Digest of Systemic Recommendations issued to An Garda Síochána: April-December 2022

GSOC Systemic Recommendation Periodic Publication #1
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Background

During the investigation of an incident by GSOC, systemic issues of policy and practice are often uncovered, even where no individual wrongdoing is found. GSOC's role then, is to identify if there are any systemic, procedural or organisational failures, that if left uncorrected can leave unresolved risk.

Where such issues are identified, it is GSOC's practice to issue 'systemic recommendations' to the Garda Commissioner. The recommendations are made on a non-statutory basis.

Systemic recommendations briefly explain the circumstances that prompted the investigation, the evidence gathered, and any conclusions and recommendations that arise. They are anonymised to protect the identity of the people involved.

To date, in addition to issuing them to the Garda Commissioner, GSOC has published systemic recommendations in summary in its Annual Reports.

In 2022, GSOC adopted a new approach to the preparation and issue of systemic recommendations. Following issue to the Garda Commissioner, GSOC now forwards the recommendation, and any information or update arising, to:

- The Department of Justice
- The Policing Authority
- The Garda Inspectorate
- The Irish Human Rights and Equality Commission

The recommendations are thereafter compiled and published, on a periodic basis.

This document is the first such publication, compiling systemic recommendations issued by GSOC to the Garda Commissioner between April and December 2022.

SYSTEMIC RECOMMENDATION

GSOC-SR1-22

Issued to An Garda Síochána 22/4/22

BACKGROUND: -

The investigation concerned a complaint that members of An Garda Síochána failed to properly investigate criminal allegations of sexual assault made against a Garda who was on probation at the time of the alleged incident.

GSOC found that the investigation conducted by An Garda Síochána was satisfactory and within acceptable parameters. It was found that an investigation had been conducted and that a file was forwarded to the DPP with all relevant evidence, resulting in a no prosecution decision from the DPP.

The GSOC investigation recommended that no disciplinary proceedings be brought against any Garda member.

ISSUE IDENTIFIED: -

Enquiries conducted by GSOC during the course of its investigation found that the original Garda investigation file concerning the complaint made against the Garda member could not be located. The misplacement or loss of any Garda investigation file is an issue of concern and, in particular, the retention and storage of investigation reports and materials after an investigation has been completed requires attention.

Secondly, enquiries conducted by GSOC found that the incident reported by the complainant to An Garda Síochána had not been recorded on the Garda PULSE IT system. Although the member with responsibility for this task is now retired and therefore no further action can be taken in this regard, GSOC wish to highlight this as an issue of concern.

Enquiries conducted by GSOC also found that there was a failure to notify Garda Human Resources Management concerning the Garda investigation in relation to the Garda suspect, as required in such circumstances by Garda policy. GSOC wish to highlight this matter to the Garda Commissioner and request confirmation that due consideration has been taken regarding the allegations that were made against this Garda member.

RECOMMENDATION: -

The Ombudsman Commission recommends that:

1. A review is conducted in relation to the storage and retention of Garda investigation files after an investigation has been completed. It is recommended that consideration be given to establishing a standardised system for the filing of investigation files and that digital scans of files be maintained. In this regard, GSOC highlights that a previous systemic recommendation was made to An Garda Síochána by GSOC concerning the loss of a Garda investigation file regarding an alleged sexual assault.

2. An Garda Síochána review current Garda policy and procedure regarding the effectiveness of its internal processes for the risk assessment of members or staff who are investigated for sexual violence and other serious crimes where the alleged behaviour could pose a threat to the public, colleagues or the integrity of An Garda Síochána.

3. An Garda Síochána review current Garda policy and procedure regarding the effectiveness of its internal processes for notifying its Human Resource Management that a member of An Garda Síochána has been accused of sexual violence.

RESPONSE RECEIVED: -

A letter of acknowledgement was received from An Garda Síochána in May 2022.

The letter confirmed that the recommendations have been forwarded to the Strategic Transformation Office, and Executive Support and Corporate Services, for consideration. It was confirmed that these offices have been requested to correspond with GSOC with respect to any action taken on recommendation 1.

With respect to recommendation 2, the letter advised that policy and procedure has been updated and implemented since this matter arose, and that criminal disciplinary matters are now reported and notified to Internal Affairs, who maintain a record of all matters, including those involving sexual violence. It was further advised that local Garda Management conduct risk assessments in respect of reported matters, and that reports are made to the Assistant Commissioner Governance and Accountability, who has been delegated responsibility for suspension.

