC, was noted not to be drinking or eating in the 48 hours prior to when he was found dead in his cell, and yet no action plan was put in place for his care during that period.</u>

91. Further, while Prisoner D.D. was found dead in his cell at 06:55 on 10 August 2022, the CSC logbook contained entries that he had been checked at 07:00, 07:15 and 07:30 on the same day; these entries clearly having been made in advance of him having been found dead. As mentioned above, the CPT is deeply troubled by the falsification of records by prison officers within the CSC books and that this issue appears to be a recurring feature across the prison estate which the IPS has still not addressed.[32]

32. Despite this issue having previously been identified by the CPT in its 2019 report in respect of deaths in custody.

92. Overall, the Committee considers that all four cases illustrate various similarities including:

- in all four cases, the deceased prisoners were found at morning unlock around 06:00-07:30 at the time of the staff shift handover or shortly beforehand, when rigour mortis shows that they had died many hours before, during the night;
- in some of these cases the prison officers, in two different prisons visited by the CPT, had falsified the recorded checks, ticking boxes, and then trying to delete entries made in advance, despite the prisoner already being dead;
- three of the four cases were linked to the suspected swallowing or internal secreting of packages of drugs yet, despite this suspicion, no care or management plan was put in place to provide for the men's safety, apart from placement in a CSC;
- these cases included young mentally ill and/or physically ill prisoners, where no action had been taken to formulate a care plan to address their immediate critical needs and where, despite medical needs, they were still put in a non-medical CSC cell, contrary to the SOP governing the use of SOCs and CSCs;
- none of the cases had an autopsy report included in the file kept at local prison level, which would be key to prison management's proper understanding of the certified cause of the deaths and contributing to a more robust lessons-learnt approach; and
- as these prisoners were held in a CSC, the 15-minute checks were regulated by the Irish prison regulations' relevant SOP. This requires only that prison custodial staff (that is, not medical staff) check every 15 minute for observations.
  Further, such checks were systematically done through the key hole/ small glass panel on door, rather than being physical checks. Had there been physical checks, help could have been provided more promptly and maybe some of them could have been saved.

93. At the end of the visit, the CPT delegation invoked article 8, paragraph 5, of the Convention establishing the CPT, requesting that the IPS immediately establish a system of meaningful critical incident reviews at local prison level into the circumstances regarding deaths in custody. These reviews should be initiated within a maximum of one week of the person's death, to review and identify the lessons to be learned, which can contribute to establishing safeguards and preventing further deaths.

94. The Irish authorities responded, on 12 July 2024, underlining that the IPS was committed to strengthening the review process for deaths in custody. It was reviewing the current systems to consider additional processes, to be provided by the Central Risk team and formalising their role in critical incident meetings in each prison to ensure a consistent approach nationally. The process will consider more central coordination to support the examination of circumstances surrounding an incident; documentation of the findings of the review including the lessons learned and identification of systems and/or processes that worked well and what areas that require review and amendment; and drafting risk review reports to mitigate against the risks arising.[33]

95. The CPT welcomes these undertakings by the Irish authorities. Nevertheless, given the gravity of the situation, and in light of considerations about the protection of the right to life and the obligations arising under ECHR Article 2 and the Irish authorities' positive duty to keep prisoners in their custody safe, the CPT remains particularly concerned about the management of those prisoners suspected of concealing drugs internally in Irish prisons, which seems exclusively, initially at least, to rely on placement in a CSC without any care plan.

96. Given this, **the CPT recommends that the Irish authorities ensure :**

- **that an update is provided to the Committee on the specific timeframe and dates of the measures taken on the review of the management and regulation**

33. The response of the Irish authorities, dated 12 July 2024, also stated that the IPS was recruiting a Clinical Governance and Risk Manager to support the delivery of clinical services in the areas of clinical quality, prisoner safety and risk management and will assist continuous improvement in the quality of care and service delivery to prisoners, and that best practice and agreed national and international standards of compliance are adhered to at all times.

of the treatment of persons suspected to have ingested or concealed drugs within their body, along with confirmation of the operation of a more detailed and multi-disciplinary system of immediate, local (prison management) level, critical incident review and lesson-learnt policy;

- **that a clear policy and comprehensive procedure is introduced on the identification of the causes of death of detained persons – including when the death occurs in (or on the way to) hospital.**
- **that a thorough and prompt investigation is carried out into every death in prison by an authority independent of the prison system to ascertain, inter alia, the cause of death, the facts leading up to the death, including any contributing factors, and whether the death might have been prevented. Further, whenever a person dies in prison (or soon after transfer from prison), an autopsy should be carried out and the prison's management and medical services should be informed of the content of any autopsy report outcome, in particular with a view to ascertaining whether there are lessons to be learned as regards operating procedures in respect of future similar episodes;**
- **inclusion of a copy of the autopsy reports in the files kept at local prison level, so that prison management can fully learn the lessons from a death and the certified cause;**
- **that while there may be highly exceptional cases in which, as prescribed by law, an independent authority may decide that an autopsy is not required. In this context, the prison administration should also take proactive measures to become a requesting party for all autopsies undertaken in respect of prisoners;**
- **an analysis should be undertaken of each death in prison to consider what general lessons may be learned for the prison in which the death occurred and whether in the case of self-inflicted death there are any systemic, nationwide measures that need to be taken. and the sharing of lessons learnt at national level;**
- **that a care plan is put in place for those prisoners who are mentally or physically ill, instead of being placed in a CSC, and ensuring swift transfer to hospital when needed;**
- **awareness raising among prison staff on the use of CSCs, the importance of the proper observation checks; and**
- **sanctions should be established for any falsification of records.**

5. Restricted regimes

97. In Ireland, there are several reasons for the significant use of restrictive regimes, the main being gang culture which has long posed a challenge for Irish society. This has also had systemic effects on the management of gang members and protection regimes in the prison system, most notably at Limerick but also Cloverhill Prisons. Many of the prisons visited by the delegation had large portions of their populations held under various protective regimes. Although these achieve their objective in terms of safety, they often entail lengthy periods when prisoners must spend most of the day locked in their cells.

98. The CPT acknowledges that providing a meaningful regime for prisoners who state that they cannot associate with prisoners on an ordinary landing, and who are often confined to associating with only a small number of other prisoners, is a significant burden on prison management and IPS resources. This is compounded by the sheer number of prisoners in the Irish prison estate needing protection, and puts a massive strain on the prison system as a whole. The CPT takes due note of the continued efforts of the Irish authorities in this regard.

99. A focus of previous CPT visits was the situation of prisoners placed on a restricted regime, whether as a security measure (Prison Rule 62) or for reasons of protection (Prison Rule 63).[34] One objective of the 2024 visit was to assess the implementation of the previous recommendations made in this respect. The CPT wished to observe how local and national prison management were

34. The regulation and background context is outlined in detail in the CPT's two previous Visit Reports of 2014 and 2019.

balancing the need to protect prisoners through the use of restricted regimes for reasons of safety, with the need to ensure that these regimes are not used excessively or abusively, all while assuring that prisoners are treated decently, with access to a sufficient regime and adequate living conditions.

a. Prisoners on protection – Rule 63 (voluntary and involuntary)

100. Rule 63 of the Prison Rules provides that a prisoner may, either at their own request or when the Governor considers it necessary, be kept separate from other prisoners who are reasonably likely to cause them significant harm.

101. As regards the time allowed unlocked from their cells, a key difference between the two rules in practice was that a Rule 62 regime entailed, in theory, one to two hours unlocked from the prisoner's cell (that is, 22-23 hours lock-up per day) while Rule 63 entailed 3 hours unlocked from cell (that is, 21 hours lock up per day).

102. In 2019, there were approximately 325 (some 10%) prisoners on 21-hour lock-up, the vast majority having chosen voluntarily to go on protection. Nevertheless, at the time of the 2024 visit, this number had increased to 596 prisoners (some 12% of the entire Irish prison population), with approximately 566 prisoners recorded as being on voluntary Rule 63 lock-up and 30 prisoners on involuntary Rule 63 restricted regime lock-up (see below).

103. Equally, prisoners held on restricted regimes spent longer, in general, on these regimes than they had done in 2019 and the length of time spent was steadily increasing.[35] In the Irish prison estate as a whole, at the time of the visit, 472 prisoners (nearly 10% of the entire prison population) had spent over 21 days within this restricted regime, with many staying over one year.

104. Regimes for these prisoners remained impoverished. Prisoners in almost all prisons visited (with the positive exception of the **Dóchas Centre**) had very little access to work or education. In practice, they were unlocked for two to three hours (and in some cases only one hour),[36] to access the shower, pace the yard (for one hour) and quickly collect their food.

They also had access to weekly (only fully-screened) visits (see *Contact with the outside world* section). Very little else was provided to them to compensate for lack of access to meaningful work or organised activities.

105. At **Limerick Prison (male and female)**, there were 103 protection prisoners (approximately a third of the prison population) spread around the prison. In practice, these prisoners were offered one hour on the landing (during which time they had to clean their cells, make a phone call and have a shower) and one hour of outdoor exercise or use of limited gym equipment on the landing. They were not offered any activities, whether through the main prison school education, access to the main gym or any work placements. Conditions in many of the cells were extremely poor, most notably in D2 and D1 (see *Material Conditions* section).

106. The most impoverished regime was in the dungeon-like high protection unit of D1 of Limerick Prison. The CPT was particularly concerned about a few prisoners who were being held alone in their cells for 22 hours or more a day and hence were in a situation of *de facto* solitary confinement. The delegation was particularly struck by the situation of a transgender woman Rule 63 prisoner, held on D1 at Limerick male Prison, who was living in squalid conditions with minimal access to natural light and ventilation, and poor and inappropriate material conditions and regime, on 23 hour lock-up.

107. At the end of the visit, the CPT delegation made an immediate observation under Article 8, paragraph 5, of the Convention, requesting that the Irish authorities ensure that the transgender woman Rule 63 prisoner (Prisoner X), located on D1 at Limerick male Prison, be offered

35. For example, in information provided to the CPT by the IPS, on 19 April 2022, 386 prisoners were on voluntary R.63 regimes in the Irish prison estate, and on the same date in 2024, 566 prisoners were on restricted regimes.
36. Limerick D1 and Cloverhill D1 and D2 Units.

a meaningful regime of activities, more out-of-cell time and be placed in another cell with better material conditions. Further, steps should be taken to immediately refurbish this cell and others on D1 Unit at Limerick male Prison.

108. The Irish authorities replied, by letter of 12 July 2024, outlining various measures undertaken in response to the CPT's preliminary observations, including a pending IPS assessment of the conditions of D1 Unit with a view to remedial works, and the availability of a gym on the landing, solely for the use of prisoners on D1. However, a response to the immediate measures recommended by the CPT for Prisoner X specifically was not included and is thus still outstanding. **The CPT recommends that the IPS and Limerick Prison offer Prisoner X, along with all the prisoners held on D1, a meaningful regime of purposeful regular activities and much more out-of-cell time and a transfer to another location within the prison offering adequate living conditions.**

109. At **Castlerea Prison**, 52 prisoners were accommodated under the Rule 63 protection scheme. Twenty-six were housed in the B1 division of the prison, 26 in the B2 division. In B1, these prisoners had more out of cell time than the persons detained in the B2 division.[37] Nevertheless, some of the prisoners interviewed by the delegation were locked up for 22-23 hours per day, some for years on end, depending on the length of their sentence. They were offered one hour of outside yard time. Many prisoners were held in dark cells with insufficient access to natural light (see *Conditions* section). The regime of those prisoners was particularly deplorable, there was a lack of any other activities offered besides the gym once per week and of any reintegration measures and preparation for release. These conditions and regime affected their mental health negatively.

110. At **Cloverhill Prison**, some of the most vulnerable prisoners, including those with mental health concerns requiring protection from other prisoners were held on Rule 63 on the C1 and C2 Units, as well as the D2 Unit. These prisoners could only associate with their other cell mates and could not associate together on the landing. In practice, prisoners were locked up for some 22 to 23 hours per day, were offered access of one hour to the yard, and a quick shower daily. No purposeful activities were offered, and there was no access to the main gym or a library. They rapidly collected meals (breakfast, lunch and tea) and ate these from their laps in the cells, given the insufficient number of tables and chairs. They ate their meals by the unscreened toilets. Many prisoners interviewed stated that the heat and the smell repelled them from their food.

111. This degrading regime was exacerbated by the fact that some of these cells were in a squalid condition, hot, unventilated, with an open (unscreened) toilet, and were shared with up to three other men, including with mattresses on the floor (see *Material Conditions* section). Taken together, this situation, in the Committee's view, may well be described as inhuman and degrading treatment.

112. Positively, in contrast to the above, at the **Dóchas Centre,** protection prisoners were unlocked from their cells for the vast majority of the day, had access to a range of activities and education and, in fact, had some of the better material living conditions of the prison (see *Women prisoners* section). This is a positive development.

113. Nonetheless, as regards incentives and levels of privilege, the Committee notes that, as was the case in 2019, overall, all prisoners who asked to go on protection were automatically placed on the "Basic" level of the Incentives and Earned Privileges (IEP) scheme. This meant that they were able to make only three phone calls of six minutes per week, and to have a visit of half an hour to one hour every second week (that is, half the entitlement of the "Standard" level of the IEP) and in **Limerick Prison** (only), these were closed/screened visits only, with no contact allowed.

114. The Committee recalls that progression or regression from one regime level to another should be based on the behaviour of each individual prisoner, as well as on their participation in activities. However, prisoners on protection who have not committed any disciplinary offence, but are unable to access activities due to their protection status, should not be *de facto* punished by being placed on the basic level of the incentivised regime system. **The CPT recommends that prisoners on**

37. The reason for this difference being that persons convicted of sex offences could not be mixed with other detained persons, whereas those accommodated in B1 could only mix in specific groups.

protection, who have not committed any disciplinary offence, should not be de facto punished by being placed on a basic regime.

115. Moreover, it also recalls that it is crucial for prisoners to be able to maintain good contact with the outside world and have open contact visits, unless there are risk assessments indicating to the contrary. This is all the more so for prisoners on protection who may have a greater need to maintain contact with family and friends, since they cannot have any safe contact with other prisoners. **The CPT reiterates its recommendation that the Irish authorities significantly increase the length of time allowed on the telephone for all prisoners, as this is an essential part of prisoners well-being and has a clear role in helping reintegration efforts back into the community upon release.**[38]

116. Further, the CPT recalls that confinement to a cell for 21 or 22 (or even 23 plus) hours per day may have an extremely damaging effect on the mental, somatic and social health of the prisoner. Therefore, while pursuing their goal of ensuring that all prisoners can serve their sentences under safe conditions, the Irish authorities should minimise the negative effects of such segregation, especially where it continues for more than a few weeks (as in the majority of cases). Additional measures must be taken in order to provide them with appropriate conditions and treatment; access to activities, educational courses and sport should be feasible. **The CPT underlined the need for change in 2019 and was disappointed to find a similar situation in 2024 in these respects.**

117. **The CPT reiterates its recommendation that the Irish authorities pursue their efforts to provide prisoners on protection for more than a short period (notably in Cloverhill, Castlerea, Mountjoy HSU, Limerick) with a range of purposeful activities, taking into consideration the above remarks.**

118. **Further, it reiterates its recommendation that all prisoners on protection be offered one hour a week of visits, under open conditions, unless a risk assessment indicates otherwise.**

Overall, the CPT remains deeply concerned about the high number of prisoners held under increasingly long, restricted and poor regimes, often in poor conditions, and **calls upon the Irish authorities to ensure the full implementation of its repeated recommendations made on this matter.**

Lastly, the CPT was concerned that there had been a notable increase, at the time of the CPT visit, in the application of Rule 63 for involuntary protection (imposed by the prison following a security assessment), as well as in its duration, including for those held for up to a year under this measure.[39] Moreover, the CPT noticed that staff were not always aware of the difference between Rule 62 (see below) and involuntary Rule 63. For example, in **Limerick Prison**, prisoners were listed as being on both – with senior management unaware of precise numbers on Rule 62.[40] **The Committee trusts that the IPS will remain vigilant in ensuring that the grounds used for involuntary Rule 63 do not *de facto* replace Rule 62. Further, it recommends that a review of the use of involuntary Rule 63 is undertaken on a regular basis.**

38. See the CPT's 21st General Report (https://rm.coe.int/1680696a88).
39. 12 on involuntary Rule 63 in 2022 and 18 in 2024. In 2022, only one prisoner had been held under this rule involuntarily for between 201-364 days, in 2024, this had increased to five prisoners being held for between 201 and 364 days.
40. Prison management and IPS records stated that there were none, but local prison paper records stated that there were 12 at the time of the delegation's visit, with several prisoners on a dual Rule 62 and 63.

b. Prisoners segregated for good order (Rule 62)

119. Rule 62 of the Prison Rules provides for a Governor to remove a prisoner from structured activity or association on grounds of maintenance of good order or safe or secure custody. The procedural regulation, the obligatory regular observations, timeframes and reviews of Rule 62 remained as seen in 2019.[41]

120. In the course of the visit, the delegation examined the situation of prisoners placed on Rule 62 and visited the specific units where they were accommodated. Positively, overall data provided by the IPS appeared to suggest a significant reduction of the use of Rule 62 since 2019 and the CPT was informed that 10 persons were being held on Rule 62 in Irish prisons[42] at the time of the visit, and generally for shorter periods than in 2019.[43] The IPS informed the CPT that no prisoners were recorded as being on 23 hour lock-up.

121. Nevertheless, at the time of the CPT visits to various prisons, the delegation found that in reality there were at least 26 prisoners held on Rule 62: eight persons in **Cloverhill Prison,** two persons[44] in the **Dóchas Centre,** and 16 persons in **Limerick Prison** (12 men and four women).[45]

122. The different data found in the local paper records as compared with the electronic IPS central records was of concern to the CPT. **The CPT recommends that the Irish authorities initiate a review of the quality and accuracy of the different databases, as well as the broader sharing of Rule 62 data across the whole Irish prison estate, to ensure greater transparency and accuracy, and to enable ready access to an overview of the situation.**

123. At the **Dóchas Centre**, data showed that Rule 62 was rarely used and, when it was, reviews were frequent and, where relevant, care plans were put in place. Nonetheless, the rationale for its use was broad, rather ambiguous and often consisted of "operational reasons" only.

124. At **Cloverhill Prison**, the eight Rule 62 prisoners were held on Wing D1 in cells designed for single or, maximum, double-occupancy. In practice, up to four prisoners had been squeezed into a cell measuring some 11 m^2, including the toilet, with three beds and a thin foam plastic mattress on the floor that was rolled under a bed during the day. Three prisoners were on Rule 62 and one on Rule 63. They were offered between one and one and a half hours a day of access to a large outdoor yard, and thirty minutes out of their cells to shower, clean the cell and collect their food (see *Material Conditions* section).

125. At Cloverhill Prison, weekly reviews did happen with a multi-disciplinary team, however, in practice, the prisoners involved stated that these reviews were a rubber-stamping exercise and that some of them were unaware of the reasons why they had been placed on D1 Unit on a restricted regime, or what could justify their extensions on this restricted regime. Others complained that reviews could merely lead to their Rule 62 being converted into a Rule 63 or vice-versa, again with no reason given or with no scheduled time limit.

At the time of the CPT visit, some of these prisoners had been on Rule 62 in these conditions for over 20 days and did not know for how much longer they would be kept on such a restricted regime.

41. The order must be reviewed at least every seven days and the prisoner must be provided with reasons in writing. The doctor and chaplain are informed immediately. If the order is to continue beyond 21 days, the Governor must inform the Director General of Prisons and include any representations by the prisoner. Any extension thereafter must be authorised by the Director General in writing.
42. IPS provided information that on 19 April 2022 there were 10 prisoners on 21-to-24 hour lock-ups, this had increased to 21 in 2023 on the same date and decreased to 10 on 16 April 2024.
43. IPS provided data for April 2024 for numbers of prisoners held on Rule 62, including seven in Cloverhill Prison and one in each of Mountjoy male, Portlaoise and Wheatfield Prisons.
44. While general IPS electronic records showed no one on Rule 62, local paper records kept showed that two persons were held on Rule 62, at the time of the delegation's visit.
45. The CPT was informed that no persons were kept on Rule 62 by senior management and IPS data, but local paper records showed that in fact 16 persons were held on Rule 62 at the time of the CPT visit.

126. At **Limerick Prison**, the delegation interviewed several prisoners who had been held under Rule 62 and examined their documentation. The reasons given for this placement included "violent", "own safety", "non-cooperative", "disruptive", (the extremely ambiguous term of) "operational reasons" or "concealed contraband" (see also *Deaths in custody* section). There was an informal, mostly oral and ad hoc, approach at Limerick Prison, underlined by operational prison staff and prisoners alike. The CPT remains concerned that decisions on Rule 62 placements could be based upon information which was not fully and accurately documented, and result from local knowledge and a "gut feeling" decision.

127. The Committee recalls that the placement of a prisoner on Rule 62 should also be viewed as an opportunity to engage more intensively with that prisoner to see whether the underlying causes of their behaviour can be addressed. Prisoners should be provided with a tailored programme of purposeful activities of a varied nature, drawn up and reviewed on the basis of an individualised needs/risk assessment by a multi-disciplinary team in consultation with the prisoners concerned. Interaction between prisoners should be the norm. Conditions akin to solitary confinement should only be used when absolutely unavoidable, in order to deal with a person who is assessed as acutely dangerous to others, and for the shortest period necessary.

128. Overall, the regime and conditions for prisoners held on Rule 62 often differed very little in practice from those held on a restrictive Rule 63. Many Rule 62 and 63 prisoners were kept along the same wing corridors and some in the same cells. In fact, some of the prisoners were on a "dual" Rule 62 and Rule 63 and did not know the difference, other than the fact that Rule 62s tended to get around one and a half hours out of the cell, rather than the three hours out of their cells allowed for most Rule 63 prisoners.

129. Moreover, on this visit, the Committee found that while the use of Rule 62 (a security measure) had decreased, local prison management particularly favoured a risk averse approach, with many prisoners placed on Rule 63 protection measures almost by default. This was as a result of family ties, however distant, and remnant gang culture. Indeed, in 2024, the Committee notes that there had been an increase in the resort to these very restrictive regimes, which were applied for longer periods (months and, in some cases, years), to a considerable portion of the Irish prison population (for example, in Cloverhill Prison almost a third of all prisoners were on some form of protective regime at the time of the CPT visit). This appeared to affect more the male prisoner population and was most notable in Limerick and Cloverhill Prisons

130. **The CPT reiterates its recommendation that the Irish authorities improve the regime on offer to prisoners held under Rule 62 in light of the above remarks.**

131. In previous reports,[46] the CPT found that there was insufficient oversight of the placement and review procedures for keeping a prisoner on Rule 62; official forms provided little information to justify the initial placement or the seven-day extensions made by the Governor. Moreover, the 21-day reviews carried out by the Director General (DG) of Prisons appeared to be little more than a rubber-stamping exercise. During this visit, while oversight varied and was sometimes inconsistent, and also varied between the prisons visited, the CPT found that generally there had been an improvement in the governance of Rule 62. Nevertheless, the CPT notes that there remain inconsistencies in the recording, and the checks were not systematically thorough, with sometimes disastrous consequences (see *Deaths in Custody* below).

In light of this, **the CPT recommends that the Irish authorities continue to make efforts to strengthen the review process for all Rule 62 placement and extension decisions, with access to all the information necessary, and any updated information or new developments, to make an informed decision.**

The Committee also notes that several of its previous recommendations remain unimplemented in this regard, and it urges the Irish authorities to fully implement the recommendations listed above.

46. Visit reports of 2014 and 2019, paragraphs 60 to 107 and Part B section 4.

c. Special observation cells (Close Supervision Cells and Safety Observation Cells)

132. According to Rule 64 of the Prison Rules, a prisoner shall be accommodated in a special observation cell only if "it is necessary to prevent the prisoner from causing imminent injury to himself or herself, or others and all other less restrictive methods of control have been or would, in the opinion of the Governor, be inadequate in the circumstances". There are two types of special observation cell: Close Supervision Cells (CSC) and Safety Observation Cells (SOC).[47]

133. For too many years,[48] the Committee has been deeply concerned by the situation of prisoners placed in special observation cells and has urged the Irish authorities to clearly identify the purpose of such cells, and to ensure clear operating standards governing the placement of inmates therein. In 2019, new SOPs were introduced for both CSCs and SOCs regulating their use with frequent checks, timeframes specified, authorisations necessary for continued placement and recording required. At the time of the CPT visit in 2024, the SOPs were still not yet in force and remained under review.