With respect to recommendation 3, the letter re-stated that policy and procedure have been updated since this matter arose, and that all criminal and disciplinary matters are reported to Internal Affairs. The letter added that an additional database is maintained by Internal Affairs of members who are the subject of investigations involving sexual offences, domestic violence, or incidents involving discrimination.

SYSTEMIC RECOMMENDATION

GSOC-SR2-22

Issued to An Garda Síochána 12/5/22

BACKGROUND:

Garda HQ Directive 044/2019, *The Managed Containment and Stopping of Subject Vehicles*, came into effect on 19 September 2019. This document sets out the procedure for how a managed containment may commence and should be managed throughout its duration. It is recognised that the document does not seek to be prescriptive, as a managed containment is a dynamic event and circumstances are constantly changing.

This systemic recommendation is being made following the investigation of three referrals made to GSOC in the 12-month period following the introduction of HQ 044/2019. Each incident involved a managed containment that ceased when each of the subject vehicles crashed. No Garda vehicles were involved in any of the collisions.

In each case, the conduct of Garda members involved was considered to have contravened the requirements of the HQ Directive.

ISSUE IDENTIFIED: -

The key issue identified upon the examination of these incidents was the absence of formal training to accompany the introduction of the new policy and its associated HQ Directive.

Members involved in these incidents recounted having been made aware of the new policy via email or via the Garda portal, and were instructed to simply familiarise themselves with its contents and their responsibilities within it.

Vehicle containment and the stopping of subject vehicles is a dynamic, high risk aspect of policing that requires high levels of practical driving skills, judgement and experience along with strong decision-making ability from those charged with the management of such incidents.

Some specific matters concerning the incidents referred are:

1. While the decision to commence a managed containment initially rests with the Garda driver concerned, there are no set parameters relating to the 'judgement, experience, skills and knowledge' they are expected to apply. For example, a certain speed over the signposted limit may result in the termination of a managed containment, notwithstanding the absence of any other risk factors at the time.

2. There is no defined threshold for the known or suspected offences that the occupants of subject vehicles may have been involved in, which may or may not justify the commencement of a managed containment.
3. There is no agreed terminology or form of words for use over the Tetra radio network during a managed containment. This includes the seeking and issuing of authorisation to continue with the managed containment.
4. There was no accepted method for recording the dynamic risk assessment that members are expected to undertake, despite submissions by members that they were undertaking such assessments as the incidents unfolded.
5. There was no recorded use of the aide-memoire from the HQ Directive. While the HQ Directive specifically details that managed containment incidents do not lend themselves to working through a checklist, it was nonetheless found that no reference was made to it by any member in these referrals.
6. The members were asked during the managed containment if they were familiar with the HQ Dir 044/2019. It was not clear what the implication of a negative answer might have been, or why. In circumstances of difficult radio reception, this created confusion and was a distraction for the Observer who was trying to pass location information and vehicle details to the Communications Centre.
7. The variation in directive control across dispatchers in the three incidents is marked and reflects the absence of standardised training and variance in experience. These disparate examples may be useful to draw upon in the development of any training program in future.
8. None of these incidents had reached the stage of appointing a containment coordinator so that aspect of the procedure cannot be commented upon.

RECOMMENDATION: -

The Commission recommends that:

- The Garda Síochána develop and implement a training program for those with the driver competencies that are authorised to conduct vehicle pursuits, and for Communications Centre staff, regarding the practical application of HQ Directive 044/2019.

- Training should focus on the use of the Garda Decision Making Model to continually balance human welfare and the threat posed by the vehicle/occupants sought.

- The training should equip those conducting /authorising/ managing vehicle pursuits to make decisions within the GDMM framework that are lawful, justified, and necessary in the circumstances, proportionate to the perceived risk, and the least intrusive option available.

Each training event should incorporate those conducting /authorising/ managing vehicle pursuits in order that each specified role and all relevant tactics are properly understood. The training should include case studies from real life scenarios to identify key learning points.

RESPONSE RECEIVED: -

- Letter of acknowledgment received from An Garda Síochána on 20/5/22.

SYSTEMIC RECOMMENDATION

GSOC-SR3-22

Issued to An Garda Síochána 14/09/22

BACKGROUND:-

A Garda Superintendent made a referral to GSOC under section 102(2) of Garda Síochána Act, 2005, following the death of a man who had been in custody.

Earlier that evening, Gardaí from the local station had attended a call for assistance. The caller alleged her husband had returned home drunk and abusive and was in breach of a Protection Order.