134. The policies surrounding the rationale for use of SOCs regulate that they should only be used when a prisoner poses an immediate risk of serious harm to self and/or others arising from a *healthcare condition*. By consequence, the placement of a prisoner in a SOC is based on the healthcare risk assessment undertaken by a registered doctor or nurse, thus providing the clinical rationale for placement in an SOC. It became apparent, however, that in a number of instances where persons were placed in an SOC, this had been done at the behest of the governor rather than healthcare staff. This was particularly the case at **Cloverhill Prison**.

135. Further, the CPT considers that being mentally ill is not a reason *per se* to justify placement in a SOC; rather it must be a measure of last resort. However, the delegation found that SOCs were often used as a measure of first resort. The CPT delegation again found that there remained confusion among the prison staff as to the use of CSCs and SOCs. On this visit, the delegation found many instances in which mentally ill prisoners, when they posed no threat to themselves or to others, were being held in a CSC. Some rooms had interchangeable signs to put on the door to change the room from a CSC into an SOC and vice versa.

In fact, because of frequent reviews and changes between the status of a prisoner, at all prisons visited, a prisoner might be placed in a CSC for a variety of reasons from "disruptive" to "threatening self-harm" and "feeling suicidal" or simply for "operational reasons". Records showed that prisoners were at times moved to a SOC for operational reasons and to a CSC for medical reasons**. The CPT reiterates its previous recommendations that the Irish authorities ensure in their review and reform of the SOPs regulating the CSCs and SOCs, that the procedures and management of prisoners placed in such cells are clarified, and that the artificial distinction between the two types of cells is removed.**

136. Generally, the CSCs and SOCs in the prisons visited were of similar layout. Each measured approximately 8 to 11 m^2 and was equipped with a wipe-down plastic mattress, a plinth bed, a moulded table and chair, a TV in protective casing, a call bell and unscreened in-cell toilet. The windows were sealed and, while lighting was sufficient, there were often blocked vents and the rooms were frequently under ventilated (for example, in **Limerick Prison**).

Although the temperatures in the cells were monitored and recorded, almost every prisoner who had spent a night in a CSC complained that the air conditioning in the cell had been extremely cold and that, besides the thin rip-proof poncho, they were naked under a (standard prison issue) small, rip-proof cover (see below).

---

47. Close Supervision Cells (a category of special cell) are designed to accommodate prisoners who are a danger to others in the prison or who are disruptive and, in the opinion of management, need to be separated from other prisoners in order to maintain a safe and secure custodial environment.
48. Since 2010 and the CPT's visit to Ireland CPT/Inf (2011) 3, and see paragraphs 55 and 56 of CPT's 2019 Visit report CPT/Inf (2020) 37.

137. Prison logs showed that the temperatures in the CSCs could get as low as 16 degrees Celsius (**Cloverhill Prison**, for example). While there, the regime was non-existent; they were not offered any outdoor exercise or permitted to associate with any other prisoners and had only the minimal amount of phones calls permissible. Occasionally, it appeared that they were not offered a shower (even though it was usually located right outside the CSC/SOC).

138. **The CPT reiterates its recommendation that all prisoners placed in a CSC for longer than 24 hours be offered at least a daily shower and access to outside exercise. Further, staff should be attentive in ensuring that the CSCs and SOCs are not too cold at night and that prisoners are provided with sufficient blankets to keep warm**.

139. Turning to the lengths of time that prisoners were held in CSCs or SOCs, the CPT found that, in all of the prisons visited, generally, prisoner stays averaged between 24 and 48 hours, and occasionally ranged from three to five days.[49] CSCs have also occasionally been used as an overspill solution for ordinary accommodation and their use was therefore not subject to the same safeguards or recording oversight as required by Rule 64 of the Prison Regulations.

140. Furthermore, as the new SOPs on CSCs and SOCs were still under review at the time of the delegation's visit, the relevant SOPs in force still stated that "a prisoner's clothing, including underwear, may be removed, before the prisoner is accommodated in a CSC, where considered necessary by the Governor."

141. The CPT considers that as the placement in a CSC is supposedly for operational reasons (that is, security), *there is no rationale for stripping these prisoners naked and placing them in a poncho* and having staff observe them through a spyglass every 15 minutes. This appears to be a punitive measure (which is contrary to the stated policy in the SOPs) and is degrading for the prisoner. Nevertheless, this practice was frequent in **Cloverhill Prison** and only slightly less frequent at the **Dóchas Centre, Castlerea** and **Limerick Prisons**.

Given that placement in a CSC is meant to be for security or operational reasons, **the CPT calls upon the Irish authorities to stop the routine stripping naked of prisoners and placing them in a poncho in a CSC, as there is no systematic justification or rationale for this practice and considers that this may well amount to degrading treatment. This principle should be reflected in the new draft SOP regulating the use of CSCs.**

142. Further, the CPT has repeatedly recommended[50] that the Irish authorities ensure that there is no *routine* removal of a prisoner's clothing upon their placement in an SOC, and that there should be an amendment of the SOPs regulating SOCs to state that *only where there is a risk of suicide by the prisoner concerned* should their clothing be removed, and the prisoner provided with rip-proof bottoms and top. The CPT has long stressed that, after placing a prisoner in an SOC, rip-proof clothing should only be provided where necessary, after an individual risk assessment. However, during the 2024 visit, the delegation found, once again, that prisoners placed in a CSC or SOC at all the prisons visited routinely had all their clothing removed (including at times their underwear) and were provided with small, thin fabric, rip-proof ponchos.

The CPT calls upon the Irish authorities to stop the routine removal of a prisoner's clothing upon their placement in an SOC or a CSC, unless an individual risk assessment indicates otherwise. The new SOP should be clarified to state that only where there is a risk of suicide by the prisoner concerned should their clothing be removed, and the prisoner provided with rip-proof bottoms and top.

143. During this visit, the CPT found that the recording of data on the use of a CSC and an SOC both in the PIMS and in the paper logbooks was variable and often had inaccuracies. In certain of the prisons visited, notably **Cloverhill and Limerick male Prisons**, prisoners were frequently held in CSCs, yet the delegation found there was inconsistent recording of logs between the electronic PIMS records and the paper records, by a wide margin. Further, the recording of the use of a SOC

49. According to local prison logs examined by the delegation.
50. Paragraphs 58 and 59 of the CPT's 2019 Visit report CPT/Inf (2020) 37.

was often not complete (in particular dates were frequently missing). As was the case with the recording of Rules 62 and 63, there were also evident discrepancies between the local prison paper files and the PIMs electronic logs. **The CPT recommends that these be reviewed both centrally and locally, and rendered consistent.**

144. Reviews did occur regularly but, in the view of the CPT, they were of a short, superficial nature. However, the integrity of the data recorded in the 15-minute officer and management checks could not be systematically relied upon. The delegation found during its 2024 visit that recorded officer checks at both **Cloverhill** and **Limerick Prisons**, at night, had been falsified, and only came to light when the prisoner had been found dead in the morning in the CSC, yet no action had been taken locally by prison management to address this issue (see *Deaths in Custody* section). The Committee considers that that such practices can be considered as dangerous and poses a real threat to the prisoner's safety and **recommends that there be a wholesale review of the use of CSC policy and safeguards.**

145. It is also important that, given that placement in a SOC is a healthcare matter, a care plan should be drawn up for each placement, yet the CPT found no evidence of this being the systematic practice. Moreover, often, at all the prisons visited, healthcare checks were done through the cell-door spy glass only, which were superficial and which, in the CPT's view, contributed to a lack of care.

146. Turning to safeguards,[51] the delegation's review of various records showed that, in practice, the National Nurse Manager was not informed at the 96 hour point and there was often no review at 24 hours. However, generally, the Director General was being notified and authorisation given for continued placement after 120 hours.

147. **The CPT reiterates its recommendation that a care and treatment plan be drawn up for all prisoners accommodated in an SOC, and that such a plan should include being monitored directly by a psychiatric nurse (one to one). The door to the SOC should be left unlocked during the day, with ready access to a shower and outdoor exercise, and increased access to chaplaincy and psychology services.**

148. Overall, the CPT considers that the SOC system remains unfit for purpose for the management of those at risk of self-harm. It does not provide a care-oriented and therapeutic environment and, in many cases, only exacerbates the person's situation.

While policy work has been undertaken to review the use of these cells, and a new draft placement policy was underway for the SOCs , the CPT considers that the draft policy (SOP) on the use of SOCs remains insufficiently clear and **it recommends that the draft policy be revised in light of theabove comments.**

Moreover, the CPT reiterates its recommendation that the Irish authorities should ensure that the integrity of data relating to all procedures surrounding the placement and stay of prisoners in CSCs and SOCs is guaranteed in accordance with the revised SOPs.

6. Conditions of detention

a. general material conditions

149. The general layout of the prisons visited was described in detail in the CPT's previous reports and, unless otherwise stated below, has not substantially changed since. Nonetheless, the overcrowded nature of the prisons visited has put significant strain on the general wear and tear of the material conditions and the need for constant refurbishment.

51. If placed in an SOC, according to the policy, the placement should be reviewed every 24 hours and after 96 hours and the National Nurse Manager informed. After 120 hours the Director General of the Irish Prison Service should be informed and should authorise or otherwise continue the placement for a further 24 hours.

150. The CPT found that the living conditions in the prisons visited were variable. The accommodation in the prisons visited for the *general prison population* held on ordinary regimes, was generally of a reasonable standard for prisoners held in single occupancy cells. These were, however, exceptional, with most prisoners held in multiple-occupancy cells.

151. Significant refurbishment work has been undertaken in certain parts of the prisons visited, such as Cloverhill Prison D2 Unit and Units E and F, Limerick male Prison B and C Units and the semi-open unit of Castlerea Prison. Equally, in the women's prison estate, there had been significant infrastructural changes including the complete renovation of the Limerick female Prison (see below), and refurbishments of a couple of the Dóchas Centre's Houses (for example, Willow). These represent positive developments.

152. On the other hand, as the vast majority of cells in the Irish prison estate were originally designed as single-occupancy cells, and the conditions in the cells with double, triple[52] and quadruple[53] occupancy fell far below standard.

153. In particular, the multiple-occupancy cells did not have fully-partitioned sanitary annexes, some had mould on the ceilings, were dilapidated and dirty, with insufficient access to natural light due to obstructed windows and limited ventilation often caused by blocked or non-functional ventilation holes or security window mesh/grills (**Limerick male (C and D units), Cloverhill (D1 and B wing) and Castlerea Prisons**). These included cells in which the occupants spent some 21 hours per day locked in, under restricted regimes.

154. The majority of cells in all the prisons visited were being used for double, triple and occasionally quadruple occupancy. This was despite the fact that they measured only 9 to 11.5 m^2, including an only semi-partitioned toilet. As mentioned in the *Preliminary Remarks* section above, in these cells, prisoners were clearly not being offered 4 m^2 of living space each and in many cases, were only afforded 3 m^2 or even less. Overall, many prisoners had insufficient living space and were being held, at the time of the CPT visit, in extremely cramped conditions.

An illustration of the situation can be seen at **Cloverhill Prison**, on **Unit D1,** a wing accommodating vulnerable prisoners and/or those held on protection regimes of 21-to-23 hours lock-up per day. At the time of the visit, Cell D1-01, a cell measuring some 11 m^2, including the toilet, was accommodating four men, affording less than 3 m^2 of living space per person. There was one bunk bed and one single bed with a desk below, and one man (who was mentally ill) was sleeping on a mattress directly on the floor, which was kept on the floor under the desk during the day. There were no cupboards or lockers, but some boxes on the floor to store the men's belongings.

There was one chair for the four of them. The toilet was only partially screened, and was dirty and malodourous. The paint was peeling off the ceiling, floors and walls, the ventilation holes were blocked in the opaque window behind a grill, which provided little natural light. The room was stuffy and under-ventilated despite the presence of a mini-fan that had been provided by the prison.

155. This situation was exacerbated by the fact that the four men only left the cell to go to the unit's showers for five minutes, to quickly collect food and then return to their cell to eat it from their beds, and to have one hour of exercise in the bare concrete yard. While these men had access to visits (closed/screened only) and calls, there was no regime of structured meaningful activities, no library or gym access, or any other form of structured, purposeful activity provided. The men had nothing to do and spent their day watching television. Some of these men had been there for over 11 weeks.

156. One of the men held in cell D1-01, an older man in his 60s, who had medical respiratory and heart problems and complained to the delegation that he regularly struggled to breathe properly, arranging himself by the holes in the window to suck in the air, and had requested a respirator to help his breathing (which allegedly had been promised but which had apparently not been forthcoming).

52. Castlerea Prison (B unit), the Dóchas Centre (Laurel, Maple and Rowan Houses), Cloverhill Prison (Units A-C) and Limerick female Prison).
53. Cloverhill Prison (D1).

157. The fourth man was recognised by the prison's health services as being mentally ill and was visited by the mental health team, but still spent his day sleeping on the floor. The CPT considers that such treatment and conditions may well be considered inhuman and degrading.

158. The situation in D wing of Cloverhill Prison was not an anomaly. The delegation found that on Wing B-1, seven of the 22 cells, measuring some 11.5 m^2 (including the unscreened toilet) were housing four men, including one wedged onto a mattress on the floor, thus affording less than 2.9 m^2 of space per person for some 28 (40%) of the 70 men held on the wing.

159. It goes without saying that every prisoner who has to stay overnight in a prison should be provided with their own bed. At every prison visited, the CPT met prisoners who had spent several weeks on a mattress or a fragile foldaway camp bed on the floor. The situation had significantly deteriorated since the CPT's previous visit. Such situations should not occur. The CPT recognises the challenges besetting prison management when striving to keep prisoners safe along with a full regime, whilst fulfilling their safety obligation in respect of keeping incompatible groups of prisoners apart for protection and other reasons. This was complicated by the fact that, in some prisons (such as Cloverhill Prison), up to a third of prisoners were on protection regimes. Nevertheless, as this practice persists, it is incumbent upon the authorities to reduce the official capacities of the prison establishments affected, to promote alternatives to imprisonment and to guarantee every prisoner their own bed (see *Preliminary Remarks*).

160. Further, it is important to ensure that vulnerable prisoners are not forced to sleep on a mattress on the floor, as occurred at **Cloverhill Prison** and the **Dóchas Centre**, including severely mentally ill prisoners and pregnant prisoners (see *Women prisoners* section).

161. **The CPT reiterates its recommendation that urgent measures must now be taken to ensure that prisoners do not have to sleep on a mattress on the floor and that they are provided with their own bed. Vulnerable prisoners should never have to sleep on a mattress on the floor. The CPT wishes to be informed of the steps being taken to put an end to the practice of prisoners having to sleep on mattresses or camp-beds on the floor.**

162. **Further, the CPT reiterates its recommendation that at Limerick male Prison (Units C and D) , Cloverhill Prison (D1 Unit, and Units A, B and C), Castlerea (C Unit), Dóchas Centre (Laurel, Maple and Rowan Houses) a programme of ongoing maintenance and refurbishment be undertaken and that efforts be urgently made to ensure that cells of approximately 11 m^2 (including the sanitary facility) accommodate no more than two prisoners.**

In addition, as recommended since the Committee's first visit to Ireland, toilets in multiple-occupancy cells should be fully partitioned up to the ceiling.

Finally, the CPT again requests an update from the Irish authorities of the definition of the minimum capacity per person in the Irish prison estate.

163. Moreover, the Committee recalls its detailed standards on the minimum threshold for the decent treatment and conditions for prisoners[54] and **it recommends that all prisoners must have their own bed, personal locker, a living space with appropriate furniture, and benefit from heating, artificial and natural light, ventilation and access to outdoor exercise, as well as from sufficient personal living space.**

164. On a positive note, the new **Limerick female Prison** had been entirely modernised and renovated and opened in the Summer of 2023. This facility comprised a bright, airy, modern space for women prisoners. This is a welcome and positive development. The cells were sufficiently spacious, well lit, adequately furnished with built-in desks, shelving units and wardrobes and chairs. In-cell, fully-partitioned sanitation annexes and in-cell phones were also appreciated by the prisoners. The longer-sentenced women prisoners also had access to their own self-catering apartments with (non-operational, at the time of the CPT visit) kitchenettes.

54. See CPT/Inf(2021) 5-part; "A decency threshold for prisons – criteria for assessing conditions of detention", Extract from the 30th General Report of the CPT, published in 2021.

Equally, there were large, bright communal spaces, which were well decorated and spacious. A children's playground and a large, well-maintained garden was laid out with benches, gardens and terraces. However, the playground was non-operational at the time of the visit and was apparently permanently shut.

The whole unit has been designed around allowing light and space. A large, bright dining room and servery has been built, but this was not being used for communal dining and was only allowed for visits. Women prisoners instead had to pick up their meal and eat it in their cells. This is an inexplicable missed opportunity.

165. **The CPT recommends that the dining room at Limerick female prison, having been designed with a servery, should be used for communal dining for all prisoners, subject to individualised risk-assessment, that the playground be opened to children visiting their mothers and relatives and that the kitchenettes be put into use.**

166. A welcome development during this visit was that the food was universally appreciated by the prisoners with whom the delegation spoke across all the prisons visited; an unusual finding in an institutional setting and one to be commended. It helped contribute to a more positive environment.

Nevertheless, the final meal of the day "dinner/tea" continued to be served early at 16:30, which meant prisoners had to wait almost 16 hours before their next full meal, notwithstanding the ability to snack on packaged foodstuffs purchased from the prison shop. As raised in the previous report, the CPT considers that meals should be eaten communally. The small size of the cells in which prisoners have to eat their meals, combined with the available space in which such communal eating could be organised (for example, the **Dóchas Centre** and **Limerick female Prison**, among others), strengthen the case for such an approach. **The CPT urges the Irish authorities to create spaces, taking due account of individualised security risks, where prisoners can eat communally.**

As regards the furniture and storage available in cells, while there were shelves and cupboards in most of the cells in the female prison estate, in *all the male prisons* visited, there was little to no lockable space in the cells, so clothes had to be put in makeshift boxes under the bed or on open shelves, if there were any. Foldaway mattress and sheets were stored directly on the floor under the cell's bunk beds.

Across the prisons visited, although there were sufficient chairs and desks in single cells, in double, triple and quadruple-occupancy cells, most of the prisoners did not have their own chair and table, and had to eat their meals sitting on another prisoner's bed or on the floor.

A shortfall was identified in the provision of sufficient numbers of pillows, and many male prisoners complained that they did not have a pillow, most notably in **Limerick male** and **Cloverhill Prisons**. **The CPT recommends that the Irish authorities remedy the above mentioned deficiencies in material conditions.**

b. general regime

167. The CPT has previously commented on the Policy on Incentivised Regimes in Irish prisons.[55] In the course of the 2024 visit, the CPT was able to note further efforts being made in some of the prisons visited to offer general (that is, non-protection) prisoners a range of activities.

168. The general regime within the Irish Prison system provides for reasonable out-of-cell time of some seven-and-a-half hours per day for most ordinary regime or enhanced prisoners and the delegation was pleased to see this in action at **Dóchas Centre** (Willow House), **Limerick male Prison** (B and C Units) and **Limerick female Prison**, **Castlerea Prison** (A2-A4 and D units) and **Cloverhill Prison** (E and F Units). Nevertheless, the range of activities and education available to prisoners varied greatly in practice, depending on the prison.

55. See CPT's 2019 Visit Report CPT/Inf (2020) 37, paragraphs 43 and 69.

169. At the **Dóchas Centre** there was a range of activities and education available, including workshops in cooking, cleaning, horticulture and hairdressing, albeit with a limited number of places available,[56] as well regular access to a main gym. There were a number of specialist in-reach programmes and offender management programmes on offer, including a specific therapy programme for high-risk offenders.

170. At **Limerick female Prison**, by contrast, despite the new facilities, the range of activities and education available to female prisoners was less broad and there were hardly any working places available for the women prisoners, while education and art classes were on regular offer. Equally, at **Limerick male Prison**, there was a relatively limited range of activities for most ordinary (non-protection) prisoners. Few prisoners benefitted from purposeful work opportunities in practice.

171. At **Castlerea Prison**, the new management appeared motivated to set up work, education and training programmes for prisoners with the aim to facilitate their reintegration into the community after prison release (gardening, barber, barista, kitchen work). Moreover, Travellers were also offered support, if they so wished (educational support). At the time of the visit, 95 prisoners were attending school. Due to a lack of staff (there were 10 vacancies), not all activities could be offered on a regular basis. Some prisoners did not engage in any education. Not all prisoners could benefit in the same way from all the activities, thus, the distribution of activities was not well balanced. Prisoners who did not participate in activities, had to stay in their cell. Moreover, while there were a number of therapeutic reintegration approaches in place, their implementation was limited due to staffing problems and structural challenges (such as psychologists being assigned to several prisons, psychologists waiting for the prisoners to be brought to the treatment).

172. At **Cloverhill Prison**, increased investment and effort had gone into developing a range of activities, education and organised sport, and access was reasonable for enhanced and non-protection prisoners. Nonetheless, for protection prisons on restricted regime (comprising approximately a third of the prison's population), the regime was virtually non-existent (see *Restricted Regimes* below).

173. The IPS has now fully rolled out its Integrated Sentence Management (ISM) system. Under ISM, a newly-committed prisoner with a sentence of one year or more should be assessed by an ISM coordinator and a personal plan drawn up. However, the CPT found that, as had previously been the case,[57] the system still remained incompletely implemented. In most of the prisons visited, the ISM system continued to be undermined by the lack of dedicated ISM coordinators, who often had to undertake normal prison officer duties within the prison.[58]

In all the prisons visited, apart from Limerick Prison (a notable exception), there was virtually no follow-up of prisoners serving sentences of more than one year, and insufficient support provided to life-sentenced prisoners.

174. **The CPT reiterates its recommendation that a sentence plan be drawn up for all prisoners, with particular attention paid to the needs of persons sentenced to life-imprisonment and other prisoners serving lengthy sentences. Such plans should be reviewed on a regular basis together with the prisoner concerned. To this end, the number of ISM coordinators allocated to each prison should be increased and their role protected from other duties. Equally, in each prison visited, the number of vocational and purposeful work placements and activities should be significantly increased. Finally, as concerns the limited activities provided for women prisoners (such as cleaning and hairdressing), sentence plans should help prepare the prisoners for life upon release and consist of purposeful activities of vocational value, going beyond gender-stereotype.**

56. There were only 64 work places for a population of nearly 180 women prisoners.
57. See CPT's 2019 Visit Report CPT/Inf (2020) 37, paragraph 70.
58. ISM Coordinators allocated: Cloverhill, Castlerea Prisons and the Dóchas Centre (2 each) and Limerick Prison (3).

7. Women prisoners – specific issues

175. Women constitute a small but steadily increasing proportion of the general prisoner population in Ireland. At the time of the visit, there were 253 women prisoners, approximately 5% of the total prisoner population of nearly 5 000.

176. While there were some medium- and a few long-term sentenced prisoners, most of the women prisoners were committed for short-term prison sentences and many for non-violent offences, including shoplifting or non-payment of fines, and in general they posed a low risk to society. The CPT notes that many of the women prisoners with whom it met had mental health problems and/or substance addiction issues, were homeless or institutionalised and/or had been victims of abuse. All women sent to prison, even for minor offences or non-payment of fines, are sent either to the **Dóchas Centre** or **Limerick female Prison**.

177. There has been a steady increase in women being sentenced to prison over the last few years.[59] This has necessitated an expansion of the female prison estate. However, it remained insufficient, and at both the **Dóchas Centre** and **Limerick female Prison**, women prisoners were seen sleeping on mattresses on the floor and or on fragile foldaway camp beds.

178. In some respects, the Irish female prison estate has started to move in the right direction. Both the **Dóchas Centre** and **Limerick female Prison** had put in place some tailored gender-specific programmes. The prisons were clearly making efforts to follow a more gender-centric and trauma-informed specific approach for the management and care of women prisoners, albeit that these support services were not reaching all the women prisoners in need and much more investment still needs to be made (see below).

179. The CPT notes positively the opening and modernisation of the new **Limerick female Prison**. This new stand-alone facility was purpose built and women at Limerick Prison were no longer held in a small wing within the men's prison. Entirely modernised and operational since mid-2023, it was a specifically designed, bright and modern space, albeit still carceral (see *Material Conditions*), and one to be commended.

180. The **Dóchas Centre** also had renovated some of its accommodation units (namely, Elm and Willow Houses). Nonetheless, these changes impacted mainly only protection and enhanced prisoners, leaving most prisoners in the remaining non-refurbished accommodation, which remained in an old, and used condition (see *Material Conditions*), with overcrowding contributing to the general wear and tear. Recreation grounds and organised sports rooms had been repurposed to cope with the increasing numbers of women prisoners.

181. Nevertheless, while the modernisation of the new Limerick (female) Prison is a positive development, it remains essentially a medium to high-secure closed prison. The numbers of women, including very vulnerable women, sentenced to custody has been steadily increasing and many were in for minor or short-term offences.

Meanwhile the female estate occupancy was steadily increasing, becoming not merely crowded but, at the time of the visit, one of the most overcrowded prisons in Ireland.[60]

182. The Committee is concerned that merely expanding the female prison estate does not reflect its recommendations made in 2014[61] to increase investment in developing alternatives to custody for minor offences and community-based responses. The CPT notes that, albeit with a temporary release solution that works for some women prisoners (and is not possible for others (due to abusive families, etc.)), targeted policy work has not yet addressed the high numbers of women in prison for pre-trial detention, non-payment of fines, and very short sentences.

---

59. Albeit also bearing in mind the annual increase of the prison population as a whole.
60. As of 31 May 2024, Limerick female Prison was the most overcrowded prison in Ireland at 130% over its official bed capacity; and the Dóchas Centre was the second most crowded prison in Ireland at 123% over capacity.
61. See the CPT's Visit report of 2014 recommendations made in Part II, Section C: CPT/Inf (2015) 38.

The number of women sentenced to prison terms continues to rise. These include several mentally ill, addicted, homeless, abused or traumatised women, as well as mothers of young children and generally extremely vulnerable women. **The Committee recommends that the Irish authorities should build on this momentum concerning the reform of the women's prison estate, and put in place a strategy, including with legislative reform, to significantly reduce the number of women in custody, especially targeting those in pre-trial detention, for non-payment of fines, for non-violent offences and for short sentences.[62] Custody for pregnant women and mothers of young children should only ever be used as a last resort for those women convicted of the most serious offences and who represent a danger to the community.**

183. The delegation found the new facility in **Limerick** and **the Dóchas Centre** to be at bursting point; having reached saturation level, the overspill was evident in the form of mattresses and camp-beds on the floor, in place for many months prior to the delegation's visit.

184. Turning to some specific findings in the female prison estate, it was positive that women prisoners at both the **Dóchas Centre** and **Limerick female Prison** could regularly call and receive visits from family and their children. Infants were allowed to stay with their mothers until 18 months old in specialist mother and baby units or houses (see below).

185. At the time of the delegation's visit, there were four pregnant women at the **Dóchas Centre** and two at **Limerick (female) Prison.** All appeared to be followed properly by the healthcare staff and obstetricians. Regular antenatal checks were conducted in the outside clinics.

186. One pregnant woman at the **Dóchas Centre** also informed the delegation that she had been sleeping on a mattress on the floor prior to the delegation's visit. The delegation also found another pregnant woman at **Limerick Prison**, also found to be sleeping on the floor on a fragile foldaway camp-bed, due to overcrowding, at the time of the visit.

187. The Committee considers that requiring pregnant women to sleep on mattresses on the floor or fragile foldaway camp beds is both inappropriate and unacceptable and cannot be justified by capacity restraints. **The CPT recommends that this is ceased at both prison establishments and that all pregnant women be offered their own bed as a matter of principle.**

188. At the time of the delegation's visit, there were no children held with their mothers at **Limerick female Prison** or the **Dóchas Centre**. At the **Dóchas Centre**, the former Mother and Baby Unit had been repurposed as the protection wing (the "Phoenix Unit") for protection prisoners, due to overcrowding and to the need to move prisoners on protection further away from the general female prisoner population to shield against intimidation and bullying (see above). The prison management informed the delegation that a room would be given in the Phoenix Unit to any upcoming mother and baby if they were still in prison at the time of the birth.

189. The pregnant women interviewed by the delegation stated their concerns about being allocated a room in the protection wing, including being so close to and potentially in contact with women who had been sentenced for crimes against children. They also underlined how they did not want their children to be in contact with the general female prisoner population. Other women prisoners interviewed by the delegation who had previously had babies stay with them in the prison, had underlined that the experience had been a positive one and that they had been allowed to stay with their babies all day and night long, and could also take them to classes and workshops.

62. See also Rule 64 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules): "Non-custodial sentences for pregnant women and women with dependent children shall be preferred where possible and appropriate, with custodial sentences being considered when the offence is serious or violent or the woman represents a continuing danger, and after taking into account the best interests of the child or children, while ensuring that appropriate provision has been made for the care of such children."

190. **The CPT recommends that the Irish authorities review the policy and conditions under which a mother and her child are kept at the Dóchas Centre as a matter of urgency, in light of the above remarks. In particular, the Irish authorities should take measures to ensure that mothers and young children held in Irish prisons have a dedicated Mother and Baby Unit (separate from the Phoenix Unit) access to cooking and washing facilities and, if possible, a shared living area and kitchen, as well as indoor and outdoor areas where they can bond over play with their child in an appropriate, child-friendly environment.**

191. At both women's prisons, the food provided to pregnant women appeared adequate and there were no complaints by the prisoners. However, it was noted in both establishments that there was no special diet for pregnant and breastfeeding women; rather this was provided on a discretional or ad hoc basis when requested. The CPT considers that every effort should be made to meet the specific dietary needs of pregnant women prisoners, who should be offered a high protein diet, rich in fresh fruit and vegetables. Breastfeeding mothers should be provided with supplementary food according to existing guidelines for this category of woman. **The CPT recommends that measures be taken in order to ensure that this is the case in both female prisons.**

192. One pregnant woman, **Ms Y**, stated that she had had control and restraint applied to her after one of her visits had abruptly ended on suspicion of the concealment of contraband being passed to her during her visit. She alleged that four prison officers had ended the meeting and, when she refused to end the visit, dragged her roughly out of the visit room in a hand-lock procedure, where her arms were apparently painfully immobilised behind her back. She then alleges that she was subjected to a body search which resulted in back pain, and she states that she was scared that she was going to lose the baby when she subsequently began bleeding.[63] The prison doctor did see her afterwards and informed the delegation's medical expert that, despite the prisoner's allegations, she had been sent to hospital, and no injuries had been noted.

193. The Committee recalls its minimum standards to be observed in the event that non-custodial alternatives are not applied, and pregnant women or mothers – with or without their children – remain in prison.[64] The CPT considers that any use of force is a measure of last resort, when de-escalation measures and other techniques have been tried and failed. It recalls that any use of force is governed by the principles of necessity and proportionality (see *Ill-treatment / use of force* section) and that no more force than is strictly necessary should be used in bringing an agitated/aggressive prisoner under control. In this particular case, the CPT considers that using force on a pregnant woman during a visit from a family member on suspicion of the passing of contraband must have a very high threshold for justification.

There was little evidence to indicate that less invasive, de-escalation techniques were first attempted and this may, in the CPT's view, amount to an unnecessary and disproportionate use of force. **The CPT recommends that the Irish authorities ensure that all prison officers at the Dóchas Centre receive training and refresher training in the use of control and restraint techniques and that communication skills and de-escalation techniques should be prioritised. Force, or the use of means of restraint, must not be used on a pregnant woman unless it is necessary to prevent her from harming herself, any member of her family or any other person. In addition, pregnant women should not be placed at physical risk when force is used on another person. Force must not be used on a pregnant woman to secure compliance. Any force used on a pregnant woman must be appropriate, justified and proportionate other less invasive and de-escalation techniques should always be resorted to first.**

194. As regards **Limerick female Prison**, at the time of the visit, (mixed-gender) staff rotated between the female and male prisons regularly and general custody staff training was not significantly different from the training of the staff working in the male side of the prison.

63. Disciplinary records show that while contraband was found, they lacked any detail regarding what it was, and provided only superficial analysis in the investigation and appeal process (see section *Discipline*). Ms Y was given a 14 day prohibition on evening recreation, which was suspended.
64. CPT standard *Women in prison*, Section 4: CPT/Inf (2018) 5.

195. The Committee recalls its view that the development of specialised training for staff assigned to work with women prisoners is crucial in order to be able to address their specific needs. For instance, it is important for staff to understand that daily operational practices can cause further trauma to women prisoners.

Strip searches for contraband may retraumatise women who have been sexually abused in the past. By contrast, implementation of gender-sensitive and trauma-informed approaches (such as a scan instead of a strip search, for example)[65] may well decrease levels of self-harm, suicide and inter-prisoner violence.

196. Therefore, the CPT considers it essential that all staff involved in the management of women's prisons should receive training relating to the gender-specific needs and human rights of women prisoners, including the prohibition of discrimination. Gender-sensitive and trauma-informed treatment and management of women prisoners should be an integral part of the curriculum of all custodial staff in women's prisons. Such training should enable staff to recognise the impact of trauma, detect mental healthcare needs and risks of self-harm and suicide, seek not to retraumatise and to promote safety and respect. Further, post-education training of women prison staff should be a part of their ongoing training, enabling them to deal appropriately with the gender-specific needs of women prisoners. *Inter alia*, prison personnel should receive training regarding the principles of equality and non-discrimination, including in relation to sexual orientation and gender identity, as stated in the Yogyakarta Principles (Principle 9g).[66] Further, the CPT considers that it is good practice to organise training sessions on the Bangkok Rules for staff assigned to the two women's prisons.

197. **The CPT would like to receive information from the Irish authorities regarding steps to strengthen specific training, including an increased emphasis on de-escalation techniques, for staff and managers entrusted with the care of women prisoners in Ireland.**

198. At both **Limerick female Prison** and **the Dóchas Centre**, specialist support and advice was available in the form of externally-contracted specialist organisations, including for rape crisis counselling, substance addiction counselling and housing assistance post-release. Nevertheless, these services were considerably *oversubscribed*. The waiting lists to see the specialists were several months long and they could only reach approximately half of the prisoners needing their support. These services were also facing potential reductions in funding and resources, which would reduce their ability to support some of the most vulnerable of all prisoners in Ireland.

199. Many of the women with whom the delegation spoke had been through significant trauma and/or were facing crises at home, either through homelessness, domestic abuse or addiction problems.

200. The delegation also spoke with several women who feared leaving the prison, and/or who had declined the option of temporary release at both the **Dóchas Centre** and, albeit to a lesser extent, at **Limerick female Prison**. Some, who were homeless and without a job, said that they would not qualify for shelter.[67] This fear was compounded as many of these women had been physically abused while living on the streets and were traumatised by the risk of this recurring without shelter and protection. Others had been abused at home and were concerned about returning to the community. They said that they felt safer inside the prison than outside. It was women like these who had joined the waiting lists to see specialist support services and had experienced delays before these could access vital services.

65. See also Bangkok Rule 20: "Alternative screening methods, such as scans, shall be developed to replace strip searches and invasive body searches, in order to avoid the harmful psychological and possible physical impact of invasive body searches."
66. See Yogyakartaprinciples.org – The Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity.
67. See also the Crowe Report *Irish Prison Service: Health Needs Assessment in prisons*, section 5.3.2.

201. The Committee considers that these specialist support services should be provided by the Irish authorities for all prisoners in need of them. In particular, prompt access should be afforded to women prisoners who may be particularly vulnerable, who may be traumatised or be victims of abuse. **The CPT recommends that the Irish authorities ensure that a significant increase in resources and investment in specialist services is undertaken to ensure that all prisoners who need specialist support services have prompt and regular access to these.**

202. Turning to sentence management and preparation for release, it was clear from discussions with prisoners, psychologists, support services at the prison and ISM coordinators that many of the women prisoners needed a transition period before being able to cope with release in the community. Indeed, some women feared release to such an extent that they thought it highly likely that they would reoffend in order to return to prison shortly after release.

203. In 2014, the CPT recommended that the Irish authorities move ahead rapidly with their plans for an open prison for women. While it is a positive step that the IPS, jointly with Probation Services, have established the Outlook Programme and set up a single, small, 8-bed facility for women at the end of their sentence, and two off-site apartments, the CPT notes that there were very few regular openings for other women prisoners, and very few women were actually able to benefit from this.[68] 10 years on, the Committee is disappointed to see that there is very limited provision for women in terms of open facilities in Ireland.

204. The Committee recognises that properly resourced step-down facilities and open prisons provide a valuable support to women to help with their preparation for eventual reintegration back into their communities. Step-down facilities with sufficient numbers of places to provide adequate access to community-based health, housing, addiction services and employment bodies are not only essential at the end of sentence, but are also a crucial support for the mental wellbeing of women prisoners at all stages of their sentences.[69]

205. **The CPT urges the Irish authorities to rapidly invest in a greater number of local small open and semi-open step down facilities with sufficient capacity to adequately support all the women prisoners who need this transitional step before being released into the community.[70]**

8. Healthcare services

206. In 2019, the CPT acknowledged the progress that has been made in the delivery of healthcare in Irish prisons. Nevertheless, there remained the need for improvement in certain areas, including the need for better screening of injuries upon arrival in prison and providing interpretation services to help communication between healthcare staff and foreign national prisoners.[71] In 2024, overall, it was positive that the CPT found that the momentum had been retained; there was generally good access to somatic healthcare in prisons and an improved drug treatment approach. Nevertheless, certain areas still required improvement, such as the inconsistent screening for and recording of injuries upon arrival in prison and after incidents of violence.

207. In contrast, the care and treatment of mentally-ill prisoners in Irish prisons remained grossly inadequate, despite the repeated CPT recommendations made in this regard (see *Mental healthcare in prisons* section below).

---

68. The programme has 10 spaces and little turnover, since 2019 (that is, in 6 years) only 51 women prisoners have had access to it directly from the Dóchas Centre.
69. See also the recommendations contained in the HNA report on *Irish Prison Service: Health Needs Assessment in prisons*, page 34 " […] this type of [Step-Down] facility may have positive impacts on the health and wellbeing of female prisoners, and this matter should be kept under review by the IPS."
70. See also Rule 45 of the Bangkok Rules: "Prison authorities shall utilize options such as home leave, open prisons, halfway houses and community-based programmes and services to the maximum possible extent for women prisoners, to ease their transition from prison to liberty, to reduce stigma and to re-establish their contact with their families at the earliest possible stage."
71. Paragraph 71 of the CPT's 2019 Visit report CPT/Inf (2020) 37.

208. The CPT had previously recommended that the Irish authorities identify an appropriate independent body to undertake a fundamental review of healthcare services in Irish prisons, which was then in a state of crisis in some prisons.[72] The CPT was pleased to note that an external review had been undertaken in 2022 and the final Health Needs Assessment (HNA) report was published in 2023.[73] The review formulated various recommendations for improvements to several areas including women's healthcare in prisons, mental healthcare provision and the development of more formal pathways between the IPS and the wider health system, including the Department of Health (DoH) and the Heath Service Executive (HSE) to ensure consistency in access to medical treatment in and outside of prison. The Committee takes due note of the fact that the IPS Strategic Plan for 2023 to 2027 includes implementation of the HNA's recommendations.

The Committee notes, however, that there have been a number of previous health-care reviews over the past few years, and **recommends that the most recent HNA's recommendations are urgently implemented by the Irish authorities. Further, the CPT would appreciate being sent an update on concrete measures taken to date, as well as those underway, to implement the HNA recommendations, and the measures to formalise pathways between the IPS, the Department of Health and the HSE.**

a. Staff, facilities, access to healthcare and medical confidentiality

209. At **Castlerea Prison**, healthcare staffing was reasonable, notwithstanding the challenges posed by recruitment.[74] At the time of the visit, there was a full-time equivalent (FTE) General Practitioner (GP) and one part-time GP. A dentist visited once every two weeks, however, there was a long waiting list, meaning that, in practice, only emergencies could be addressed. A psychiatrist, a psychiatric nurse and a social worker had sessions every day for four days per week (overall, 1.4 FTE). Other specialist services visited on a less regular basis,[75] however, access to specialist services remained generally equivalent to that in the community. For a prison population of around 388 such staffing levels can be considered adequate. However, at the time of the visit there was a backlog of 63 patients waiting to be seen by the GP and it was taking up to two weeks before most patients (other than urgent cases) could have be seen.

The CPT recommends that access times to the GP should be reviewed and that, if delays continue, the hours of the additional part-time GP be increased to address this situation. It would appreciate being sent an update on this matter.

210. At **Cloverhill Prison**, healthcare staffing levels were adequate.[76] Two FTE GPs attended the prison Monday to Friday and a part-time GP attended three times per week.[77] Two healthcare assistants worked on the specialist unit of D2 part-time. Further, there were two consultant forensic psychiatrists and a registrar in forensic psychiatry who provided regular services. Nonetheless, there was no occupational therapy provision or service and there was only one psychologist and one assistant psychologist who provided some individual and stepped care input for a prisoner population of 485 persons, which was insufficient (see recommendation below).

211. At **Limerick Prison** (**male and female prisons),** healthcare staffing levels were, generally, reasonable.[78] Nevertheless, at the time of the visit, at night, there was only one nurse on duty who

72. Paragraph 72 of the CPT's 2019 Visit report CPT/Inf (2020) 37.
73. https://www.gov.ie/en/publication/health needs assessment Irish prison service final report.
74. There was a chief nurse and 10 FTE nurses, out of a complement of 11 FTE nursing posts. Four nurses on duty from 08:00 to 20:00 on weekdays (Monday to Friday). One nurse was on duty at night. For out of hours' medical emergencies, another GP or the hospital is contacted.
75. Such as a chiropodist, an optician, and a physiotherapist.
76. There were 17 FTE nurses out of a full complement of 18 and a nursing manager. Between 08:00 and 20:00 seven nurses were on duty and from 20:00 to 08:00 one nurse was on duty, with six nurses on duty at the weekend (Saturday and Sunday from 08:00 to 20:00).
77. On weekend mornings, a GP is on call, shared with Wheatfield prison.
78. There was one nursing manager and 13 FTE nurses, of whom six were mental health nurses, one part-time nurse and one additional part-time (0.2 FTE) addictions nurse. From Monday to Friday, as well as weekends between 08:00 and 20:00, five nurses (three in the male prison and two in the female prison) were on duty.

had to cover both male and female prisons. There was one FTE GP Monday to Friday who worked in the male prison, and one part-time locum GP who worked 08:00 to 17:00, three times a week in the female prison.[79] There were also weekly visits by specialists,[80] including a counsellor from the Rape Crisis Centre, who visited the female prison twice per week, as well as one FTE and two part-time external drug counsellors from the specialist service, Merchant's Quay. There were three psychologists[81] who attended the prison. However, there was only one psychiatrist who attended the prison for some two hours per week which, in the CPT's view, provided insufficient coverage for both male and female prison populations of 389 prisoners. **The CPT recommends that the presence of a psychiatrist be increased to enable regular clinical sessions for at least four days per week** (as is the situation in the other prisons visited by the CPT).

Given the layout of the prison, with the female prison being some distance from the male prison, as well as the obligation on nurses to visit all placements in a CSC (at least initially) or an SOC, to look after vulnerable prisoners and to examine new arrivals, **the CPT recommends that a second nurse should be on duty at night.**

Generally, the CPT notes positively that the organisation and management of healthcare services at Limerick Prison had considerably improved since the CPT's previous visit in 2014. Access for prisoners was better, a FTE GP had been recruited, and the previous situation of a lack of prison officers being available to provide escorts to and from the health centre had been addressed.

212. At the **Mountjoy Female Prison (the Dóchas Centre),** healthcare staffing was also generally adequate. There was one FTE GP Monday to Friday and one part-time locum GP for weekends.[82] In addition, there was access to specialist services, albeit limited (see below). A consultant psychiatrist visited the Dóchas Centre for two half-days each week, supported by a psychiatric registrar and a FTE mental health nurse and forensic social worker, who are based at the Dóchas Centre on weekdays. One FTE and two part-time (0.6) psychologists provide one to one sessions. There were two FTE substance addiction social workers from Merchant's Quay at the Dóchas , as well as one Rape Crisis Counsellor who attended the prison weekly.[83]

213. Generally, the CPT considers that for a population of 180 prisoners, such healthcare staff levels are adequate. Nevertheless, many of the women held there met the criteria to be considered vulnerable and the CPT was informed by staff and prisoners alike that access to specialist services was hampered by long waiting lists and delays (of many months) for psychologist and drug counsellor, sessions which deprived women of ready access to these important services.

The CPT recommends that the Irish authorities further invest in increasing ready and regular access to these crucial specialist services (notably psychologists, rape crisis counsellors and substance use counsellors) for women prisoners held at the Dóchas Centre.

214. Overall, the healthcare facilities in all of the above prisons can be considered well-equipped.

215. Medical confidentiality, appeared to be generally respected in the prisons visited (with the exception of **Castlerea Prison**), both as regards medical consultations and the storing of medical documentation. Nevertheless, at **Castlerea Prison**, the psychiatrist held sessions in a room on C2 Unit (for prisoners on C1 and C2), systematically through a plexiglass screen. Equally, when the GP examined prisoners in their cells, when needed, this was done systematically with an officer present in the cell. Moreover, the prison doctor held medical consultations with the consultation room door open, in sight and in hearing of prison staff. At the **High Secure Unit of Mountjoy Prison**, this also happened, but occasionally.

79. On weekend mornings, a locum doctor attends the prison (the same one as the FTE weekly doctor).
80. The dentist, optician and podiatrist, and a gynaecologist.
81. Two FTE and one part-time.
82. The healthcare team consisted of a chief nurse officer, six registered FTE nurses, with two nurses on duty every day of the week from 07:45 until 20:15, and one nurse on duty overnight. There was also one FTE and one part time healthcare assistant, as well as the FTE GP and locum part-time GP.
83. Further specialists included a clinical nurse, who visited to administer in-reach hepatology services once per week. An optician and chiropodist attended the prison every 3 months.

216. The CPT must stress that there can be no justification for prison staff being systematically present during medical consultations of persons held in prison. Their presence is detrimental to the establishment of a trustful doctor-patient relationship and usually unnecessary from a security point of view. Moreover, the presence of non-medical staff during medical consultations may discourage the person concerned from disclosing sensitive information to the healthcare professional (e. g. that he or she has been ill-treated, information about drug use or contagious diseases). Therefore, the CPT considers that, as a general rule, all medical examinations/consultations of persons in prisons should be conducted out of the sight and hearing of prison staff, under conditions fully guaranteeing medical confidentiality.

However, the Committee recognises that the presence of non-medical staff at the request of the healthcare professional may be warranted in exceptional cases. Such exceptions should be specified in the relevant regulations and should be limited to those cases in which, based on an individual risk assessment, the presence of prison staff of the same sex as the person being examined is considered absolutely necessary, most notably to ensure the safety of the healthcare professional. Moreover, an exception should only be permissible if other, less intrusive security measures are considered not to fully contain the perceived risks posed by the prisoner. As a possible alternative, consideration should be given to the setting up of a secure room or ensuring the presence in the room of additional healthcare personnel. Another possibility may be the installation of a call system, whereby healthcare professionals would be in a position to rapidly alert prison custodial staff in those exceptional cases when a prisoner becomes agitated or threatening during a medical examination. The healthcare professionals concerned should be duly informed of any relevant prior behaviour on the part of the prisoner, the applicable rules and how to react in high-risk situations.

As such, **the CPT recommends that the Irish authorities take measures, including by amending the relevant regulations, to ensure that the above-mentioned precepts are fully implemented in practice. In particular, as a general rule, all medical examinations/consultations of persons held in prisons should be conducted out of the sight and hearing of prison custodial staff, under conditions fully guaranteeing medical confidentiality.**

217. The CPT recognises that due account needs to be taken of security considerations, but the principle of confidentiality requires that all medical examinations of prisoners be conducted out of the hearing and – unless the doctor concerned requests otherwise in a particular case – out of the sight of prison officers. **The CPT recommends that the principle of medical confidentiality be respected, taking due account of the above remarks**. **Further, in the CPT's view, systematically conducting psychiatric consultations through plexiglass, without an individual security risk assessment, should be ended as a practice, as it does not enable a proper medical examination to be carried out or promote an adequate doctor-patient relationship.**

218. In 2019, the CPT raised its concern about the issue of foreign national prisoners who did not have a command of the English language and could not make themselves understood, and underlined that healthcare staff must be able to access language interpretation services in order to communicate with these prisoners. This situation had not changed in 2024 and **the CPT reiterates its recommendation that healthcare services in prison be provided with the means to access telephone interpretation services when required.**

b. Initial medical screening and recording of injuries

219. The IPS Health-Care Standards require that an initial assessment be carried out by nursing staff on the day of reception. Further, within 24 hours of reception, a doctor should undertake a clinical assessment of the prisoner's physical and mental state. An examination of a number of medical records in all the prisons visited by the CPT showed that this procedure was followed, the healthcare notes were generally very good, and the information was electronically out into the Prison Healthcare Medical System (PHMS) database.