The Garda arrested the man for breaching the Protection Order and he was taken to the local Garda station. He was intoxicated at the time of arrest and placed in a cell. Regular checks were conducted by Gardaí. The man was found unresponsive in his cell. An ambulance was called and he was conveyed to the local hospital. The man never regained consciousness and he later died.

GSOC conducted an independent investigation of the incident, and found that there had been no breach of Garda Discipline Regulations.

ISSUE IDENTIFIED: -

In the course of its investigation, GSOC noted that there were no CCTV cameras at the Garda Station, and that it was not equipped with a Defibrillator. GSOC further noted that Gardaí did not appear to make note of the medical alert bracelet worn by the detainee.

These gaps align closely with the broader analysis of gaps in Garda custody practice identified by the Garda Inspectorate in its recent report *Delivering Custody Services.*

This report highlighted that:

"There are many ways, both physical and technological, to check the health, safety and wellbeing of persons in custody. These include the use of CCTV systems and regular visits to the person by the member in charge or gaoler."

Rather than multiple recommendations focusing on the same core issue (the safety of detained persons), the Commission in the public interest will endorse the existing relevant recommendations by the Garda Síochána Inspectorate, and provide additional recommendations based on our case-specific findings.

RECOMMENDATIONS: -

Based on the GSOC investigation of this case, the Commission wishes to recommend as follows:

1. To affirm the Garda Inspectorate findings and the following recommendations:

- That the Garda Síochána improve the monitoring of the health, safety and wellbeing of persons in custody;

- That the Garda Síochána develop a mandatory training and development programme for all those who undertake member in charge and gaoler roles. The training and development programme should incorporate all aspects of custody, including law and policy, human rights, risk management, vulnerability, diversity and mental health awareness, first aid, use of force in custody and de-escalation techniques.

2. The Commission recommends that the Garda Commissioner:

- Develop a strategy for the installation of defibrillators in Garda Stations, including appropriate training to all Garda members based in the identified locations;

- Ensures all Garda members are made aware of the significance of medical alert bracelets.

RESPONSE RECEIVED: -

- Letter of acknowledgment received from An Garda Síochána on 19/09/22

SYSTEMIC RECOMMENDATION

GSOC-SR4-22

Issued to An Garda Síochána 14/09/22

(Matter also raised with HM Inspectorate of Constabulary in the UK)

BACKGROUND: -

In 2019, a member of the public made a report of sexual assault to Gardaí. The assault had taken place in the UK, although the victim and other relevant persons, including the suspect, were all residing in Ireland.

The member of the public subsequently complained to GSOC that they believed the Garda investigation was ineffective and incompetent. They stated that they lived in fear of the suspect, and that the delays on the part of Gardaí had made the situation worse. They also stated they had received conflicting information from Gardaí and the UK police force.

The investigating Garda initially received advice that Gardaí could investigate the sexual assault allegation. Contact was made with the relevant police force in the UK, and the investigating Garda subsequently carried out enquiries in Ireland.

The investigating Garda made contact with the Garda Interpol liaison and received advice that they could send a file to the DPP in Ireland, quoting legislation which turned out not to be applicable to the offence. They subsequently received a response from the Garda Crime Legal team, confirming that Gardaí could not lead the investigation, as the country where the incident occurred had not ratified the Istanbul Convention, and therefore the Criminal Justice (Extraterritorial Jurisdiction) Act 2019 did not apply.

The UK police force subsequently accepted jurisdiction, after a delay. The net effect on the victim was that they received conflicting information from the UK police force and An Garda Síochána, leading to a loss of confidence in the criminal justice system.

ISSUE IDENTIFIED: -

The key issue identified is that there was a lack of awareness amongst Gardaí of Garda policies regarding offences committed outside their jurisdiction, and a lack of understanding that there are a number of countries in the Council of Europe for which Gardaí do not have the authority to investigate offences under section 3 of the Criminal Justice (Extraterritorial Jurisdiction) Act 2019.

Although the UK has now ratified the Istanbul Convention, it will not have the power of law until 1 November 2022.

The following countries in the Council of Europe have also not ratified the Convention: Armenia, Azerbaijan, Bulgaria, the Czech Republic, Hungary, Latvia, Lithuania, the Slovak Republic and Turkey (which has since withdrawn from the Convention).

RECOMMENDATION: -

The Commission recommends that:

- The Garda Síochána inform its members of the countries for which the Criminal Justice (Extraterritorial Jurisdiction) Act 2019 cannot be used, and remind its members of the processes to be followed regarding offences committed outside their jurisdiction.