220. For women prisoners arriving at the **Dóchas Centre and Limerick Female Prison**, the delegation found that women were screened and asked some gender-specific and trauma-informed questions to help identify any specific needs or vulnerabilities. This is positive and can be even further developed.[84]

221. Nonetheless, the CPT considers that a great number of (both female and male) persons who enter the prison system have mental health disorders. Thus, all levels of staff should receive adequate training to recognise the impact of trauma, and sensitised to mental health care needs and risks of self-harm and suicide. **The CPT recommends that the Irish authorities should promote a trauma-informed and mental health needs-oriented intake screening for men as well as women (including screening for the risk for suicide, self-harm risk, their mental health needs, any prior trauma, etc.).**

222. The delegation found that, in general across all prisons visited, the recording of injuries was cursory, and lacked sufficient detail. Moreover, it was apparent that the IPS policy remained, which placed the onus on the Prison Governor to take the initiative concerning the recording and reporting of allegations of assault, to secure evidence and to liaise with the Garda Síochána. Healthcare staff are only required to document and treat all injuries sustained by prisoners and to objectively document them on the PHMS database, not to report alleged ill-treatment to any third party. Further, there was no central trauma register at any of the prisons visited.

223. **The CPT reiterates its recommendation[85] that the Irish authorities review the existing procedures regarding the reporting of injuries.**

Upon admission to prison, every person should undergo a thorough medical examination following which a detailed record should be established. The same procedure should be followed after a violent incident within a prison establishment or whenever a prisoner is brought back to prison by the police, after having participated in investigative activities.

The record should contain:

- **(i) an account of statements made by the person which are relevant to the medical examination (including the description of their state of health and any allegations of ill-treatment made by them),**
- **(ii) a full account of objective medical findings based on a thorough examination;**
- **(iii) the healthcare professional's observation in the light of i) and ii), indicating the consistency between any allegations made and the objective medical findings.**

The record should also contain the results of additional examinations performed, detailed conclusions of the specialized consultations done and treatment applied for the injuries or any further procedures conducted.

Recording of the medical examination in cases of injuries should be made on a special form provided for this purpose, with "body charts" for marking injuries that will be kept in medical file of the prisoner. Injuries should be photographed and the photographs filed in the medical record of the person concerned. In addition, documents should be compiled systematically in a special trauma register where all types of injuries should be recorded.

The existing procedures should be reviewed in order to ensure that whenever injuries are recorded by a healthcare professional which are consistent with allegations of ill-treatment made by a prisoner (or which, even in the absence of allegations, are indicative of ill-treatment), the report is immediately and systematically brought to the attention of the relevant investigative authority.

84. In line with Bangkok Rule 6(a).
85. Paragraph 77 of CPT/Inf (2020) 37.

The healthcare professional should advise the prisoner concerned that the writing of such a report falls within the framework of a system for preventing ill-treatment, that this report automatically has to be forwarded to a clearly specified independent investigative authority and that such forwarding is not a substitute for the lodging of a complaint in proper form. The results of every examination, including the above-mentioned statements and the healthcare professional's opinions/observations, should be made available to the prisoner and to their lawyer.

The national authorities should offer special training to healthcare professionals on the manner in which medical screening of prisoners is to be performed, on the recording of any injuries observed and on the reporting procedure.

States should ensure that there are no reprisals against any healthcare professionals in their duty to record and report injuries.

c. Substance use

224. During the 2024 visit, it was evident that substance use was prevalent and drugs remained a major problem in all the prisons visited, most notably at **Cloverhill Prison**.[86] This had implications on many aspects of safety, use of segregation and observation cells, control and restraint procedures, among other aspects across the Irish prison estate. Positively, the Irish authorities have paid increased attention to this issue and have updated their prevention policies (see below). Nevertheless, there remained no central policy on how to manage prisoners who had ingested or secreted drugs internally. The lack of oversight of this and its consequences is outlined in detail in the *Deaths in Custody* section above.

225. The external HNA mentioned above made a series of recommendations to counter the prevalence of substance use and addiction in prisons across Ireland, as well as for strengthening prison health and care services, policies, and strategies, and for improving governance.[87] It indicated that approximately half of the prison population across the IPS estate may be using, or seeking to use, illicit substances, with a high percentage of these presenting with current or historical addiction challenges. In some prisons, the percentage of prisoners with substance use and addiction problems is much higher.[88]

226. The Committee takes note of the fact that the IPS has recently updated its substance use prevention policy and has a new IPS Drugs Strategy for the years 2023 to 2026, published in November 2023, taking account of the recommendations made in the external healthcare review. Further, IPS information states that methadone treatment is available at 11 of the 14 Irish prisons, covering some 80% of the prison population and addiction in-reach services have increased. Addiction counselling services are provided by resources external to the IPS and are subject to a Service Level Agreement with Merchants Quay Ireland.

227. During its visit, the CPT found that in all the prisons visited, with the exception of the Dóchas Centre, while it was possible to *continue* opioid agonist therapy on a maintenance basis for newly-arrived prisoners, with prescriptions from the community, it was rarely possible to *initiate* opioid agonist therapy (except for the purposes of detox). **The CPT recommends that the Irish authorities increase their provision of opioid agonist therapy in Irish prisons and foresee initiation for all prisoners who need this, in line with equivalent services in the community**.

86. See the recent IPS Drug Strategy 2023-2026 and the Crowe HNA report, Department of Justice publish Crowe report on Health Needs Assessment | Crowe Ireland, concluded in March 2022 and published on 18 May 2023; these show an increase since 2020 of drugs found and seized within Irish prisons, with the exceptions of Arbour Hill Prison and the two open prisons, Loughan House and Shelton Abbey.
87. HNA Report.
88. The HNA report outlines that "the primary source of addiction in prisons was reported to be opiates, with, for example, Mountjoy Prison health staff estimating that over one-fifth of all prisoners are currently prescribed opioid substitution treatment. There is a range of other substance misuse and addictions within the prison such as alcohol, Benzodiazepines, and painkillers."

228. The delegation noted that substance addiction services were well known to the prisoners interviewed and were available in the prisons visited, but with long waiting lists and an insufficient number of places and advisers regularly available. Some of the most vulnerable prisoners suffering from addiction issues underlined that they could not promptly access these valuable services. Merchants Quay also confirmed this and acknowledged this as a challenge but stated that they were resource-constrained.

229. **The CPT recommends that the Irish authorities continue to pursue vigorously the various strands of the new Drugs Strategy programme and notably to ensure an increase of resources for addiction and prevention services to be able to provide their services effectively and on a more regular basis throughout the Irish prison estate.**

d. Mental healthcare in prisons

230. A recurrent concern for the Committee is the treatment of mentally ill persons in Irish prisons and the lack of change in this regard.[89]

231. Overall, it remained the case that Irish mental health law provides that mentally ill persons involved in the criminal justice system *initially have to be committed to prison* before a pathway can be provided to the Central Mental Hospital (CMH) (see Part C below). At some Irish prisons visited, there were formal vulnerable high support units (HSU) designated for "medical" reasons, such as the HSU at Mountjoy and at Castlerea Prisons and D2 Unit of Cloverhill prison. At others, such as the Dóchas Centre, there was a reliance on the use of informal special healthcare high support units for mentally ill prisoners. Nevertheless, these units generally did not accord mentally ill prisoners a sufficient range of reviews or regulated safeguards. Indeed, these HSUs were a misnomer, and were not providing the high support that they were designed for.

232. Often mentally ill prisoners were held in SOCs, special healthcare rooms or even CSCs. The Committee remains of the view that these observation cells with extremely restricted regimes are not a suitable therapeutic environment for a mentally ill prisoner.

233. The Committee also underlines that there is an absence of a pathway for prisoners who do not require the CMH for the treatment of their mental health, owing to a gap in legislation to access local psychiatric hospitals from prison (see *Part C* and its recommendations).

234. For many years, there has been an acknowledgement by the Irish authorities of the issues in the treatment of mentally ill persons in prisons. Recent policy focuses have centred on the mental health and addiction challenges of those who come into contact with the criminal justice sector, including a high-level task force set up by the Irish authorities to address these concerns, which made many recommendations.[90] It has also been the subject of various external reviews from the Irish OIP[91] and other bodies.[92]

235. In the course of the visit, the delegation paid follow-up visits to the designated units of **D2 Unit in Cloverhill Prison** and the **High Support Units (HSU) at Mountjoy** and **Castlerea Prisons**.

It also met many mentally ill prisoners located in the other prisons visited, including in the **Dóchas Centre, Limerick male (D unit) and female Prisons, Castlerea (C2 Unit)** and **Cloverhill (D1 Unit).**

89. Since the CPT's January 2010 Visit Report (CPT/Inf (2011) 3).
90. This report identifies over 60 recommendations to improve the treatment of persons with mental health and addiction difficulties within the criminal justice system, Department of Justice publish Crowe report on Health Needs Assessment | Crowe Ireland.
91. Thematic inspection on psychiatric care completed by the OIP (published in February 2024), An Evaluation of the Provision of Psychiatric Care within the Irish Prison System - Inspector of Prisons.
92. Department of Justice publish Crowe report on Health Needs Assessment | Crowe Ireland.

236. At **Castlerea Prison**, the seven-cell C1 Unit is formally the HSU. Most patients held there at the time of the CPT visit were held there due to "medical" reasons, with just one held for "operational" reasons. All of the cells were occupied at the time of the visit. The five-cell C2 Unit is the Challenging Behaviour Unit (CBU), this implies that somehow the behaviour of the prisoners is "behavioural" as opposed to being caused by a mental disorder, as the prisoners are there for "operational" as opposed to "medical" reasons. In fact, the prisoners held there were all also severely mentally ill.

237. In C1 and C2 Units, the cells were sombre with poor access to natural light and the environment was austere. Nevertheless, for C1 Unit (only), there was a recreation hall with chairs, two tables, a TV and a phone and decorated with a mural and a servery. The regime in the Unit was poor, with prisoners locked in for between 21 and 23 hours a day and given a choice of the recreation room or the exercise yard. Some prisoners had been there for long periods of time (up to two years). There was a bare concrete outside yard.

238. In C2-Unit, there was an impoverished regime with virtually no activities offered for prisoners. Prisoners were on 3-man unlock (opened by 3 officers plus a more senior officer). The prisoners were only unlocked for one hour per day to access the outside yard, and occasionally they were not even afforded that due to resource limitations. Prisoners ate their meals locked alone in their cells and could not mix with each other or anyone else. There was very limited human contact other than when the nurse came to deliver the medication through the hatch, or the officers the meals. They did not have a therapeutic or activity programme, there was no occupational therapy, only limited access to a psychologist and an overall reliance on pharmacotherapy. No care or management plans were set up to help guide the approach on how to move out of C2.

239. Overall, for both C1 and C2 Units, prisoners were offered no purposeful activities apart from access to the exercise yard. Further, there was minimal staff interaction with the vulnerable men located on the unit.

240. The CPT considers that such an impoverished regime is unacceptable. Given that these prisoners are mentally ill, some severely so, and were on the waiting list for the CMH, the CPT considers that this treatment, in its view, may well be considered as inhuman and degrading.

241. The CPT paid a follow-up visit to the nine-cell **HSU in Mountjoy Prison** on Unit F1,[93] where nine prisoners were being held at the time of the visit (including three persons waiting to be transferred to the CMH). The Committee was again disappointed to note there was still a complete lack of structured activities for this group of prisoners, nearly all of whom had severe and enduring long-term mental health illnesses. While prisoners here could spend eight hours unlocked from their cells including time spent in the outside exercise yard, there was no access to the gym or organised sports, education, work or any type of purposeful activity to structure the day.

242. Yet again, the CPT found that there was no occupational therapy, individual or group psychotherapy or recreational therapy; only recourse to pharmacotherapy. In sum, the prisoners wandered idly around the unit or the yard and watched television. One cell, where one of the mentally ill prisoners was being held, was filthy, and the man, who needed daily healthcare assistance, had no bed sheet or pillow.

243. As was the case in 2014 and 2019, the mental health team, which is comprised of a psychiatrist and a mental health nurse, visited the HSU once a week.

The prison officers on the Mountjoy Prison F1 HSU[94] and on C1 and C2 of Castlerea Prison did not receive systematic and ongoing mental health training, other than attending an occasional mental health first aid course. The Committee considers that these HSUs are a misnomer, as very little healthcare support is provided to prisoners held there**. Overall, the CPT reiterates its recommendation that the Irish authorities ensure that at the HSUs of Castlerea and Mountjoy Prisons:**

93. In addition there is one SOC/CSC. The layout of the unit remained the same as described in the CPT's 2019 visit report, CPT/Inf (2020) 37.
94. Three officers for F1 and F2 during the day and one for FI, F2 and F3 at night.

- **a programme of structured purposeful activities is urgently developed for prisoners held on these units;**
- **steps are taken to ensure that all prisoners kept on these units are held in clean cells and provided with the necessary support to maintain their hygiene;**
- **occupational therapy sessions for the prisoners held on the HSU are introduced, as well increasing the provision of psychological, psycho-therapeutic and other relevant services;**
- **all prison staff responsible for these units have specific training in mental healthcare; and**
- **staff meaningful interaction with the vulnerable persons located on the HSU is increased.**

244. Turning to the **Dóchas Centre**, the delegation found two mentally ill women prisoners held in the healthcare designated unit ("HCU" (cell 6) and in cell 5) situated on the Committals Unit of the Dóchas Centre.

245. These cells measured 9 m^2 and 12 m^2 respectively and were former, repurposed CSC cells. As such, they possessed similar moulded plinth beds, no furniture or storage, encased high-set televisions exactly the same as in a CSC (see above). These rooms remained in dark, sombre conditions, with only limited natural light through a small high-set opaque glass window. One of the women held therein had not had access to a shower for four days prior to the delegation's visit. There was no purposeful regime and the women held there were offered daily exercise of up to one hour per day alone, with a staff member.

246. Other than the 30-minute checks by staff, often conducted through the window of the door, there was a notable lack of human interaction with the mentally ill women in these two cells. Neither woman had been given a care plan. One of the women had been held in these conditions for several weeks and neither woman knew for how long they would continue to be held there.

247. The delegation considered that these were inappropriate places for mentally ill persons to be held. The delegation invoked article 8, paragraph 5 of the ECPT and requested that cell 5 and the HCU/cell 6 of the Dóchas Centre be taken out of use and the women held there moved to a location providing a more therapeutic environment with appropriate care for their needs.

248. The Irish authorities, by letter dated 12 July 2024, underlined that the IPS was considering options to best address these issues regarding the Committals Unit. Further, the authorities underlined that both cell 5 and cell 6 are no longer utilised as accommodation. They are utilised as committal cells only; new committals are assigned to these cells when no other cell is available, however, the prisoner is then accommodated in the general population the next day.

249. The CPT welcomes this information. However, **it recommends that Cells 5 and 6 on the Committals Unit should not be used for any type of accommodation, including committals and reiterates that mentally ill persons should not be held in the Committals Unit.**

250. During the visit, the delegation paid a follow-up visit to the **D2 unit of Cloverhill Prison**. The landing was comprised of 15 single cells and five double cells. In addition, it had two SOCs and four CSCs, which often accommodated mentally ill prisoners. At the time of the visit, it had an occupancy of 27. It had been refurbished, and freshly painted, and was generally clean and bright at the time of the CPT visit.

251. On the first day of the delegation's visit, the unit was accommodating 27 prisoners, with 11 prisoners on the waiting list to enter either the CMH (four) or a local psychiatric hospital facility (seven). A month previously, from interviews with prisoners and staff, it appeared that mattresses on the floor or overspill into the CSC cells occurred when the capacity of the other cells in the unit was exceeded. Moreover, there were several mentally ill prisoners also being held in Unit D1, at least one of whom was on a mattress on the floor at the time of the delegation's visit. **The CPT reiterates it recommendation that steps be taken to ensure that mentally ill prisoners do not have to sleep on mattresses on the floor in Wings D2 and D1 of Cloverhill Prison** (see also *Material Conditions* above).

252. As regards staffing and resources, despite the increase in the number of mentally ill prisoners entering Cloverhill Prison, insufficient investment has gone into resources providing for the care and management of these persons and has not increased since 2019, despite the CPT's recommendations made in this regard.[95] Further, there remained no social worker, psychologist or occupational therapist in the PICLS team.

253. **Again, the CPT recommends that the Irish authorities reinforce the mental health team at Cloverhill Prison urgently. There should be at least six mental health nurses, as well as an occupational therapist, a psychologist, a social worker and some administrative support.**

254. Interviews with prisoners showed that experiences varied on D2 Unit. When it was not overcrowded, generally prisoners held there had their own cell. There was some care planning undertaken in consultation with the respective prisoners.

255. On D2 Unit, prisoners were generally allowed out of their cells three times per day.[96] However, cells were apparently locked during association time, and prisoners could not go into their cells during this time. On D2, there were some other recreation activities available, with access to the yard and freshly refurbished indoor recreation areas. There was a library, and access to education classes[97] for D2 prisoners had recently begun. **The CPT recommends that a programme of regular structured activities should be further increased for prisoners held on the wing.**

256. Many of the persons coming to D2 and D1 Units could be granted bail by the Courts but, due to their homeless status were excluded from Health Service Executive (HSE) community mental health team services, resulting in long periods in prison. This state of affairs had not changed since the situation observed in 2019, and remained problematic. This was notable at **Cloverhill Prison**, but also at the **Dóchas Centre.**

257. The CPT recalls that prison must not become a solution for managing mentally ill homeless persons and **it recommends that the Irish authorities put in place a comprehensive policy (that is, one that includes housing, welfare, primary care, mental healthcare, substance use) in order to tackle this issue.**

258. **The CPT reiterates its recommendation that urgent steps be taken, including of a legislative nature, to ensure that mentally ill homeless persons in prison, who the Courts are willing to bail, can be transferred rapidly to a psychiatric facility in the community to receive appropriate treatment** (see also *Part C*).

259. Overall, the CPT considers that the HSUs at all the prisons visited do not offer a sufficiently therapeutic environment for mentally ill persons. There was a notable lack of occupational therapy, very limited access to psychologists or any single or group therapies. At all the prisons visited, there remained an insufficient number of psychologists to cope with the demand for their services in the prison system.

The CPT recommends that the Irish authorities invest in increasing the number of and access to psychologists, occupational therapists and social workers in all Irish prisons.

260. Equally, the placement of severely mentally ill prisoners on certain prison wings with more restricted regimes, as well as the insufficiency of the mental healthcare support provided is, in the CPT's view, both unacceptable and inappropriate, which could amount to inhuman or degrading treatment. These people remain vulnerable, ill and difficult to treat in prison.

95. At the time of the 2024 visit, the mental health team (PICLS) consisted of 1.2 FTE consultant, 2 FTE junior doctor posts and 0.8 FTE senior registrar and three nurses.
96. Two hours in the morning, two in the afternoon, and 90 minutes in the evening.
97. With options to study Art, Irish language and IT.

261. The CPT recalls that there needs to be a multi-pronged approach to addressing the mental health needs of prisoners. It considers that plans to create *additional step-down beds in the community* and to increase the provision of *psychiatric low-security settings* can only be beneficial in this context. Overall, the Committee underlines the fundamental principle that mentally ill persons should not be held in prison but transferred to an appropriate healthcare facility or, more specifically, the CMH.

Given that the expanded CMH is not able to absorb the demand (see *Part C*), **the CPT recommends that the Irish authorities take measures to create additional step-down beds in the community, to provide additional secure beds in local psychiatric hospitals and to increase the provision of psychiatric low-security settings.**

262. If the HSUs in prisons are to provide a stepping stone towards admission to a psychiatric hospital or a step-down unit for managing persons returned to prison from a psychiatric facility, it is essential that they be provided with the appropriate resources. This means that a HSU should not only be visited on a regular basis by a mental health team (psychiatrist, psychologist and psychiatric nurse) but that the staffing complement should include psychiatric nurses, occupational therapists and officers with special training to work with mentally ill prisoners, and a structured programme of activities should be offered to all prisoners accommodated within a HSU.

Overall, **the CPT reiterates its recommendation that the staffing at all HSUs be reviewed in order to include the appropriate expertise to offer a structured programme of activities beneficial to the prisoners, in light of the above-mentioned remarks.**

9. Other issues

a. prison staff

263. The IPS has one of the more favourable staff-to-prisoner ratios[98] among Council of Europe member states.[99]

264. At the time of the visit, staffing numbers were high and their retention rate in the IPS, compared to other Council of Europe member states, was good. Staff were well remunerated, and appeared, generally, committed and positive about their work and saw their role as important, and many stayed for their whole careers. The prison staff culture encountered in the prison visited by the CPT was both positive (dedicated professionals) but it also presented a relatively closed culture with a strong union that could, and at times did, present challenges to the management to implement reform; **the Committee recommends that the IPS helps local prison management to ensure a more robust leadership.**

265. The problems linked to the number of staff needed for escorting purposes, as seen in 2019, remained but had decreased. Roles such as ISM coordinators were often encroached upon and they were required to perform a dual role, or their roles were merged with general duties.

266. However, it is evident that additional measures are required to ensure that prisons operate full regimes and services, including sentence management, with activities and services not being hampered by staff shortages due to escorting and other priority commitments. **The CPT would like to be informed about the continued measures being taken to address this.**

b. contact with the outside world

267. In-cell telephony had been rolled out to almost the entire Irish prison estate and this made a considerable improvement to prisoners' lives, with regular allowances of six minutes of calls, once or twice per day, depending on the regime levels. While the CPT considers that the installation of in-cell telephony is a positive development, it believes that the six-minute limit for calls is an insufficient

98. There were 3 994 IPS staff of which 2 586.5 are custody staff with a prisoner to custody staff ratio of 1.1:1.
99. According to the SPACE statistics for 2023.

amount of time for prisoners.[100] **The CPT recommends that the six-minute limit be significantly increased and requests that the Irish authorities also provide the rationale for imposing this limit**.

268. Nevertheless, the delegation was informed by prisoners at nearly all of the prisons visited that the six-minute limit was also imposed for calls to lawyers. The CPT considers that prisoners' calls to lawyers should not be subject to restrictions. **The CPT requests that the IPS review the current practice across the prison estate and, if necessary, inform prison management and raise awareness with prisoners that calls to lawyers should not be subject to restrictions in length**.

269. Visits from family and friends were regular at all the prisons visited but they were not always allowed for a full hour per week. Video-link visits were also possible and were used widely across all prisons visited. **The CPT recommends that visits should be allowed for an hour per week.**

270. Nonetheless, the delegation noted that certain prisoners on protection, such as those held on the **D Unit at Limerick male Prison**, were subject to systematic obligatorily fully-screened visits, a practice that had evolved during Covid and had remained in place. In addition, the CPT was not convinced that sufficient efforts had gone into providing child-friendly visiting places in the male prisons, most notably at **Castlerea Prison** and **the Committee recommends that this be addressed by the Irish authorities.**

271. The CPT accepts that in certain cases it will be justified, for security-related reasons or to protect the legitimate interests of an investigation, to have visits take place in booths and/or be monitored. However, "open" visiting arrangements should be the rule and "closed" ones the exception, for all legal categories of prisoners. Any decision to impose closed visits must always be well-founded and reasoned, and based on an individual assessment of the potential risk posed by the prisoner. **The Committee recommends that all prisoners be able to receive visits from their visitors without physical separation, except in individual cases where there may be a clear security concern.**

c. discipline

272. Disciplinary procedures are regulated by the IPS Prison Rules 2007, Rule 66, 67 and 68. The rules authorise the holding of disciplinary adjudications by governors, outline the requirements of due process, and refer to obligations with respect to the appeals process. In addition, guidance is provided in the recently updated SOP 01/23, which outlines instructions on process, rules concerning the imposition of sanctions, and guidance for the management of hearings.[101]

273. The disciplinary procedure is referred to as the "P19" process. In practice, P19 reports are triaged by the wing staff and then go to the Governor. The Governor reviews allegations the following morning, with all prisoners facing a P19 being seen within 24 hours. The requirement of the rules is that the hearing will occur between one and seven days following the incident. Hearings take place on each wing as part of the "Governor's parade" process.

274. In its previous visit reports, the CPT has expressed its serious reservations over the effect, in practice, of the sanction of "loss of all privileges" for a period of up to 60 days based on Article 13.1(d) of the Prisons Act 2007. IPS Guidance steers away from this and recommends an upper limit of 40 days of "loss of all privileges". The CPT is pleased to note that the findings of the 2024 visit demonstrate that the above Guidelines were being applied in all the prisons visited. This is positive.

100 For example, as concerns women prisoners, such a limitation on calls to children and families could run counter to Bangkok Rule 26: "Women prisoners' contact with their families, including their children, their children's guardians and legal representatives shall be encouraged and facilitated by all reasonable means. Where possible, measures shall be taken to counterbalance disadvantages faced by women detained in institutions located far from their homes."

101. Elements include ensuring accused prisoners are informed of charges at least a day in advance and in writing, as well as the grading of breaches of discipline and potential sanctions, according to three tiers of seriousness; level one being the most serious.

275. An examination of the relevant documentation showed that in the majority of disciplinary cases, the sanction imposed according to Article 13.1(d) of the Prisons Act 2007 was one or more of the following: prohibition of evening recreation, use of gym, using money/credit for periods ranging from seven to 40 days. Prisoners subject to a disciplinary punishment are allowed a minimum of one phone call and one family visit a week. The Committee found that the procedure itself in those cases examined appeared to be generally fair, not used excessively or punitively and sanctions were often suspended or remitted.

276. Nevertheless, the CPT found, notably at **Limerick male and female Prisons** and the **Dóchas Centre**, there was little oversight of the whole disciplinary process, both locally and nationally. There was very limited evidence of any robust system of oversight or governance dedicated to the monitoring of disciplinary procedures and outcomes. Further, the appeals system appeared to be merely a rubber-stamping exercise and did not comprise a meaningful avenue of appeal or any form of robust scrutiny process.

277. In practice, from an examination of disciplinary records and interviews with the relevant staff and prisoners both in **Limerick male and female Prisons** and the **Dóchas Centre**, the CPT found that, while records of the use of P-19 process are maintained and uploaded on to PIMS, recording was chaotic. Records were not kept in any systematic way, which made analysing the data and gaining an accurate global oversight challenging.

Data was rarely used by local prison management (or indeed, nationally) to ensure any meaningful governance or gain better insights into the experience and treatment of prisoners undergoing the disciplinary system. Equally, investigation into the charges was limited, the process was often informal and the paper records were not sufficiently detailed.

278. **The CPT recommends that the Irish authorities take steps to increase oversight, both locally at prison management levels and nationally, to ensure robust oversight and meaningful governance.**

In particular, it recommends that prison management ensure that all data concerning disciplinary proceedings is recorded accurately and uploaded onto PIMS regularly to ensure central oversight.

Further, the CPT recommends that the investigation process and its analysis into alleged disciplinary infractions are recorded in detail. It also recommends that the appeals process be monitored and subject to regular oversight and review, and dip-sampling locally at prison leadership meetings, as well as nationally.

B. Children detention establishments

1. Preliminary remarks

279. The delegation undertook a visit to Oberstown Children Detention Campus.[102] It also paid, for the first time, a targeted visit to Ballydowd Special Care Unit, focussing on healthcare services, legal safeguards and the use of restrictive measures.

280. The Children's Act 2001 dictates, in respect of young persons involved in the criminal justice system, that they should only be placed in custody when there are no suitable alternatives,[103] a principle reflected in the Youth Justice Strategy 2021-2027. The Criminal Justice Act 2006 stipulates that young persons shall be detained in "children detention schools" under the authority of the Minister for Children, Equality, Disability, Integration, and Youth. Following a merger of three different institutions in 2016, Oberstown Children Detention Campus is Ireland's only children detention school. Young persons who turn 18 while in a children detention school and who are still subject to a detention order may remain in a children detention school for a period not exceeding six months, after which they are transferred to a prison establishment for adults to serve the remainder of their sentence, if any.[104] **The Committee invites the authorities to consider the possibility of extending the period during which young persons may continue to be detained at Oberstown after having turned 18 years old in order to allow the completion of a course of education or training, subject to an individualised risk assessment including consideration of the other young persons' best interest.**

The Children's Act 2001 delineates that the primary objective of children detention schools is to provide appropriate educational and training programmes and facilities for young persons, promoting their reintegration into society. Along with the Oberstown Strategy 2022-2026, Oberstown developed a model of care known as CEHOP[105] and a rights-based approach expressed in the 12-rule Children's Rights Policy Framework. During the visit, the delegation was informed that discussions were underway regarding possible changes to the current legislation and policy, especially as regards behaviour management and restrictive practices (see paragraph 299), to ensure their alignment with the CEHOP model of care and the Children's Rights Policy Framework. **The CPT would appreciate being kept informed of the progress of this reform process.**

281. The Child Care Act 1991 stipulates that young persons who have not committed a criminal offence may be detained in a special care unit, if their behaviour poses a real and substantial risk to their health, safety, development or welfare, and they need special care which is unlikely to be available without such a placement.[106] Those facilities were run by Tusla (the Government's Child and Family agency). While Ireland's three special care units had a nominal capacity of 24 places, at the time of the visit the prevailing staffing levels only allowed such units to operate at 50% of their capacity. Seven young persons had for several months been on a waiting list after a special care placement had been ordered by the High Court,[107] remaining exposed, in the meantime, to the risks posed by their prolonged stay elsewhere. This situation pointed to a significant deterioration in waiting times, when compared to figures from previous years,[108] culminating in a finding of the Supreme Court that Tusla had failed to perform its statutory functions.[109]

---

102. The CPT visited the establishment in 2014, while in 2002 it visited the Trinity House School (one of the three institutions that merged into Oberstown Campus).
103. Section 143.
104. Section 155 of the Children's Act 2001, as amended by the Children's (Amendment) Act 2015.
105. The CEHOP model embraced five components relating to young persons' Care, Education, Health and wellbeing, Offending Behaviour and Preparation for returning to families and community.
106. Part IV A of the Child Care Act 1991, as introduced by the Children's Act 2001.
107. Four young persons had been waiting from four to six months, two from one to two months, one for less than a month.
108. On 1 January 2022 special care units accommodated 17 young persons, and only one young person was on a waiting list for placement. On 1 January 2023, occupancy reduced to 15, while the waiting list comprised three young persons. On 1 January 2024, occupancy was 13 and the waiting list included eight young persons.
109. *In the matter of M Mc D, A Child: Mc D v. Child and Family Agency & Ors, [2024] IESC 6.*

In turn, due to the lack of appropriate onward placement options, young persons accommodated in special care units often ended up staying there well beyond the time needed to provide the 'short-term intensive therapeutic interventions' for which those facilities were conceived.[110] **The Committee recommends that the Irish authorities take appropriate steps to ensure that the operational capacity of special care units is sufficient to meet demand (see paragraph 310). Furthermore, the authorities should address the question of onward placement as a matter of high priority, including step-down progression.**

282. *Oberstown Children Detention Campus*, located 25 km north of Dublin city, had a capacity of 46 young persons (40 boys and six girls) and an occupancy of 38 boys (18 on remand, 20 sentenced) at the time of the visit. Young persons' age, on average, was 16 and a half years old.[111] Their average length of detention was 171 days.[112] A total of 110 young persons entered Oberstown in 2022, 129 in 2023 and 48 in the first four months of 2024. The establishment comprised five eight-bedded residential units for boys and one six-bedded unit for girls, enclosed in large, well-maintained grounds.

283. *Ballydowd Special Care Unit* was located in Lucan, 12 km west of Dublin city. With an official capacity of ten, it was accommodating six young persons at the time of the visit (four boys, two girls). Young persons were 12 to 17 years of age and had been detained from two to 23 months, the average length of stay being nine months. There had been five admissions in 2022 and three in 2023, and none in the first five months of 2024.[113] Ballydowd comprised three units – one of which was empty at the time of the visit – situated within fenced-off premises encompassing a dedicated school building.

2. Ill-treatment

284. The delegation did not receive any credible allegations of ill-treatment of detained young persons by staff at either Oberstown or Ballydowd. The vast majority of young persons at both institutions spoke positively about the staff. The atmosphere in the residential units appeared to be generally relaxed, and the delegation observed a young person-centred and caring approach.

285. Episodes of heightened tension, bullying and sometimes violence did occur from time to time in the two establishments visited, primarily between young persons, but also against staff.[114] As borne out by documents and interviews with young persons, and as assessed through a review of CCTV footage,[115] staff responded appropriately in most cases, especially so at Oberstown. Further remarks, including on the situation at Ballydowd, will be provided below when outlining the findings on the use of restrictive measures (see paragraph 299 and following).

286. At Oberstown, the delegation examined the database containing allegations made by young persons against staff or Gardaí.[116] Out of 12 allegations of Gardaí misconduct made in the first period of 2024, nine concerned ill-treatment or excessive use of force in the context of apprehension, two referred to denial of provision of food and water during court escorts, and one to a strip search. Allegations appeared generally to have been taken seriously, with follow-up meetings with the young persons in question and, as appropriate, formal complaints being submitted to the Garda Síochána Ombudsman or Tusla.

---

110. The average period of detention in a special care unit for the 15 young persons held in those facilities at the time of the visit was approximately eight months, whereas it was around 11 months for the 19 young persons discharged from special care units since January 2023.
111. 19 young persons were 17-18 years old, 17 were 15-16 years old, and two were 14 years old.
112. Nine young persons had stayed more than a year (up to 18 months), four from six to 12 months, 12 from one to six months, and 13 for less than a month.
113. There were two discharges in 2022, five in 2023 and one so far in 2024.
114. For example, at Oberstown in 2023 there have been 22 incidents of assault of young persons against young persons, and ten incidents of assault of young persons against staff. In the first four months of 2024, there have been 11 young person-on-young person assaults and two young person-on-staff assaults.
115. The delegation examined the CCTV footage related to incidents dated 6 and 28 April 2024, and 33 written CCTV reviews of incidents which had occurred in 2023 and 2024.
116. Six allegations had been made against staff in the same period of 2024.

However, one allegation made to a nurse that an injury she had noted during admission had been caused by the Gardaí was not submitted to the competent authorities, because the young person had failed to provide further details during a subsequent interview with staff. In other cases, allegations against the Gardaí were not taken forward; at times, this was because the young person in question did not consent, while at other times the reason was unspecified and it was unclear whether other follow-up actions had been taken by staff.

The CPT recommends that effective procedures be put in place to ensure that, whenever injuries are recorded which are consistent with allegations of ill-treatment made by the person concerned (or which, even in the absence of an allegation, are clearly indicative of ill-treatment), the record is systematically brought to the attention of the competent monitoring and prosecuting authorities (see also recommendation at paragraph 293). Furthermore, the CPT would like to receive detailed information regarding the guidelines and practice related to the provision of food and water to young persons during court escorts.

3. Conditions of detention

a. material conditions

287. Material conditions at Oberstown were of a good standard. Rooms, measuring 9 m^2, were all used for single occupancy, and enjoyed adequate access to natural light and sufficient ventilation. They were equipped with a bed with storage compartments underneath, a television placed in the wall behind a plastic casing, and a call bell. However, the furniture did not include a table, chair and lockable space, and room decoration was generally limited, thus creating a rather impersonal environment for young persons. The adjoining sanitary annexe consisted of a shower, toilet and wash basin.

Of similar design, the common areas were bright, and included a kitchen with tables and chairs, a laundry, several multipurpose rooms and a spacious, homely living area with sofas, television and games, with access to an outdoor yard. The overall state of repair of units for sentenced young persons (units 5, 6 and 8) was better than in units for remand (units 9 and 10),[117] which appeared also somewhat austere, including in their courtyards. Video surveillance covered all areas within the institution, save for the young persons' rooms. Regrettably, some of the elements of the campus were of a carceral nature, such as the high security fences and metal prison doors used to compartmentalise the residential blocks, school building, sports hall and horticulture area, which detracted from the overall positive impression.

The CPT recommends that the Irish authorities pursue their efforts to create a healthy and appropriate environment at Oberstown which is conducive to the young persons' rehabilitation and well-being; for example, by making the conditions less carceral, providing safe furniture in the rooms (tables and chairs), and encouraging room personalisation and decoration of common areas.

288. The three residential units at Ballydowd provided good conditions of detention overall, even though they generally displayed some signs of age; for example, as regards state of repair, furniture and architectural design. Similarly organised, units 2 and 3 divided in two wings, each with two or three standard rooms along with a segregation room (styled "safe room").[118] The rooms, each measuring about 8 m^2, were fitted with a matrass on a plinth, a television, shelves and a call bell, and were adequately lit and ventilated. However, they looked rather barren, with no table, chair or other furniture. Each room had access to a separate sanitary annexe with wash basin, shower and toilet. Common areas consisted of a homely reception hall with carpet and sofa, a homely living room, a smaller television room, a kitchen and a dining room. The residential units had access to a large and well-maintained outdoor area with sports courts, wooden tables and benches, and playgrounds.

117. Unit 7, reserved for girls, was vacant at the time of the visit.
118. Unit 2 accommodated three boys and a girl, unit 3 a boy and a girl. Unit 1 was vacant at the time of the visit, but had been used in the past for single occupancy.

The CPT recommends that the Irish authorities improve the conditions of the young persons' rooms at Ballydowd; for example, by equipping them with safe furniture (a table and chair) and by encouraging their personalisation.

b. regime and activities

289. The delegation gained a positive impression about the regime and activities at Oberstown. Young persons regularly attended school and programmes organised by teachers and other social care professionals, in two-on-one settings designed to meet both security concerns and special educational needs.[119] Classes and workshops took place during weekday mornings and early afternoons (9:40-12:15 and 13:25-15:20), followed by recreational and sport activities. After-school programmes comprised a good range of structured activities, such as workshops promoting life skills and encouraging creativity through arts and crafts, as well as specific group interventions focussing on risk behaviour, physical education and recreation. Sessions for most activities, for example fitness, digital music, textiles, boxing, gardening, triathlon, cinema and mechanics, lasted for 45 minutes and involved no more than two young persons at a time, so as to allow wide room for individual adaptation.[120] A QQI (Quality and Qualifications Ireland) certificate could be obtained in horticulture, kitchen, barista and manual handling. In the future, it was planned to introduce workshops and training courses in forklift truck driving, bakery, barbering and electrician. However, at the time of the visit, vocational training courses, along with paid work opportunities, were rather limited and should therefore be expanded.[121]

The Committee welcomes the tangible efforts made by the authorities and staff at Oberstown to engage young persons in educational and other structured activities. It was impressed by the resources committed to the school – a bright, clean and friendly educational environment – and the dedication of staff. In this regard, the CPT believes that it is particularly important that young persons receive adequate support in preparation for their transfer to prison or release into the community. It was positive that young persons had a key worker assigned on an individual basis, who would offer support and try to maintain or develop ties with the community (and the families). The Committee is also appreciative of the Assessment Consultation Therapy Service (ACTS),[122] which provided focused interventions to support young persons' mental health, gave workshops on personal development and social skills, and facilitated interactions with the healthcare and education teams, while also contributing to psychological assessments.

Yet, it appeared that, while an adequate support mechanism was in place for young persons who were going to be transferred to prison,[123] there was a lack of appropriate step-down arrangements before release into the community, including opportunities to be granted temporary leave outside the institution, potentially also for work traineeships. This generated a number of significant repercussions that adversely affected young persons. Efforts made to provide education and training programmes at Oberstown, for example, risk evaporating if young persons are not further accompanied in their gradual reintegration into society.

---

119. From 1 January 2024, 122 young persons have attended the school. Good communication among staff and careful grouping of students in each classroom ensured a safe environment for both students and teachers, with no recent notable incidents of aggression. No security staff are normally present in the school building.

120. Football sessions lasted for 90 minutes and involved up to six young people. There is a gym with six machines and a punching bag (some young people also attend an external gym) and in addition a large sports hall. There is a barber room, a cinema room and a bar/café. There is also a so-called essence room (with musical instruments; drums, electric piano and synthesizer) and a sensory room for relaxation.

121. For example, only four to eight young persons a month were involved in paid work during the first period of 2024, usually for about 20 total hours monthly. Work consisted of horticulture, coffee van, kitchen and painting.

122. The team was composed by a clinician, a counselling psychologist, a speech and language therapist, a social worker, a social care worker, and a clinical manager.

123. Young persons with whom the delegation spoke confirmed that, as indicated by the management, preparatory meetings would regularly take place with those who were going to be transferred to prison, in which all stakeholders are engaged, such as the young person, parents, teacher, key worker, prison representative, to provide information about the process and easing the transition by establishing links with the institution (for example, regarding schooling).

The CPT recommends that the Irish authorities redouble their efforts to develop reintegration programmes for young persons in advance of their release, including opportunities for temporary leave in the community. Further steps should also be taken to increase the number of vocational places and work opportunities on offer at Oberstown.

290. It was positive that young persons at Oberstown had the possibility to exercise outdoors for at least one hour a day, often for longer or several times a day. Room doors were locked, including when young persons asked to be on their own in their rooms during the day. Nighttime confinement was imposed from 21:30 to 08:30, although bedtime hours could vary slightly depending on a young person's behaviour and engagement in activities. On weekends, times were more flexible, but a few young persons complained about the reduced array of activities on offer, while others recalled how in the past, due to understaffing, they would be confined to their rooms for long hours during the day. **The CPT trusts that a sufficient staff presence is always guaranteed to avoid that young persons be confined to their rooms during daytime over the weekend.**

4. Healthcare services

291. Healthcare staffing levels at Oberstown were satisfactory. A fully staffed team of five nurses was available every day from 8:00 to 21:00 and a clinic held twice per week. Every young person was allocated a nurse as focal point. Young persons could ask to see a nurse or doctor including through a unit's social worker. Furthermore, a general practitioner visited the establishment three times a week. As regards mental healthcare, in addition to the above mentioned ACTS, a psychiatrist, a psychiatric nurse and a psychiatric social worker were on site once per week. While the psychiatrist primarily dealt with court assessments, she also treated young persons with mental health needs. Dental care was adequate, with a dentist coming every week to treat up to five or six young persons. A physiotherapist, a podiatrist and an optician were available as needed, whilst appointments with other specialists could be organised through the local hospital.

292. Young persons underwent a medical examination by a nurse upon arrival at Oberstown, and were then seen by the doctor in the following two or three days. The screening consisted of a full medical history and a physical examination. Blood tests were performed as needed. Young persons were asked about sexually transmitted infections and treated if necessary. Detoxification on admission, if required, was supervised by the doctor.

293. Regarding the recording of injuries at Oberstown, injuries would be described by a nurse and the doctor. If a young person alleges that they have been assaulted or subject to ill-treatment by Gardaí, the doctor takes a statement from them and documents the injuries, and then passes the information to a social worker at Oberstown who, acting as 'designated liaison person', takes care of liaising as appropriate with the protection officer, the young persons' parents and solicitor, and of submitting the file to the competent authority for investigation. Nevertheless, the delegation could not retrieve specific forms for the recording of injuries, and neither the medical service nor the social worker kept a register for allegations or signs of injuries noted on young persons, or a record of the allegations forwarded.

The CPT trusts that the record drawn up after the medical examination of a young person at Oberstown contains the description of the injury, the young person's allegation and the doctor's observations indicating the consistency between any allegations made and the objective medical findings. Further, injuries should be photographed and filed in the medical record of the young person and all types of injuries should be recorded in a special trauma register (see also recommendation at paragraph 286).

294. The delegation learnt that a substantial number of young persons detained at Oberstown had a history of illicit drug use, principally cannabis, cocaine and benzodiazepines, although healthcare staff stated that only a few were cases of serious addiction requiring medical interventions. Young persons would be able to receive assistance from the ACTS, withdrawal symptoms would be treated by the physician, and referrals would be made to the psychiatrist as needed. Urine tests and room searches were carried out upon suspicion of illicit drug use.

Body searches were routinely conducted upon return to the institution after court appearances or leave in the community (see paragraph 313), which were reportedly the occasions during which young persons managed to procure themselves drugs. Young persons who tested positive to drug tests would be isolated in their rooms and kept under observation.[124]

295. Adequate self-harm and suicide prevention protocols were in place in Oberstown, which envisaged, inter alia, the development of individual safety plans that included observations and risk management strategies appropriate to the risk and presentation of the young persons concerned, as well as the provision of aftercare, with involvement of the healthcare team, in-reach mental health services and external services as appropriate. According to data provided to the delegation, in 2023 there were ten incidents of self-harm by seven young persons as well as two suicide attempts by two young persons. In January-April 2024, there have been five incidents of self-harm by four young persons and no suicide attempts. The staff approach was to address incidents therapeutically, not punitively. Depending on the case, a doctor or child protection services might be involved.

296. The delegation examined the arrangements on consent to treatment that were in place at Oberstown. The practice was that the Director of the institution, who by law had control over the young persons detained therein as if he were their parent, expressed consent to treatment for each young person at the moment of their arrival at the establishment. The form would later be submitted for approval to the parent or guardian concerned. However, the consent form in use at the time of the visit was overly inclusive, giving advance consent for both emergency and non-emergency treatment. Rather than giving blanket, all-encompassing consent, the Director (or other competent authority) should only authorise specific, targeted and narrowly identified treatment.

The CPT recommends that the Irish authorities review the framework and practice regarding consent to treatment at Oberstown, ensuring that appropriate safeguards are in place, and that, except in emergency situations, consent for treatment is only given on a case-by-case basis, and after having duly considered the views expressed by the young person and parent/guardian concerned. Consent forms should contain a clear indication of the authorisation's period of validity and justification, along with the views expressed by the young person, depending on their maturity and mental capacity.

297. At Ballydowd, there was no healthcare service on site and no dedicated doctor for surgeries or on call. General medical services, including examinations on admission, were ensured by two on-call doctor providers which, ostensibly, may provide a physician around the clock, within 30 minutes. However, it took the delegation a significant amount of time to reach a doctor via the telephone hot line. This arrangement is problematic as it does not ensure continuity of care, irrespective of the fact that only a limited number of doctors are usually in the rota. Moreover, the lack of a doctor assigned to the institution means that no stable physician is involved in the strategic development of the service, case reviews, trainings and other wider issues beyond direct patient care.

The CPT recommends that adequate measures be taken to ensure that a physician (or healthcare manager) is assigned to Ballydowd Special Care Unit, ensuring the overall supervision of healthcare services in that institution and a regular presence therein.

298. As regards mental healthcare at Ballydowd, a psychiatrist came in once a week and attended the multidisciplinary team meetings. There was also an ACTS service, which carried out young persons' initial assessments and, if appropriate, could refer them to the psychiatrist. Medication was administered by staff who, despite not having nursing qualifications, had an additional certificate allowing the performance of this task. The delegation learned that, as adequate services in Ireland were lacking for young persons with autism having heightened special needs, some young persons have had to be transferred to facilities abroad. **The CPT wishes to receive the comments of the Irish authorities on this question, including on potential plans to fill this apparent service gap.**

124. For example, in 2024, a young person was separated for seven days due to 'drug withdrawal and subsequent presenting behaviours of concern'; another had been separated for six days after he tested positive for drugs and was found to have brought some inside the establishment.

5. 'Restrictive practices'

299. The Children's Act 2001 grants the Director of children detention schools (namely, Oberstown) authority to discipline young persons who breach the rules of the institution 'in a way that is both reasonable and within the prescribed limits'.[125] This power appears not to have been exercised in the past, as the authorities confirmed to the delegation.[126] Sections 18 and 19 of the Children (Amendment) Act 2015 introduced a comprehensive reform of the disciplinary framework envisaged in the Children's Act. They lay down rules governing, *inter alia* the Director's power to conduct inquiries into alleged breaches of the institution's rules and impose (or suspend) disciplinary sanctions,[127] along with the young persons' rights to information, to be heard by a judge, to have representation and assistance, and to lodge an appeal against the Director's decision. However, these 2015 rules are yet to come into effect. The authorities explained that this is because they are undergoing a broader reconsideration, which involves not only the disciplinary system but also its interplay with the rules governing remission of sentence for juveniles. Pending the overhaul of the normative framework, there was no formal disciplinary system at Oberstown at the time of the visit.

300. Staff nonetheless resorted to 'restrictive practices', defined as physical interventions limiting an individual's movement, activity or function, and consisting of 'single separation' (that is, segregation), the application of physical restraint, the use of handcuffs and carrying out searches.[128] These measures were imposed pursuant to the Director's overall responsibility for the 'immediate control and supervision' of the institution.[129] Guidance for their application was provided in several policies adopted by Oberstown's Board of Management and the Department of Children, and procedures issued by the Director, which were to be read in conjunction with the Children's Rights Policy Framework.

While these measures served primarily a preventive function, there was an inherent risk that, lacking a formalised disciplinary system, they – notably, segregation – also came to embody, on occasion, an element of discipline enforcement, without a comprehensive regulation under the law. This lacuna in the legislation translated into uncertainties and gaps regarding fundamental procedural safeguards such as the young persons' rights to be heard,[130] to receive a reasoned decision, to legal assistance and to appeal, which should apply to restrictive measures effectively amounting to segregation, no matter their concrete implementation or legal characterisation.[131] The Committee understands the authorities' concern about a possible formalisation of the system. Nevertheless, it believes that adherence to basic principles of youth justice would increase the transparency, accountability and credibility of the process, thereby contributing to the young persons' reintegration into society and development as law-abiding persons.[132]

125. Sections 158(d) and 201.
126. See also CPT report on the 2014 visit to Ireland, CPT/Inf (2015) 38, paragraph 127.
127. Envisaged sanctions comprised caution, reprimand, prohibition, for a period not exceeding 60 days, on (i) engaging in specified recreational activities, or (ii) possessing specified articles, the possession of which is permitted as a privilege, forfeiture of pocket money, and forfeiture of not more than 14 days' remission of sentence.
128. As per CPT practice, the application of means of restraint, including segregation, are addressed under this section of the report, whereas other aspects such as handcuffs and searches are addressed under 'security measures' (see paragraph 329 and following).
129. Section 180(1) of the Children's Act 2001. See *SF v Director of Oberstown [2017] IEHC 829*, para. 111.
130. Rule 9 of the Children's Rights Policy Framework indicates that young persons should 'have the opportunity to express their views and have them taken into account in the implementation and review of the use of restrictive practices'. This is framed, however, as a guiding principle, not a prescriptive rule.
131. See *M v Director of Oberstown [2020] IECA 249* (denying a range of procedural safeguards in a case of a six-day separation, given that the measure did not represent a form of punishment but of behaviour management and that a minimum threshold of severity was not achieved).
132. See Section 158 of the Children's Act 2001.

The CPT recommends that the Irish authorities take the necessary measures, at the legislative level, to adopt a comprehensive regulation on the application of restrictive measures which may be imposed at children detention schools, whether as disciplinary or preventive measures, in compliance with international standards.[133] In particular, the regulations on separation should recognise the young persons' rights to information, to be heard, to receive legal assistance, to be represented, to receive a reasoned decision and to appeal.

301. The policy documents regulating the application of restrictive measures at both Oberstown and Ballydowd aligned with the principles of last resort, proportionality, individual risk assessment, management approval and oversight, accurate recording, staff training and young person debriefing.[134] Positively, from a review of incident reports, intervention registers, CCTV footage, and interviews with young persons and staff, the delegation found that, generally, staff appeared to have a clear understanding of the policies, including their underlying principles, of the procedures in force and of their practical implementation.

302. In respect of means of physical restraint, their application at Oberstown appeared not to be excessive and, in 2024, to be on an encouraging downward trend compared to the previous year.[135] At Oberstown, staff applied physical restraint (escorts, manual holds, etc.) in an appropriate manner, including by using de-escalation techniques in most cases before resort to physical restraints. Insofar as the delegation could ascertain from the records and interviews,[136] restraints appeared to be as short and pain-free as possible, while staff continued to engage with the restrained young persons to encourage voluntary cooperation. However, it remained unclear to what extent young persons (and other young witnesses, if any) were properly debriefed following the application of physical restraint. **The CPT trusts that young persons detained at Oberstown who are subject to or witness the application of physical restraint are properly debriefed after each incident.**

303. At Ballydowd, most incidents of young persons' agitation or aggression appeared to have been dealt with in an appropriate manner by staff. However, the delegation examined a few cases in which it had serious doubts as to whether de-escalation techniques had been applied to their full potential before resorting to the Gardaí to apply physical restraints. For example, in cases of not particularly high risk,[137] staff appeared to have called An Garda Síochána without having first made reasonable attempts to de-escalate the situation.

More generally, on several occasions, Gardaí were called to provide assistance in the performance of tasks which properly trained staff should normally have been able to carry out autonomously, for example applying physical holds, escorting young persons to their rooms after violent incidents, or conducting room and body searches.[138] As borne out by the records, Gardaí intervention did at times lead to heightened tensions, including, in one case, to the application of handcuffs. It is, moreover, particularly concerning that private security guards were hired to ensure the safety of staff engaged in managing a young person's challenging behaviour.[139]

133. Importantly, the CPT fully endorses the principle that solitary confinement shall not be imposed on juveniles (see Rule 60.6.a of the European Prison Rules; see also Rule 45(2) of the United Nations Standard Minimum Rules on the Treatment of Prisoners (*Nelson Mandela Rules*) and Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (General Assembly Resolution A/RES/45/113, Annex)).
134. Restrictive practices in special care units were regulated in the 'National Standards for Special Care Units' issued by the Health Information and Quality Authority (HIQA) in 2014.
135. Records referred to 71 physical interventions in 2022, 93 in 2023 and 19 in January-April 2024 (of which six involved the most restrictive type of MAPA holding (Management of Actual or Potential Aggression), involving at least three members of staff to hold the young person on the floor).
136. The delegation also reviewed CCTV footage from some of the most serious incidents recorded in 2024.
137. For example, when a young person refused to leave the grounds, and when a young person got unauthorised access to the grounds.
138. Police intervened 21 times in 2023 and six times in January-April 2024, for a population of five to six young persons.
139. The delegation learnt that two close protection officers (later reduced to one) have been present in the establishment for six months between 2023 and 2024.

In some other cases, staff seemed not to fully appreciate the special needs and complex conditions of young persons in their care, which should call for individualised approaches to behaviour management and routines, provoking largely preventable escalations.[140]

The Committee is cognisant of the challenges inherent in the care and treatment of young persons with such complex needs and vulnerabilities as those detained in special care units. However, it considers that staff working in such a demanding environment should be trained to handle, if necessary through the measured application of means of restraint, the vast majority of incidents of aggressiveness, including threats and assaults. Evidently, staff should receive comprehensive training on management of aggressive behaviour and de-escalation techniques to ensure that all interventions with challenging young persons are managed professionally.

304. **The CPT recommends that the Irish authorities take urgent measures to ensure that appropriate and tailored training is provided to staff working in special care units on the management of aggressive behaviour, de-escalation techniques and the application of means of restraint. Such training should not only focus on instructing staff how to apply means of restraint but, equally importantly, it should ensure that staff understand the impact that the use of restraints may have on young persons and that they know how to care for a restrained young person. Further, the authorities should take steps to ensure that An Garda Síochána officers are only called upon in well-defined and wholly exceptional cases.**

In addition, the CPT recommends that the Irish authorities definitively end the practice of hiring external security staff to manage challenging behaviour by young persons in special care units.

305. There appeared to be generally no excessive resort to 'single separation' (that is, segregation) at Oberstown. From January to April 2024, there had been around 329 recorded instances of separation, involving 50 to 60 distinct young persons. Separation lasted in the vast majority of cases for a few hours. Nevertheless, in around 60 cases the length of separation extended to nine hours or beyond, the longest periods being six, seven and 23 days, which the Committee considers excessive, irrespective of the reasons for separation.[141] It was of concern that the records had several inaccuracies, partly due to human error and partly linked with the functioning of the automated registration system. As to the latter, the recording of incidents of separation lasting more than a day were registered as a multitude of individual shorter incidents, rather than a single measure spanning several days and nights. This affected the overall reliability of separation records at Oberstown, hindering effective external monitoring as well as close supervision from the management of the institution.

The segregation took place in the young persons' own rooms[142] and was primarily used as a tool for behaviour management (but see paragraph 294). The detailed documentation and the interviews with young persons attested to the constant efforts made by staff to reengage with a separated young person, with the aim of discussing the reasons for the imposition of the measure and ways to reintegrate the young person into the unit as soon as possible.[143] While on separation, young persons had daily access to the unit's outdoor yard and, to the extent possible, to school classes, although they could not mix with the others. "Individual recovery programmes" were drawn up and implemented. This was a positive practice.

140. For example, staff refused to reschedule the sessions of individual work with a young person, including a young person with ASD, to allow some time outdoors. This led to the young person's increased aggressivity.
141. Moreover, from January to April 2024, ten young persons had been separated more than ten times.
142. 'Protection rooms' were only used to conduct searches. Young persons confirmed that they would never be kept there longer than the time needed to carry out a search, as stated by staff.
143. The delegation observed for itself one such case. A young person was separated after being disrespectful during activities. Shortly thereafter staff engaged with him to discuss the incident, and the teacher also came to speak with him. The young person was allowed to rejoin activities later on the same day.

306. Also at Ballydowd the application of single separation did not appear to be generally excessive, usually lasting for periods of a few hours at most in the young person's room. However, another restrictive practice known as 'single occupancy' similarly involved a removal from association with others, which in some cases extended over several days and in one case over many weeks. As single occupancy was not defined or regulated in the National Standards for Special Care Units, it was unclear which specific safeguards applied. Another issue was the absence of a centralised register of restrictive practices.

307. **The CPT recommends that the Irish authorities ensure that the separation of young persons or their removal from association – whatever form this may take – be applied only as a means of last resort and for the shortest time possible, and that the young persons concerned continue to be granted access to education, physical exercise and possibilities of prompt reintegration to the fullest extent reasonably possible. Moreover, the authorities should invest the necessary efforts in ensuring that every instance of separation or removal from association is accurately recorded in a centralised register kept at each establishment, containing the measure's date, start and end times, duration, reasons for application, and periodic reviews.**

6. Other issues

a. legal safeguards

308. Young persons' civil detention in special care units may be authorised by the High Court pursuant to provisions in Part IV A of the Child Care Act 1991, as amended by the Children Act 2001. To this effect, the High Court may issue special care orders for an initial period of up to three months, extendable twice for up to three months each. Hence, the statutory maximum length of detention in a special care unit is nine months. However, many young persons had been detained for longer periods,[144] given that the High Court could issue a fresh special care order. In the Committee's view, this practice undermined legal certainty, creating a mechanism for continuing detention. **The CPT recommends that the Irish authorities take steps to review the legal framework governing the continuation of young persons' detention in special care units.**

b. staff

309. Staffing levels at Oberstown were only partly satisfactory. Positively, there were no vacancies for the positions of central security officer (14 FTE), schoolteacher (27 FTE), activity manager (16 FTE),[145] psychologist (1 FTE), children's advocate (1 FTE), child protection officer (1 FTE), and chaplain (1 FTE). The particularly favourable teacher-to-student ratio was a testament to Oberstown's commendable focus on young persons' education and reintegration. Yet, the institution employed only 74 FTE out of 90 theoretical posts of social care workers (18% vacancy rate), who were staff operating in direct contact with the young persons in the living units.[146] This shortage may lead to a reduced availability of activities and unacceptable restrictions of movement (see paragraph 290), especially in situations in which staff also have to ensure the supervision of young persons requiring enhanced observation. **The Committee recommends that the Irish authorities take concerted action to fill the above mentioned vacancies at Oberstown.**

144. Of the 15 young persons held in those facilities at the time of the visit, five were staying beyond the maximum statutory period of nine months. Of the 19 young persons discharged from special care units since January 2023, at least eight had been detained for over nine months.
145. Five staff members assigned to the activities team, four to child care projects, and seven to health and wellbeing.
146. Working in direct contact with the young persons were also seven senior managers, eight site managers (three vacancies), and eight unit managers. There were also 26 FTE filled out of 30 positions of unit-based night supervision officers (13% vacancy rate).

310. The serious deficiencies in staffing levels at Ballydowd mirrored a nationwide recruitment issue affecting special care units and, consequently, their operational capacity (see paragraph 281281). Against a theoretical allocation of 70 social care personnel,[147] Ballydowd employed 37 staff members.[148] As that level did not meet even the minimum staffing requirement based on the current occupancy of six young persons, the establishment made regular use of overtime and external agency staff. The management said that, for this reason, operational capacity was soon to be reduced to five places. The Committee was apprised of and understands the significant complexities underpinning the recruitment of sufficient qualified personnel for servicing those establishments. Apparently, rigid regulations on conditions of employment are part of the problem.[149] In this regard, the Committee noted that, regrettably, high levels of turnover and recourse to agency staff at Ballydowd was an obstacle to the acquisition of the essential practical experience by staff. Therefore, **the CPT recommends that the Irish authorities redouble their efforts to develop an effective recruitment strategy to fill the staff vacancies in special care units, including, as appropriate, a review of relevant employment regulations.**

311. Staff training at Oberstown was appropriate, as borne out by the professional handling of violent incidents and complex situations of behaviour management. In contrast, not all staff at Ballydowd appeared to have been adequately trained, especially as regards the management of young persons' challenging behaviour, de-escalation techniques, and physical interventions (see paragraph 303 and related recommendation in paragraph 304).

c. security measures

312. Handcuffs were used frequently at Oberstown, in nearly all cases for escorting young persons to court or medical appointments outside the institution. Although the relevant policy requires individualised risk assessments, and handcuff use as a last resort, the significant number of applications raises doubts as to the actual compliance with those precepts in all cases.[150] **The CPT recommends that the Irish authorities review the practice related to the use of handcuffs on young persons detained at Oberstown in line with the principles of last resort and individualised risk assessment.**

313. Personal searches were systematically conducted when young persons (re)entered Oberstown from the outside. Searches were carried out in small rooms in a manner that ensured respect for the young persons' dignity, as the delegation could verify through interviews with young persons and review of the records.[151] Room searches were primarily conducted on a routine basis and did not raise any particular concern.[152]

d. contact with the outside world

314. Young persons detained at Oberstown could ask staff to make phone calls to specified persons from their rooms (or other rooms in the unit) without unwarranted restrictions; videocalls were available as well. Visits could be arranged for more than once a week, on any given day, with transportation from the nearest station facilitated by the institution when necessary. The CPT welcomes this liberal and flexible approach to young persons' contact with the outside world. However, young persons on remand and, irrespective of status, all young persons on their first three visits were only allowed to receive screened visits, which prevented any physical contact with visitors. In the CPT's view, this blanket limitation was not only detrimental to the young persons' emotional development but also out of alignment with the institution's reintegration mission. Screened visits should be the exception rather than the rule.

147. Two social care managers, four deputy managers, ten leaders and 54 workers.
148. Six social care leaders, 31 social care workers.
149. See also *In the matter of M Mc D, A Child: Mc D v. Child and Family Agency & Ors, [2024] IESC 6*, para. 1.
150. Handcuffs were applied in 209 instances in 2023, and in 87 instances in January-April 2024.
151. Upon arrival at the institution the young person has to undress only half the body at a time, and always with a towel in front of the intimate parts. Cavity searches were not carried out.
152. Between 1 January and 9 May 2024, 262 room searches were conducted on a routine basis, and 14 on a non-routine basis.

The CPT recommends that all young persons detained at Oberstown, whether remanded or sentenced, be granted visits under open conditions, unless otherwise determined upon an individualised risk and needs assessment.

e. complaints procedures

315. Young persons at Oberstown had adequate avenues of complaint open to them, both within and outside the institution, with which they showed sufficient familiarity during interviews with the delegation.[153] They received information on their rights, including on the complaints procedures, through both verbal information provided to them on arrival at the institution and the simple, young-person-friendly and comprehensive brochure that was provided on arrival. Young persons were generally encouraged to talk to staff about their concerns or to the advocacy officer, whose role was precisely to guide them through the complaint process. In addition, a designated liaison person for young persons had responsibility for coordinating the reporting of protection concerns. The Office of the Children's Ombudsman (OCO) would also visit Oberstown and could receive and address complaints directly.[154] Advocacy services were further offered by the NGO "Empowering People in Care – EPIC".

However, it appeared that young persons at Oberstown would not know how to complain confidentially to an independent outside body. It would also be preferable that the advocacy officer be independent from the management of the institution. **The CPT invites the authorities to submit their comments on these remarks.**

f. inspection procedures

316. The Health Information and Quality Authority (HIQA) is an independent statutory authority with a mandate, among other duties, to inspect children detention schools as well as special care units at least annually.[155] The Ombudsman for Children's Office (OCO) promotes the rights and welfare of young persons up to 18 years old living in Ireland. The Children's Ombudsman is vested with the power to examine the complaints made by or on behalf of young persons, including those in Oberstown and Ballydowd, in relation to the actions of public bodies. In addition, any judge may visit children detention schools or any other place of young persons' detention at any time.[156]

The Committee received information that Oberstown, unlike other residential facilities for young persons in Ireland, is not obligated to formally notify HIQA of significant events such as death of a young person, serious injury, allegations of misconduct, and the application of restrictive measures. **The CPT invites the authorities to submit their comments on this aspect, including on potential reforms aimed at extending to Oberstown the notification requirement imposed on other young persons' residential facilities.**

153. A total of 14 complaints had been submitted in the course of 2023 through the advocacy officer, and 12 during the first five months of 2024.
154. The OCO received two complaints in 2023 from young persons detained at Oberstown, and recorded nine key interactions in the first five months in 2024, in which young persons expressed a concern or dissatisfaction with some element of their care.
155. The latest publicly known inspection visit in Oberstown took place from 12-14 September 2023, and in Ballydowd from 4-5 July 2023.
156. Section 192 of the Children's Act 2001.

C. Central Mental Hospital

1. Preliminary remarks

317. The delegation visited the Central Mental Hospital for the first time since the institution's relocation to Portrane in November 2022. The CPT welcomes the long-awaited transfer to the new facilities, which provided a more appropriate therapeutic environment as compared with the former building in Dundrum.

318. Incorporated in the National Forensic Mental Health Service, the Central Mental Hospital is Ireland's only 'designated centre' under the Criminal Law (Insanity) Act 2006, and as such may admit forensic patients, notably those: (i) transferred from prison for treatment, (ii) found to be either 'unfit for trial' or 'not guilty by reason of insanity', or (iii) transferred for observation to determine their unfitness or insanity.[157] As an 'approved centre' for the purposes of the Mental Health Act 2001, the hospital is authorised to also accommodate involuntary 'civil' patients,[158] and is subject to the regulatory and inspecting authority of the Mental Health Commission. In addition, the National Forensic Mental Health Service runs a number of facilities in the community (see paragraph 322) and manages the in-reach units in the prisons (see paragraph 11 and following).

319. The Committee notes that there are a number of legal frameworks (at least three) by which people can be detained in mental health settings with differing legal requirements and levels of healthcare oversight and scrutiny. It further notes that the regulations in force do not provide for the possibility for prisoners to be transferred to 'approved centres' unless such facilities also qualify as 'designated centres', or to be transferred from 'designated centres' to 'approved centres', thereby creating a system in which the two frameworks of civil and criminal detention in psychiatric settings do not interact. This arrangement led to a situation in which there is no mental health path out of prison to treat severely mentally ill prisoners who do not meet the threshold for admission to the 'designated' centre in terms of risk, and they remain vulnerable, ill and untreatable in prison, which may amount to inhumane treatment. Equally, those detained in the 'designated' centre under the Criminal Law (Insanity) Act 2006 may not access the alternative discharge pathways that are available to detainees under the Mental Health Act 2001, thus unnecessarily prolonging their detention in conditions of high security, such as those at the Central Mental Hospital. The current reform of the Mental Health Act 2001 may provide an opportunity to address this issue through consultation between the Ministries of Health and Justice, healthcare professionals and other stakeholders.

320. The Central Mental Hospital was situated next to St Ita's Hospital, 30 km north of Dublin. Its extensive grounds comprised five one-storey buildings housing the following inpatient units:

- Mournes Unit, a 40-bed High Secure Unit divided in Lamagan (for admissions), Donard (subacute) and Binnian (challenging behaviour) wards accommodating male patients;
- Cooley Unit, a 30-bed Medium Secure Unit consisting of Foye and Clermont wards for medium-support male patients;
- Wicklow Unit consisting of two ten-bed male wards (Kippure and Sugar Loaf) specialising in Mental Health Intellectual and Developmental Disabilities;
- Blooms Unit for female patients dividing into an acute and a medium-support ward (Arderin and Barcam) with eight and six operational beds, respectively,[159] in addition to a four-bedroom apartment (Capard);
- Nephin Pre-Discharge Unit comprising Bengorm, an 18-bedded ward and Tristia, a two-bedroom apartment.

157. Under the Criminal Law (Insanity) Act 2006, patients may be admitted for the purposes of *inpatient care and treatment* in a designated centre following a finding of unfitness to be tried (Section 4), not guilty by reason of insanity (Section 5), or a transfer from prison (Sections 15(1) and (2)). Patients may also be admitted for the purposes of examination on whether they are suffering from a mental disorder and are in need of inpatient care or treatment in a designated centre (Sections 4(6)(a) and 5(3)(a)).
158. Section 21(2) of the Mental Health Act 2001.
159. Arderin's and Barcam's theoretical capacity is ten beds each.

321. A number of wards were yet to be opened, namely, Sugar Loaf and the two apartments (Capard and Tristia), along with a 10-bed Forensic Child and Adolescent Mental Health Service and a 30-bed Intensive Care and Rehabilitation Unit adjacent to the hospital's grounds. Two further buildings called Reception and Village Centre hosted various services and facilities, such as visitors' rooms, primary care facilities, a multifaith room, workshops, a hairdresser, a music room, a laundry, a sports hall (not currently in use), a gym and a café.

322. Despite an official capacity of 130, at the time of the visit the Central Mental Hospital could only operate 112 beds, all of which were occupied (98 men and 14 women). In particular, the hospital was accommodating 89 forensic patients admitted pursuant to the Criminal Law (Insanity) Act 2006,[160] 13 involuntary 'civil' patients under the Mental Health Act 2001, eight legally incapacitated patients ('wards of court') and two patients detained under the inherent jurisdiction powers of the High Court (see paragraph 355). Most patients had a diagnosis of psychosis, mainly schizophrenia, with only a few (around 6%) having a primary diagnosis of intellectual disability. There had been 65 admissions since November 2022, 55 of which were transfers from prison for treatment,[161] three for insanity[162] and the rest for observation.[163] In addition, the National Forensic Mental Health Service was managing a 'hostel' and overseeing five 'residences' in the community accommodating a total of 30 patients.[164]

323. The CPT appreciates the increase in bed capacity following the relocation from Dundrum to Portrane (from 95 to 112 beds). However, prisoners in need of treatment, many of whom were seriously ill, continued to face lengthy waits in prison for transfer to the Central Mental Hospital. The waiting list at the time of the visit included 15 mentally ill prisoners who needed transfer for treatment, in addition to four individuals the admission of whom for observation purposes was likely to soon be requested by the courts. Therefore, severely ill persons were being detained in unsuitable prison conditions, while their state of health continued to worsen.[165] The Committee is of the view that making the Central Mental Hospital fully operational, thereby expanding its current operational capacity, should remain a matter of utmost priority for the Irish authorities. While lack of staff was adduced by the authorities and hospital management as the reason why several units were not yet in service (see paragraph 321), the delegation understood that, even more fundamentally, the authorities had not yet made a definitive determination regarding the function of these units, as an assessment of current and future needs and priorities had not been completed. Regrettably, no clear roadmap or timeline had been set for the new openings. Determined action is required as a matter of urgency to assess the clinical needs and provide the necessary resources to operate the new units.

The CPT encourages the authorities to take all necessary steps to make the Central Mental Hospital fully operational. The opening of the Intensive Care and Rehabilitation Unit, for example, is likely to significantly reduce waiting times for admission to the hospital and increase the quality and cost-effectiveness of psychiatric care in Ireland.[166] The CPT would like to be kept informed of the schedule for the intended opening of the new hospital units and the category of patients which may be placed therein.

324. Another factor hindering a seamless flow through the service was the fact that the hospital was accommodating several long-term patients.[167] The average length of stay was especially protracted for involuntary civil patients and legally unfit/insane patients (11 and eight years respectively), while it was considerably shorter for patients transferred from prison to hospital for

160. 51 of whom were not guilty by reason of insanity, 28 transferred from prison, nine unfit for trial and one under observation to determine fitness for trial.
161. Section 15 of the Criminal Law (Insanity) Act 2006.
162. Section 5(2) of the Criminal Law (Insanity) Act 2006.
163. Section 4(6) or Section 5(3) of the Criminal Law (Insanity) Act 2006.
164. The National Forensic Service also provided support for 18 (former) patients who lived independently.
165. See paragraph 243 and following (mental healthcare in prisons)
166. Of note is that the development of additional Intensive Care and Rehabilitation Units has been a priority since the 'A Vision for Change' policy document (2006), confirmed in the more recent 'Sharing the Vision' policy (2022) and its implementation plan for 2022-2024.
167. 29 patients had been in the hospital for over 10 years, seven of whom over 20 years. Around 10-15% of the hospital population is composed of chronic patients.

treatment (two and a half years).[168] Reportedly, new options for onward placement should become available soon (a five-bed hostel expected to open in January 2025), but their expected capacity – patently insufficient – should be increased.

The delegation found that many long-term patients in the medium-security wards appeared to be clinically stable, and yet discharge was not being prepared for any of them due, in most cases, to 'lack of insight' (see paragraph 360). In the Committee's view, additional efforts should be made to explore possible avenues for onward placement for this cohort of patients, such as the development of an accelerated discharge programme. In this connection, it remained not entirely clear why it would not be possible to operate the apartment in the pre-discharge unit (Tristia) to accommodate patients who are ready for discharge but are on a waiting list for onward placement. Moreover, as reportedly a substantial proportion of the inpatient population is homeless – a factor hindering their assignment to local community services – an effective regulation and policy should be developed to clarify the competent service provider to receive this vulnerable group of patients. A similar issue apparently concerned foreign nationals.

The CPT notes that the High Level Taskforce report published in 2022 recommended the opening of a facility to meet Long Term Medium Secure male bed capacity requirements in the Central Mental Hospital. The report also mentioned the possible 'designation' under the 2006 Insanity Act of a number of regional psychiatric inpatient units across the country. This could allow for the decentralised admission of low-security forensic patients, as well as the transfer there of low-security patients from the Central Mental Hospital.

The Committee encourages the authorities to fully implement the recommendations made by the 2022 High Level Taskforce on Mental Health and Addiction by expanding the offer of alternative step-down options for patients, including decentralised low-security forensic psychiatric units.[169] The CPT wishes to be kept informed of the progress in the implementation of the recommendations from the Taskforce.

The authorities should also consider developing national programmes for accelerated discharge into appropriate settings (including residential facilities), focusing on patients' quality of life and life-skills support. In addition, the CPT wishes to be informed of the measures taken by the authorities to facilitate the assignment of homeless and foreign patients to local service providers.

325. The legislative framework governing mental healthcare was undergoing a reform process, as the Government published a bill in July 2024 to radically amend the Mental Health Act 2001. The bill is intended to substantially revise many key areas, such as the criteria for involuntary admission and detention, consent to treatment and the use of means of restraint (see paragraphs 345 and 354). **The Committee would like to be kept informed of the progress of the reform on a regular basis.**

2. Ill-treatment

326. The delegation did not receive any credible allegations of ill-treatment of patients by staff in the Central Mental Hospital. On the contrary, patients mainly spoke positively of staff and the delegation observed a genuine commitment to provide care and treatment to patients, often in difficult circumstances. Episodes of violence between patients and from patients against staff did occur, particularly in the High Security Unit. Since 1 January 2024, for example, there had been 42 recorded incidents of violence, harassment or aggression, 12 of which had resulted in injuries. Victims were patients in 21 cases, healthcare staff in most other episodes. However, it emerged from the documents consulted and the interviews conducted with patients that staff responded swiftly and professionally, with incidents recorded accurately and follow-up actions clearly identified.

168. Similarly, recent discharges mostly involved patients returned to prison after treatment: of the 51 discharges since November 2022, 43 were returns to prison of patients who had been transferred to hospital for treatment, whereas the others related to legally unfit or insane patients under the Criminal Law (Insanity) Act 2006.

169. The High Level Taskforce report published in 2022 recommended a facility to meet Long Term Medium Secure male bed capacity requirements in the Central Mental Hospital. See also recommendation 2.11 on the possible designation of regional approved centres.

3. Patients' living conditions

327. The premises of the Central Mental Hospital were in a very good state of repair and hygiene, in great part thanks to the substantial investments made by the Irish authorities in recent years to build and operate the new facilities.

Many of them personalised, rooms – all for single occupancy – were fitted with a mattrass on a plinth, generally a chair and a desk, storage shelves, a TV set and a call bell.[170] They were well lit, while ventilation was ensured through grilles on the window. The ligature-free sanitary annexe comprised a toilet, a sink and a shower. Although without a door, its design ensured protection for the patients' privacy. The common areas in each ward included two large lounges (a quiet room and a TV room) and a dining room (used also for visits) equipped with safe therapeutic furniture, as well as a room for video link, a laundry, gym and other activity rooms. Accessibility for patients with reduced mobility was ensured across the establishment. The delegation was pleased to find that the conditions of the wards reflected a therapeutic setting, but considered that the general atmosphere in the common areas was rather austere, with limited personalisation such as pictures on the walls and other safe forms of decoration.

328. As all wards were designed with individual, properly equipped outdoor yards, patients could generally enjoy unrestricted daytime access to fresh air, including from the visitors' rooms, which is positive.[171]

However, other elements of the hospital routine reflected an overall approach that, in the CPT's view, was exceedingly driven by security considerations. Firstly, there were stricter limitations in place compared to the rules applied in the hospital's previous location at Dundrum (for example, unlike in the past, women were not allowed to knit or to wear their jewellery). Secondly, patients in the High Security Unit were subject to significant restrictions on free movement within the unit. For instance, patients were barred from their bedrooms during the day, and were therefore bound to stay in the common areas from 9:00 to 20:00. This meant that there was no room where patients could go if they needed some privacy and, if they needed a nap, it had to be taken on a chair in a communal room (the quiet lounge), in which the number of chairs appeared to be insufficient. In addition, patients of the High Security Unit, Arderin and Kippure were subject to nighttime confinement, although the delegation was told that nighttime confinement was due to be phased out towards the end of June.[172] Thirdly, incoming patients were all admitted to the High Security Unit irrespective of individual risk assessments, and oftentimes placed in seclusion.

The CPT recommends that the Irish authorities, in close consultation with the Central Mental Hospital, review the aforementioned restrictive practices, including daytime denied access to the patients' rooms and nighttime confinement, in accordance with the patients' individual risk assessments. If it is deemed essential for the safety of some patients that they be prevented from staying in their own bedroom during the day, a living room with a sufficient number of chairs should be set aside for relaxation.

329. The delegation ascertained that many long-term patients at the Central Mental Hospital may not have required special security conditions, such as those which existed at the institution (see paragraph 324). Their stay there, as managerial and medical staff recognised, was less related to therapeutic exigencies than to the lack of a clear discharge pathway and suitable facilities in the community. In this regard, the CPT emphasises that it regards as highly problematic, and under certain conditions potentially degrading, the practice of imposing greater levels of restrictions on patients than those required by their condition.

170. Rooms measured some 11 m^2 excluding the separate sanitary annexe.
171. Wards also had access to shared outdoor yards for exercise, with three distinct daily slots allotted to each adjoining ward.
172. The routine was slightly less strict in the female high-security ward (Arderin), in which patients were allowed to go back to their rooms for an after-lunch nap and room doors could be left open at night for patients who needed extra support.

The CPT recommends that the authorities review the security classification of patients at the Central Mental Hospital and accordingly allocate them to security-appropriate psychiatric units or facilities in compliance with the principle of the least restrictive care.

330. Patients in the Central Mental Hospital could be granted escorted or unescorted ground leave, meaning that they could be allowed to go out of the wards and walk in the grounds of the hospital, either with or without staff, in groups or individually.
Patients could go to the coffee shop and other designated areas within the campus but, as a matter of general policy, were not allowed to stop and speak with each other except for greeting. Decisions on ground leave were made upon an application filed with the Leave Panel, based on a risk assessment carried out by a multi-disciplinary team,[173] following a procedure set out in the hospital's operational guidelines. Regrettably, a very limited number of patients were granted unescorted ground leave, and typically patients on the High Security Unit were not even granted escorted leave.

Patients could also be granted leave in the community (that is, outside the hospital), either escorted or unescorted. Leave is most usually allowed for up to two hours, and patients are in most cases accompanied by one or two members of staff. In the case of forensic patients, applications for community leave are decided upon by the Ministry of Justice upon request from the hospital Leave Committee, which considers a patient's risk of absconding, risk of harm and risk of non-compliance. However, staff reported that the procedure is lengthy and burdensome and, due to the limited duration of the leave granted by the Ministry (generally three to six months) and the time needed to renew the application for community leave, it is not uncommon to see interruptions (or regressions) in the patients' entitlement. Patients similarly complained of delays in applications for leave, and sometimes attributed them to doctors' busy schedules, which prevented a prompt preparation of the requisite files. Moreover, a significant number of planned session of leave had been cancelled due to shortages of accompanying staff or unavailability of transportation.[174]

Given its potential for rehabilitation and overall therapeutic benefits, the Irish authorities should strive to facilitate and encourage access to leave, both within the hospital's grounds and in the community, whether escorted or unescorted, by simplifying the applicable procedure if appropriate. In this regard, the authorities should reconsider, as regards ground leave, the blanket ban on meaningful contacts with other patients on ground leave, and as regards community leave, the short duration of the ministerial authorisation. These efforts should be part of a broader strategy to expand programmes preparing patients for community living, especially patients in medium-security and pre-discharge units. Of note is the fact that, for patients detained under the Mental Health Act 2001, the procedure for granting community leave does not envisage ministerial authorisation and, accordingly, the hospital management may already consider a revision of their current practice.
The CPT recommends that the authorities take measures to increase the opportunities for patients to benefit from leave, both within the hospital's grounds and in the community, including by authorising patients to associate with each other, unless individual security or other concerns prevail, and by streamlining the procedure to deal with requests for leave, ensuring that it is concluded within a reasonable time frame. Moreover, the Committee recommends that patients in the High Security Unit are also offered reasonable opportunities to benefit from ground leave.

331. The vast majority of the patients interviewed in the Central Mental Hospital indicated that the food was generally good, both in terms of quality and quantity. Patients may also buy food from a shop inside the premises.

332. Smoking was prohibited within the hospital's premises. The delegation heard a few complaints from patients who found the smoking ban difficult to comply with or unfair. However, patients suffering from nicotine addiction were offered nicotine replacement therapy (for example, patches or inhalers) on an individual basis and free of charge. It remained unclear if

173. The multi-disciplinary team comprised nursing staff, a consultant psychiatrist, psychologist, occupational therapist/activity specialist and social worker.
174. For example, staff reported that 24 planned sessions of community leave were cancelled due to staff shortages in the 40 days prior to the visit.

such a therapy would be routinely made available to secluded patients. **The CPT trusts that nicotine replacement therapy is made available to all patients who need and consent to it, including patients in seclusion.**

4. Treatment

333. The CPT considered that the pharmacotherapeutic treatment offered at the Central Mental Hospital was of a reasonable standard and afforded individualised care, depending on the patients' diagnosis. There was no shortage of medication, and the delegation found no evidence of systematic overuse. However, it noted the not infrequent high-dosage antipsychotic treatment and polypharmacy in certain wards.[175] While this reflected the complex needs of patients, it was not completely clear if any specific register or additional physical monitoring processes were in place (for example, ECG and urea and electrolytes as well as lithium monitoring, as necessary). Moreover, the CPT has misgivings regarding the medication of choice for rapid tranquillisation, which did not appear to align with relevant international standards.[176] **The Committee wishes to receive the comments of the authorities on this point.**

334. There was some recourse to pro re nata (PRN) medication at the Central Mental Hospital, especially for rapid titration (see paragraph 333). In principle, PRN medication was surrounded by appropriate safeguards and its administration was well documented. However, long-acting psychotropic drugs (depot and acuphase formulations) should not be used as PRN medication. **The CPT recommends that the authorities review this type of prescription at the Central Mental Hospital.**

335. The delegation was pleased to note that, in addition to pharmacotherapy, treatment comprised a robust component of occupational and psychosocial activities overseen by a committed multi-disciplinary team allocated to each patient. Occupational therapy was offered on a fairly regular basis to willing patients in accordance with their treatment plan, consisting of self-care and wellness, development of learning and relationship skills, acquisition of specific competencies and improvement of self-image, as well as cognitive remediation therapy, with sessions normally lasting up to one hour and including online courses.[177]

Social workers supported patients in maintaining relationships with the community, including through family visits, home visits, group work, finance, employment and accommodation, with a focus on preparation for reintegration into the community. They also assisted patients with children, especially by facilitating contact and visits. A team of 10 psychologists conducted several activities including a two-hour group session and two individual one-hour sessions per week per patient (including patients transferred from prison), in order to foster patients' personal development and carry out individual talks.[178]

Psychologists also performed neurocognitive capability assessments which informed placement decisions and treatment. Long-term psychotherapy involved a programme to review a patient's 'book of evidence' concerning their offence, recognition of responsibility for the offence and management

175. For example, in the Admission Ward (Lamagan), the delegation found evidence of polypharmacy and quite widespread use of high dose antipsychotic treatment (multiple depots and oral olanzapine comprising high dose olanzapine, co-administration of clozapine with other medications, immediate progression to IM acuphase and clopixol without evidence of offering oral medication); in the Intellectual Disability Ward (Kippure), there was evidence of polypharmacy and some prescribing outside official guidelines (clozapine for disorders of intellectual development).
176. Reference is made to the use of Zuclopenthixol acetate and decanoate i.m. for rapid titration, whereas international standards recommend using shorter acting substances such as haloperidol and a benzodiazepine which, unlike Clopenthixol, do not remain in the patient's body for several days and might make interventions less complicated in case of an adverse reaction. Consultants at the Central Mental Hospital explained in this regard that benzodiazepines are not used except when there is an absolute clinical indication.
177. In 2023, 12 patients completed a vocational training course in the hospital's catering department.
178. In 2023, according to the records provided to the delegation, 37 patients (29 male, eight female) participated in neuro-psychologically informed psychoeducation, 30 newly admitted patients (24 male, six female) participated in baseline neuropsychological assessments, and nine patients participated in the Book of Evidence Formulation Programme.

of violence risks. The range of therapeutic options thus comprised group therapy, individual psychotherapy and creative therapies in the Village Centre, such as woodwork, gardening, art, drama and music, as well as sporting activities to prepare patients for more independent living and/or a return to their families.

However, the records provided to the delegation showed that a relatively limited proportion of patients actually participated in the activities organised at the Village Centre.[179] Several activities were only offered on a limited number of days[180] and, as some patients told the delegation, the number of places available for certain activities did not meet demand from interested patients. Moreover, patients of the High Security Unit were granted little to no access to such activities.[181] While this had to do with security considerations, the delegation had the impression that not enough efforts were made to involve these patients in tailored activities. Furthermore, the personal files of some newly admitted patients did not contain psychology entries for months. **The CPT recommends that further steps be taken to broaden the availability and range of therapeutic and recreational activities available to patients, including patients in the High Security Unit. The authorities should further ensure that newly admitted patients receive psychosocial assistance promptly after hospitalisation, with regular follow-up sessions, and that all interventions are accurately recorded in the patients' files.**

336. The monitoring of the level of white blood cells for patients who are administered clozapine was carried out by nurses in the primary care facility of the Central Mental Hospital. This concerned between 50 and 60 patients at the time of the visit. **The CPT wishes to receive more detailed information on the system of required blood tests for patients treated with clozapine, including on the guidelines drawn up at the national or local level, and the training of nursing staff about the early signs of the potentially lethal side effects of this medication.**

337. Individual treatment plans were developed and reviewed by the multi-disciplinary team, the meetings of which, however, psychologists were not always able to attend owing to staff shortages (see paragraph 340). The plans indicated the goals of treatment, the therapeutic means used and the staff member responsible. The plans also contained the outcome of a regular review of the patient's mental health and somatic condition (including substance use or problematic behaviour issues), and prescribed medication. Plans would be reviewed regularly at multidisciplinary team meetings. Patients appeared to be involved in the drafting of their individual treatment plans and their subsequent modifications, and informed of their therapeutic progress. Most patients with whom the delegation spoke stated that they knew what medication they were taking and that they could discuss their medication regime with their treating psychiatrist. However, it was generally difficult to clearly understand from the treatment plans what the patients had to do in order to be discharged, a shortcoming which also emerged from interviews with patients. In addition to the treatment plans, each patient had a 'Model of care report', containing a number of assessments (HCR-20, Dundrum scale, etc.), a summary of completed therapeutic interventions, and a summary of the goals, needs and actions pertaining to the seven pillars constituting the model of care. **The CPT recommends that the authorities take steps to remedy these gaps, in particular regarding the identification of risk factors for acute patients and of the objectives to be achieved for moving into less-secure units, as well as for discharge.**

338. The delegation was pleased that patients with intellectual disabilities were accommodated in a dedicated unit with individualised care. It was positive that, unlike in other wards, patients had unrestricted access to their rooms during the day. However, a nighttime confinement was in place, with seven patients locked in their rooms at 23:00 and three patients at 20:45 (see recommendation at paragraph 328). It remained somewhat unclear why some patients could not be accommodated in the apartment adjacent to the ward.

179. Attendance records of January and February 2024, for example, documented around 11 to 25 patients (out of a total patient population of around 110) participating in activities at the Village Centre during most of the days (most popular activities were gym, band and woodwork).
180. In 2023, for example, the educational centre operated for 227 days, woodwork was offered on 131 days, gardening on 216 days, music on 60 sessions, gym/fitness on 154 sessions.
181. Patients from Donard were only allowed to go to the coffee shop, whereas patients from Lamagan had no access at all to the Village Centre.

339. The in-campus presence of a well-resourced primary care facility ensured prompt and comprehensive attention to the somatic healthcare needs of patients at the Central Mental Hospital. Patients received physical examinations by a healthcare professional upon admission and thereafter benefited from regular health check-ups and visits.

The primary care service consisted of a physician (coming in half day a week), four nurses-midwives (one focusing on infectious diseases) and a dentist coming every two weeks to treat up to five patients. Access to other specialists was via referrals to the local hospital. Since March 2023, there was a metabolic clinic every two weeks, which is positive, though the service still lacked a dietician and a physiotherapist. A podiatrist and an optician were available as needed. Both the medical files and interviews with patients attested to the very good level of somatic care provided to the hospital's patients, except for a three-week average wait for x-rays, which was reportedly longer than in the community. Patients who are wheelchair users would benefit from an occupational therapist with knowledge of physical disability. **The CPT invites the Irish authorities to consider procuring the services of a dietician, a physiotherapist and an occupational therapist with knowledge of physical disability.**

5. Staff

340. The staffing situation at the Central Mental Hospital appeared to be satisfactory vis-à-vis the patient population at the time of the visit. The staff complement deployed to the hospital comprised nine consultant psychiatrists (no vacancies), a part-time contracted physician (0.25 FTE), nine psychiatric registrars (trainees), 266 nursing staff (12 vacancies), 76.5 FTE healthcare assistants[182] (26 of whom were assigned to security duties) and 9.5 FTE social workers (0.5 vacancy). Staff shortages mainly affected the fields of psychology (seven vacancies out of 10 posts; problems have only been partly mitigated by the recruitment of eight assistant psychologists) and occupational therapy (three vacancies for 10 posts). Two positions of pharmacist were also vacant. **The CPT recommends that the Irish authorities reinforce their efforts to recruit an adequate number of staff to fill the aforementioned vacancies, with special regard to the positions of pharmacist, psychologist and occupational therapist.**

341. At the time of the visit, a moratorium on new recruitments was in place which, with few exceptions (namely, consultant psychiatrists), prevented the National Forensic Mental Health Service from employing new healthcare staff. As a consequence, the Service was unable to open the remaining wards in the Central Mental Hospital and additional stepdown facilities in the community (see paragraph 323), and could not replace retiring staff on a ongoing basis. This was not a sustainable situation in the long run. **The CPT would like to receive information from the Irish authorities on the long-term recruitment strategy of the National Forensic Mental Health Service and the related application of the moratorium to the Central Mental Hospital.**

342. In accordance with agreed minimum staffing levels, during the daytime there were always at least nine nurses[183] in the admission ward (Lamagan), seven to eight nurses in the acute wards (Binnian, Donard, Arderin), and six to seven nurses in the medium security and pre-discharge wards (Foye, Clermont, Kippure and Bengorm). This translated into an excellent average ratio of one nurse to one to two patients in the acute and medium security wards, and one nurse to three patients in the pre-discharge ward. Positively, the ratio was about 1:1 on the female acute ward. At night, nurses' presence ranged from three to six, depending on whether the ward observed nighttime confinement. Moreover, approximately five additional nurses would be assigned as reinforcements to deal with patients in seclusion or special observation. Nursing working hours were 7:45 to 21:00 (two consecutive shifts on duty followed by two shifts off) and, at night, 20:45 to 8:00 (six shifts on, six off).

182. Similar to the duties of staff designated as 'orderlies' in other jurisdictions, healthcare assistants were in charge of general supervision, hygiene and meals support of patients, along with providing assistance in therapeutic and recreational programmes.
183. Figures in this paragraph include circa 20% healthcare assistants.

343. As regards training, it is positive that all nursing staff working at the Central Mental Hospital were qualified psychiatric nurses. However, the delegation was concerned to learn that, due to a reform of the nursing training system, in the future there might no longer be nurses specifically trained for mental health. **The CPT would like to receive further information on this potential development, and strategies to avoid a potentially detrimental impact on the quality of care in psychiatric settings.**

344. The delegation was informed that nursing staff received regular training on Therapy Management of Violence and Aggression (TMVA), which included de-escalation techniques, as well as Basic Life Support and the Dangers of Restraint. Policy documents indicated that refresher courses were mandatory annually for application of restraint and bi-annually for Basic Life Support. Ten nurses were trained both in mental health and in intellectual disabilities, which is positive. A number of the nursing staff had undergone additional training, such as cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT), as well as family therapy.

6. Seclusion and means of restraint

345. Section 69 of the Mental Health Act 2001 constitutes the legal basis for the resort to seclusion and means of mechanical restraint in psychiatric settings. It authorises the Mental Health Commission to issue rules for the application of the said restrictive measures which are legally binding on 'approved centres' under the Mental Health Act, including the Central Mental Hospital. In contrast, as the law is silent on physical restraint, the Mental Health Commission only issued in this area a 'code of practice', which does not as such entail a legal duty to comply. In addition, the hospital's relevant policy mentions 'common law powers' to apply physical restraint to certain categories of patients, without any further specification. The CPT considers it to be good practice that a specialised and autonomous body, like the Mental Health Commission, be vested with the authority to develop and review rules on restrictive practices. However, **the Committee recommends that the Irish authorities clarify, by amending relevant legislation if necessary, the legal basis for the use of means of physical restraint and the related power to regulate it.**

346. The Mental Health Commission in September 2022 published revised rules governing the use of seclusion and mechanical restraint, which came into effect on 1 January 2023. The rules enshrine, among others, the key principles that seclusion and means of mechanical restraint may only be used in exceptional circumstances and must be the safest and least restrictive option of last resort vis-à-vis the prevailing situation, applied for the shortest possible duration and following reasonable attempts to use alternative means of de-escalation.[184] They shall not be used as a punitive action or to confront operational difficulties including staff shortages. They introduce a ban on the use of mechanical means of restraint for young persons, including the use of hand and leg cuffs. The rules stipulate various legal and medical safeguards, including in relation to the procedure for initiation and review, recording of instances and notification to the Mental Health Commission, and they largely align with the relevant CPT standards.[185] The rules now also require that, when seclusion or mechanical restraint is initiated by a registered nurse, a medical practitioner be informed immediately and carry out a medical examination of the patient no later than two hours following the application of the measure, thus implementing a recommendation made by the CPT in its last visit report.[186]

However, the rules on the use of seclusion are silent on the possibility of secluded patients taking at least one hour of outdoor exercise on a daily basis, if their medical condition so permits. As regards mechanical restraint, the applicable rules do not dictate that a qualified member of staff be permanently present in the room; video surveillance is not a substitute for personal direct monitoring. Moreover, the requirement that persons should be mechanically restrained out of the view of other patients should be explicitly specified. **The CPT recommends that the Rules Governing the Use**

184. This section does not address the use of mechanical restraint 'for enduring risk' of harm to self or others, such as the use of cot sides, bed rails, and lap belts.
185. See Means of restraint in psychiatric establishments for adults (Revised CPT standards), published in March 2017.
186. CPT report on the 2019 visit to Ireland, CPT/Inf (2020) 37, paragraph 110.

of Seclusion and the Rules Governing the Use of Mechanical Means of Bodily Restraint be amended accordingly, and the necessary revisions reflected in all relevant policies and procedures adopted by the National Forensic Mental Health Service.

347. Regarding the actual resort to seclusion and means of restraint at the Central Mental Hospital, the delegation positively noted the effective implementation of a last resort policy, meaning that, as attested by documentary evidence and interviews, seclusion was applied after other alternative options were explored including de-escalation techniques.
While no excessive recourse to seclusion in terms of the number of episodes was noted, seclusion appeared to be applied for lengthy periods of time. Of the 108 instances of seclusion recorded since 2023,[187] only ten lasted for less than 24 hours, while 38 were longer than ten days and 14 extended beyond one month. The CPT has doubts as to whether the seclusion of patients for such lengthy periods is justifiable.

In this context, the delegation examined the case of a patient who had been in uninterrupted seclusion for years on end, first at the hospital's previous premises in Dundrum and then at its current location. There was overall good quality care delivered, including a comprehensive individual care plan and capacity assessments, along with opportunities provided for some human interaction, family visits and access to fresh air. However, the move to the new premises had potentially been detrimental to this patient's quality of life, since he previously had access to a small suite of rooms, which allowed for a less restrictive environment.

In light of the lengthy duration of many instances of seclusion at the Central Mental Hospital, and in particular with reference to this case of extremely long seclusion, **the Committee invites the authorities to consider the development of a Long Term Segregation policy, which would allow for patients to be secluded in the ward, under specific arrangements regarding risk management and individualised levels of restriction. This policy should make sure that a range of strong safeguards are guaranteed (see following paragraph), an appropriate programme of therapeutic activities developed (including access to fresh air and, possibly, leave outside the hospital), and meaningful human contact ensured.**

348. Seclusion was practically always initiated by a nurse, with subsequent medical examinations carried out by a registrar (psychiatrist in training). Approvals and reviews by a consultant psychiatrist, medical examinations by a registered medical practitioner, and observations by a nurse generally took place within the statutory timeframes.[188] The relevant documentation, which comprised a seclusion care plan, was detailed and recorded in the electronic system. Nevertheless, the reasons for longer seclusion periods – that is, why seclusion should continue – and the performance of de-briefing sessions with the patient were not always clearly documented. This led to the delegation's impression, confirmed in interviews with patients, that patients were not made aware of what was required of them in order to be released from seclusion, and after release, were not always involved in a de-briefing.

Further, seclusion forms subsequent to the initial one were rarely fully completed and the nurses' observation records appeared to be a box-ticking exercise, with no indication as to whether the nurse had meaningfully engaged with the patient or had only performed passive observation.[189] Also, it further transpired from the documents that secluded patients were not routinely offered psychological or occupational therapy sessions.

187. 65 episodes of seclusion commenced in 2022 (in respect of 20 patients), 71 episodes commenced in 2023 (in respect of 50 patients), and 32 episodes commenced between 1 January and 30 April 2024 (in respect of 20 patients). At the time of the visit, three patients were in seclusion.
188. Medical examination by a registered medical practitioner no later than two hours after the commencement of the episode of seclusion. Continuation of seclusion ordered by a consultant psychiatrist no later than 30 minutes following the medical examination, for a period not exceeding four hours. Examination by a consultant psychiatrist within 24 hours of the commencement of the seclusion episode. Direct observation by a nurse during the first hour, then continuous observation. Written record every 15 minutes for the first two hours, then every two hours, subject to risk assessment.
189. It appeared that observation took place either though the glass panel or via video surveillance, thus it was unclear whether observation checks were used as an opportunity to interact and engage with the secluded patient.

The CPT recommends that records be properly maintained, with reasons for the initiation and continuation of seclusion exhaustively expressed. Adequate information should be provided to patients, in a manner adapted to their condition, about the reasons underlying the continuation of seclusion and, consequently, the conditions that patients need to satisfy in order for the measure to be ended. Furthermore, secluded patients should receive regular visits from psychologists or occupational therapists.

349. There were 11 seclusion rooms in the hospital wards that were operational at the time of the visit.[190] They all were of reasonable size and in a good state of repair, with sufficient access to natural light and adequate ventilation. They were fitted with a mattress on the floor,[191] a call bell, a clock displaying the hour and date, and a beanbag, and had a toilet area with a washbasin. A water jet from the ceiling served as a shower. No means of distraction were present in the room. An adjacent nurses' room with glass panel allowed observation, including through CCTV monitoring that ensured the privacy of patients was respected. Nurses and patients could communicate via microphone and speaker, but a significant echo effect in the seclusion room prevented clear comprehension, therefore staff explained that they often had to go to the garden and speak through the open window. The ward's seclusion wing also contained a de-escalation/relaxation area with sofa and TV for use on a case-by-case basis and a secure outdoor exercise yard. **The CPT recommends that measures are taken to improve the way in which secluded patients and nurses in the observation room can engage in meaningful communication. The CPT further recommends that more distractions be offered to patients kept in seclusion for long periods of time.**

350. Resort to means of mechanical restraint – notably, at the Central Mental Hospital, metal or fabric handcuffs – had to be authorised in advance by a consultant psychiatrist (or, in certain cases, by the executive clinical director and the area director of nursing) following a risk assessment, as per the hospital's policy. According to the records, there had been eight applications of mechanical restraint in 2023, and seven in the first four months of 2024, mostly for the purpose of transferring patients to court or external hospitals. The longest instances ranged from three to six and a half hours, all related to escorts to external hospitals. In a recent case, it appeared that a patient who had not been restrained during transportation to an external hospital had been handcuffed during the medical examination there, reportedly due to risk of absconding. **The Committee trusts that the use of means of restraint such as handcuffs when transporting a patient to an external hospital or during a medical examination is only resorted to as a last resort option, when no lesser form of control is deemed effective to address the risks posed by unrestricted movement, and that this is assessed on a case-by-case basis.**

351. As regards physical restraint, various types of possible manual holds were set out in a policy adopted at the Central Mental Hospital, which specified key principles such as use on a last resort basis, prohibition of pressure being applied to certain body parts including neck, thorax and back, and that the prone position should only be applied when it has become unavoidable. Since 2023, there had been 115 recorded applications of physical restraint at the Central Mental Hospital, principally consisting of holding patients in prone and upright positions. Their reported duration never exceeded 10 minutes, and was often shorter. Reasons adduced included aggressive or threatening behaviour towards staff or other patients and administration of treatment. Staff explained that, as a way to avoid the resort to more restrictive forms of restraint, patients would at times be cornered using a beanbag for a short period while they calm down. While the Committee considers this to be a potentially good and promising practice, it emphasises it being nonetheless a restriction on the patients' freedom of movement, which must be surrounded by adequate safeguards, including notification to a doctor, approval and recording. **The CPT recommends the consistent application of the policy on the use of physical restraints to all forms of restriction on the patients' freedom of movement.**

190. Six rooms in the High Security Unit, two in the Medium Security Unit, one in the Intellectual Disability Ward (Kippure), and two in the Female Unit (plus a high observation room).
191. Sometimes two, one of which was thinner and often used for applying a means of restraint.

352. Rapid tranquillisation ('titration'), whether administered orally or by injection, was prescribed by doctors at the Central Mental Hospital in response to patients' potentially harmful, agitated or aggressive behaviour (see paragraph 333). However, as in the past,[192] the administration of medication to calm or sedate a patient to reduce risk of harm, agitation or aggression did not qualify under the Irish legal framework as a form of restraint ("chemical restraint"), and therefore was not subject to the same legal and medical safeguards as other forms of restraint. **The CPT recommends that use of chemical restraint be regulated by clear rules and subjected to the same safeguards applying in Ireland to other means of restraint, including medical approval, review and oversight, recording in a centralised register, and reporting to an outside monitoring body.**

7. Legal safeguards

353. Concerning legal safeguards, the delegation analysed the situation of legally incapacitated patients ('wards of court') and forensic patients, both categories being involuntary detained at the Central Mental Hospital.

354. In Ireland, the legal framework governing the deprivation of legal capacity has been for many decades primarily based on the 1871 Lunacy Regulation (Ireland) Act, the main axes of which the CPT has already criticised for lacking the necessary minimum safeguards.[193] In short, the Lunacy Regulation allowed the President of the High Court to legally incapacitate any person found to be "of unsound mind and incapable of managing himself or his affairs" (thus making them a 'ward of court'), and also to detain such a person in a mental hospital. To overhaul this outdated system of wardship, the Assisted Decision-Making (Capacity) Act 2015 was passed, which for the most part entered into force on 16 April 2023.

The 2015 Capacity Act, as amended, aims to minimise any restriction on a person's rights, abiding by the principles of proportionality and least intrusive measure. It envisages a tiered system of decision support arrangements, depending on a person's level of capacity at the time a specific decision has to be made. For example, applications to a court may be lodged to seek the appointment of decision-making representatives or the approval of co-decision making arrangements entered into by the person lacking capacity. Over a three-year transitionary period, a comprehensive review of the situation of existing wards of court should take place. However, the delegation learnt that the projected review process was far behind schedule, due to insufficient resources. Furthermore, the scope of the 2015 Capacity Act does not encompass all patients involuntarily detained in a psychiatric facility, especially as regards consent to treatment. In particular, (i) it does not apply to young persons; (ii) it does not fully apply to patients detained under the Criminal Law (Insanity) Act 2006; and (iii) it does not apply to all categories of involuntary patients under the Mental Health Act 2001 (notably, patients detained on the grounds of risk). The CPT considers that the ongoing reform of the Mental Health Act 2001 could be the opportunity to extend the safeguards under the Assisted Decision-Making (Capacity) Act 2015 to all patients detained in psychiatric settings, irrespective of the legal basis for their detention.

The CPT wishes to receive updated information on the ongoing reform progress, in particular in respect of the scope of applicability of the Assisted Decision-Making (Capacity) Act 2015 for issues of consent to treatment. It also wishes to be kept informed of the progress of the transitional review of the situation of the persons who had been deprived of their capacity under the system of wardship.

355. At the time of the visit, the Central Mental Hospital was accommodating eight patients qualifying as wards of court and two patients detained under the inherent jurisdiction powers of the High Court. The Committee is concerned about the legal framework applicable to those patients, who enjoyed limited safeguards compared to persons detained under the Mental Health Act 2001 or the Criminal Law (Insanity) Act 2006.

192. CPT report on the 2010 visit to Ireland, CPT/Inf (2011) 3, paragraph 132.
193. CPT report on the 2010 visit to Ireland, CPT/Inf (2011) 3, paragraphs 143-148.

For instance, unlike in proceedings before the Mental Health Tribunal or the Criminal Law Review Board, patients and psychiatrists rarely appeared in person before the High Court[194] and judges were not necessarily specialised in the field of mental health. Judicial decisions were stereotyped and lacked adequate reasoning enabling the patients concerned (and other potential interested persons) to grasp the significance of the decisions and, where appropriate, avail themselves of avenues of appeal. As in the past,[195] decisions mandated a consultant psychiatrist to treat the patient "in his best interest" and medical staff would only seldom consult with the Office of Wards of Court. In the few recent cases to which the new Assisted Decision-Making (Capacity) Act 2015 was applied, the procedure and safeguards have not significantly improved, including the quality of judicial reasoning and patients' involvement in the process. It was positive, however, that reviews took place regularly on a six-month basis.

356. Several patients with whom the delegation spoke expressed frustration with the system, especially the indeterminate length of their detention. Most of them mentioned having little understanding of the legal decisions and the reasons why they were still detained, had no knowledge of possible ways to challenge them and, in some cases, complained of their inability to choose their legal representative.[196] As courts' decisions deprived them of any say, patients found themselves without agency.[197] Some patients wished to be transferred to a facility closer to home or family, but seemed unaware of whether and how this could be formally requested or obtained. Overall, the delegation gained the impression that nobody had been assigned to truly assist these patients in navigating the system, and had misgivings about whether there was sufficient engagement from the Office of the Wards of Court.

357. In addition, the delegation found that in certain cases the system of wardship (and the court's inherent jurisdiction) was resorted to in order to continue the detention of patients whose admission or renewal orders had been revoked by the Mental Health Tribunal, or whose sentences had expired years prior.

For example, the delegation examined the case of a patient whose detention order was revoked in 2021 by the Mental Health Tribunal, which found him not to be suffering from a mental disorder within the meaning of the Mental Health Act 2001. On the same day, an application was lodged to, and granted by, the High Court to make him a ward of court and detain him at the Central Mental Hospital. In another case, dating to 2024, the Mental Health Tribunal revoked the renewal order due to a procedural error. On the same day, the High Court ordered the patient's (continued) detention based on its inherent jurisdiction powers.

The Committee is highly critical of this situation, which not only tarnishes the credibility of the review systems in place for involuntarily detained patients, but also raises questions about compliance with the requirements of legal certainty and effective judicial review. The CPT does appreciate the complexities of those situations, including the patients' state of health and need for a high level of support. However, from a clinical and therapeutic perspective, it believes that long-term, low-risk patients should be given the opportunity to live under less restrictive conditions, with a focus on their quality of life, and that a highly secure hospital setting may not be suitable for them.[198] The delegation learnt that the wardship system has also been used to admit 'civil' patients directly into the Central Mental Hospital,[199] an avenue not envisaged under the Mental Health Act 2001. This is another lacuna that the Irish authorities should fill without further delay.

---

194. Their appearances occurred usually via video link.
195. CPT report on the 2010 visit to Ireland, CPT/Inf (2011) 3, paragraph 147.
196. A patient said he could not speak with the lawyer before his first hearing at the High Court. At a month's distance from the decision, the hospital could not provide evidence refuting the patient's assertion that he had not yet been given a copy of the said decision.
197. Asked about the functioning of the wardship system, a patient replied: "It's just the court deciding everything for you". Others recalled the questions by the judge being: "Are you fine there?", with no inquiry into a patient's state of mind concerning their continued detention or involuntary treatment.
198. From the several psychiatric reports analysed, the delegation gained the impression that they were often quite repetitive, including as regards recent progress and conclusions, and that they lacked precise indications as to how patients would ever be able to demonstrate that their risk factors had reduced, given that opportunities to test their behaviour in less restrictive settings were very rarely, if ever, granted.
199. For example, patients transferred from another jurisdiction.

The CPT calls upon the Irish authorities to review, as a matter of urgency, the legal basis for detention and the safeguards afforded to patients detained under the provisions of the 1871 Lunacy Regulation (Ireland) Act (wards of court) and the inherent jurisdiction powers of the High Court. New mental capacity legislation should follow the principles outlined in Recommendation R (99) 4 of the Committee of Ministers of the Council of Europe, ensuring that the personal autonomy of patients is respected to the extent possible.

358. A related legal issue regards consent to treatment for patients who are incapable or refuse to consent. Consent to treatment is governed by Part 4 of the Mental Health Act 2001. Consent of a patient is required for treatment except where, in the opinion of the treating psychiatrist, the treatment is necessary (i) to safeguard the life of the patient, (ii) to restore their health, (iii) to alleviate their condition, or (iv) to relieve their suffering, *and* by reason of their mental disorder the patient concerned is incapable of giving such consent.

An opinion from a second consultant psychiatrist is required by law within three months of the commencement of the involuntary treatment.[200] It remained unclear whether Part 4 of the Mental Health Act 2001 also applies to patients detained under the Criminal Law (Insanity) Act 2006.

The delegation appreciated that it was common practice at the Central Mental Hospital to request an opinion from a second consultant psychiatrist within days of starting the treatment. However, the Committee considers that the three-month statutory deadline for the independent assessment of the necessity and appropriateness of the involuntary treatment is excessively long. An involuntary placement order should not automatically enable the administration of treatment without consent.

In addition, having reviewed several 'second' psychiatric opinions, the delegation often found them lacking in adequate depth of analysis and specificity. **The CPT recommends, once again, that the Irish authorities amend the legislation and practice on consent to treatment accordingly, including by introducing appropriate procedures and safeguards for patients detained under the Criminal Law (Insanity) Act 2006.**

359. Under the Criminal Law (Insanity) Act 2006, responsibility for the review of the detention of a forensic patient at a designated centre (that is, at the Central Mental Hospital) is entrusted to the Criminal Law Review Board, which shall carry it out at least every six months. During a review, the Board will have regard to the welfare and safety of the person being reviewed and to the public interest. The Board will determine, as appropriate, the questions of (i) whether inpatient care or treatment at the Central Mental Hospital is still required or, (ii) whether the patient is still unfit to stand trial by reason of mental disorder. On proposal from the clinical director or on its own initiative, the Board may release patients with or without conditions (for example, outpatient treatment or supervision) or transfer them back to prison. It was unclear whether the decisions of the Board were open to judicial review. **The Committee wishes to receive detailed information on the possibility for patients to challenge the decisions of the Criminal Law Review Board before a judicial authority.**

360. According to information received by the delegation, in 2023 the Board held 187 review hearings related to 88 patients, nine of whom were discharged (five patients with conditions, four unconditionally); in January-April 2024, the Board held 68 hearings for 67 patients, six of whom were discharged (four with and two without conditions). Interviews with staff and patients indicated that the Board held its hearings at the hospital, and that patients regularly attended the hearings in person, enjoyed legal aid, were offered an opportunity to make submissions, and were provided with a copy of the decision. In case of need, the Board would hold the hearing in the patient's unit to facilitate their participation, which is a good practice. Nevertheless, the Board's decisions appeared in most cases to be inadequately motivated. In addition to being cursory, they often failed to give a meaningful account of the evolution of a patient's state of health, including recent and concrete elements indicating the patient's present (and not past) dangerousness, and the reasons underlying the renewal of a patient's detention at the Central Mental Hospital. This appeared to be especially problematic for long-term patients, as the longer the period of detention, the stronger should be the

200. Section 60 of the Mental Health Act 2001.

reasons for their continuing detention. Many of the patients perceived the hearings as a mere formality. In addition, the CPT is critical of the fact that patients' refusal to recognise or accept their mental illness was often considered a factor militating against discharge. **The CPT would like to receive the comments of the Irish authorities on these questions.**

8. Other issues

361. As mandated by law, the Central Mental Hospital had a written policy on complaints. The policy set out the procedure to deal with complaints from patients or their representatives, including internal investigation, review and possible referrals to external bodies such as the Ombudsperson, the Mental Health Commission or the Health Information and Quality Authority. In practice, staff told the delegation that complaints would be most usually made to a nurse and discussed during community/unit meetings. Information on the possibility to submit a complaint was posted on the wards' boards, but the only avenue of complaint specified in the sheets was to 'write a letter to the Complaints Office' and give it to a member of staff. This could be difficult to understand for patients, whereas a form with a predefined layout might be easier to complete. Moreover, it would be helpful that patients be assisted by an independent advocacy service in filing complaints. The majority of patients interviewed by the delegation were not aware of the possibility and the modalities to submit a complaint (especially to an external body), though most would speculate that they would have to speak with a nurse. Some patients expressed scepticism about the effectiveness of the complaints system. No complaint boxes had been installed in the wards.

It was positive that the information booklet given to newly admitted patients did contain comprehensive information on the complaints procedure, including advocacy services and external monitoring bodies.

The CPT recommends that the Irish authorities develop a complaint form adapted to the special needs of the patients at the Central Mental Hospital and increase the visibility and accessibility of the information on how to submit a complaint, with inclusion of the possibility to provide independent advocacy service to assist patients in submitting complaints to internal or external bodies, as appropriate.

362. The situation as regards contact with the community was satisfactory. Patients were allowed visits from family and friends, usually in the visiting rooms of the wards, which had access to an outdoor yard, and under supervision of staff. Meetings with lawyers would take place in separate rooms to ensure confidentiality. Visits from children, which had to be authorised by the multidisciplinary team,[201] also took place in special rooms, under supervision of staff. Options to make phone calls (including VOIP calls) were adequate and did not raise particular issues, with many patients permitted to use their personal device. **The Committee encourages the Irish authorities to explore options to introduce unsupervised visits for patients, based on an individualised risk assessment.**

363. Concerning inspections, the Inspector of Mental Health Services carried out annual inspections of all approved centres, including the Central Mental Hospital, assessing, among other things, compliance with the regulations (and codes of conduct) issued by its parent body, the Mental Health Commission. The CPT welcomes the existence of this effective inspection mechanism.

201. The multidisciplinary team would assess whether the visit would be in the child's best interest.

APPENDIX I – ESTABLISHMENTS VISITED

The delegation visited the following places of detention:

Establishments operating under the authority of the Department of Justice

- Castlerea Prison (Castlerea)
- Cloverhill Remand Prison (Dublin)
- Limerick Female Prison (Limerick)
- Limerick Male Prison (Limerick)
- Mountjoy Female Prison (Dóchas Centre) (Dublin)
- Mountjoy Prison High Support Unit* (Dublin)

Establishments operating under the authority of the Department of Health

- Central Mental Hospital (Portrane)

Establishments operating under the authority of the Department of Children, Equality, Disability, Integration and Youth

- Oberstown Children Detention Campus (Lusk, Co. Dublin)
- Ballydowd Special Care Unit* (Lucan, Co. Dublin)

*Targeted visit to assess the provision of mental healthcare and the application of restrictive measures.

APPENDIX II – CONSULTATIONS HELD

List of the national authorities, other bodies and non-governmental organisations with which the CPT's delegation held consultations:

A. National authorities

Department of Justice and Equality

Helen McEntee, T.D.	Minister for Justice
Oonagh McPhillips	Secretary General
John O'Callaghan	Deputy Secretary General
Deirdre McDonnell	Assistant Secretary, Head of Criminal Governance
Neil Ward	Assistant Secretary, Head of Transparency
Ben Ryan	Assistant Secretary, Head of Criminal Policy
Rachel Woods	Assistant Secretary, Head of Criminal Legislation
Siobhan Barron	Principal Officer, Criminal Justice Governance, National Liaison Officer
Patrick Cluskey	Special Advisor to the Minister for Justice
Cliona Doyle	Press Adviser to the Minister for Justice
Eileen Leahy	Principal Officer, Immigration Service Delivery
Mary O'Regan	Principal Officer, Criminal Justice Policy
Gail Malone	Principal Officer, Criminal Justice Governance

Irish Prison Service (IPS)

Caron McCaffrey	Director General
Alam Armstrong	Press and Communications Manager
Emma Regan	Director of Care and Rehabilitation
Don Culliton	Director of Operations
Paul Mannering	Principal Officer, Operations
David Joyce	Acting National Clinical Lead
Enda Kelly	National Nurse Manager
Emmett Conroy	National Infection Control Manager

An Garda Síochána

Justin KELLY	Assistant Commissioner, Serious and Organised Crime
Ann MARKEY	Chief Superintendent

Department of Health

Mary Butler, T.D.	Minister of State for Mental Health and Older People,
Corona Joyce	Minister's Advisor
Siobhan McArdle	Assistant Secretary, Social Care, Mental Health, Drugs Policy and Unscheduled Care, Chair
Philip Dodd	Policy and Clinical Advisor, Mental Health Unit
Siobhan Hargis	Principal Officer, Mental Health Unit
Michael Murchan	Assistant Principal Officer, Mental Health Unit
James Kelly	Assistant Principal, Mental Health Unit
Laura Casey	Principal Officer, Social Care Projects
Philip Dodd	Policy and Clinical Advisor, Mental Health Unit
Siobhan Hargis	Principal Officer, Mental Health Unit
Michael Murchan	Assistant Principal Officer, Mental Health Unit
Laura Casey	Principal Officer Social Care Projects

Health Service Executive

Dervilla Eyres	Assistant National Director, Head of Operations Mental Health
Pat Bergin	Head of Service, Central Mental Hospital, National Forensic Mental Health Service
Bernard O'Regan	Head of Operations, Disability Services

Central Mental Hospital

Brenda Wright	Executive Clinical Director, CMH

Department of Children, Equality, Disability, Integration and Youth

Kevin McCarthy	Secretary General
Colm O'Conaill	Assistant Secretary, Disability and Youth Division, Chair
Úna Ní Dhubhghaill	Principal Officer, Children Detention Schools Unit
Audrey Hagerty	Principal Officer, Disability Residential Services Unit
Marie Kennedy	Principal Officer, Alternative Care Policy Unit
Niall Brunell	Principal Officer, Disability & Equality Policy
Marie Kennedy	Principal Officer, Alternative Care Policy Unit
Patricia Davey	Higher Executive Officer, Children Detention Schools Unit
Laura Cosmescu	Executive Officer, Children Detention Schools Unit

Tusla

William O'Rourke	Service Director, Children's Residential Services

Oberstown

Damien Hernon	Director

<u>Other authorities</u>

Ger DEERING	Ombudsman and Information Commissioner for Ireland,
Mark KELLY	Chief Inspector of the Office of the Inspector of Prisons,
Niall MULDOON	Ombudsman for Children
Orla KEANE	General Counsel for the Mental Health Commission
Jim LUCEY	Inspector of Mental Health Services.
Stephen COLLINS	Senior Solicitor, Irish Human Rights and Equality Commission (IREC)
Eva BOYLE	Head of Children's Service, Health Information and Quality Authority (HIQA)
Bronagh GIBSON	Head of Programme International Protection Accommodation, HIQA

B. Non-governmental Organisations

Irish Penal Reform Trust

Irish Council for Civil Liberties

Mental Health Reform

Empowering People in Care (EPIC).

C. Other Organisations

College of Psychiatrists of Ireland