RESPONSE RECEIVED: -

- Letter of acknowledgment received from An Garda Síochána on 19/09/22
- Letter of acknowledgment received from HM Inspectorate of Constabulary on 3/10/22

SYSTEMIC RECOMMENDATION

GSOC-SR5-22
Issued to an Garda Síochána: 23/11/2022

BACKGROUND: -

GSOC received a referral pursuant to s.102 of the Garda Síochána Act, 2005, as amended, following the death of a man in hospital a number of days after being released from custody.

The deceased suffered from alcohol dependency. He had fallen down on a public street having consumed a significant amount of alcohol. An ambulance was called and paramedics identified that the man had suffered a wound to the back of his head, but noted that it was not haemorrhaging. On the way to the hospital, the patient became aggressive and the paramedics brought him to a Garda station. The man refused to go to hospital and was then arrested under s.4 of the Public Order Act, 1994 and s.25 of the Liquor Licensing Act, 1874. On arrival at the Garda Station, a small amount of dried blood was visible on the man's head.

The man was placed in a cell at 18:00. At 18:55, he was taken from his cell to the room of the member in charge, where he was left lying on the ground for a period of time. At 18:58, the man's daughter was brought into the room, and attempted to bring him to his feet unsuccessfully. The man was left lying on the ground until 19:14. A taxi was then called for the man and members carried him out to the taxi but the driver refused to take the man, asserting that an ambulance was required. The man was returned to his cell where he remained until 22:00, at which time he could not be roused. An ambulance was called, arrived at 23:00, and brought the man to the hospital. The man was diagnosed with skull fractures and extensive internal bleeding in his head. He did not regain consciousness and died from his injuries a number of days later. The pathologist's report revealed three fractures to the man's head which were caused by the fall. It also found that the injury to the brain was so severe that earlier medical intervention may not have resulted in a different outcome. The pathologist also stated that the external injury was not representative of the seriousness of the internal injury. The man's blood alcohol was revealed to be at a toxic level.

Following the investigation conducted by GSOC, one member was found in breach of the Garda Síochána (Discipline) Regulations 2007.

ISSUE IDENTIFIED: -

The key issues identified during the course of this investigation included the lack of formal training relating to the duties of the member in charge in a Garda station, the lack of formal training relating

to dealing with intoxicated persons, and the lack of training relating to dealing with prisoners suffering from a medical injury.

The investigation also identified a lack of adherence to the Treatment of Persons in Custody regulations. There were a number of inconsistencies and flaws in the custody record relating to this incident. Some entries were false or inadequate, while other relevant details had not been recorded.

In addition, the Garda members failed to properly monitor or rouse the prisoner who was both intoxicated and suffering from a head injury, in accordance with the relevant regulations.

At the inquest, the Coroner made the following recommendation and requested that it be brought to the notice of An Garda Síochána: "Medical opinion should be sought before a pre-comatose, comatose, or intoxicated prisoner is incarcerated in a Garda Station".

RECOMMENDATION: -

The Commission recommends that:

- Medical opinion should be sought before a pre-comatose, comatose, or intoxicated prisoner is incarcerated in a Garda Station.
- An Garda Síochána improve the monitoring of the health, safety and wellbeing of persons in custody (*as recommended by the Garda Inspectorate in the Report on "Delivering Custody Services" (July 2021))*
- As per the Garda Inspectorate Report on *"Delivering Custody Services" (July 2021),* that An Garda Síochána improve its arrangements for the provision of medical services to people in custody. To achieve this, it should:
    - Improve the standard of the documented medical information in custody records;
    - Proactively monitor the time between when a doctor is called and when a medical examination is carried out, and address any shortcomings with the service provider;
    - As part of its custody strategy, consider embedding healthcare professionals in custody facilities;
    - Ensure better recording and supervision of in-cell observations;
    - Include the installation of in-cell technology in the specification for custody suites in the custody estate plan;
    - Routinely review CCTV footage to check that persons in custody are treated with dignity and respect and in accordance with regulations and policy; and
    - Ensure that CCTV signage is prominently displayed in all areas where CCTV systems are installed.
- As per the Garda Inspectorate Report on *"Delivering Custody Services" (July 2021),* that An Garda Síochána appoint sergeants as members in charge in all custody facilities and assign the roles of member in charge and gaoler on a permanent basis. To support this model the following actions need to be taken:

    - The role and responsibilities of gaoler should be defined;

- Only those trained and operationally competent should be authorised to undertake custody duties; and
- Consideration should be given to recruiting detention officers to assist members in charge in locations where demand justifies it.

- As per the Garda Inspectorate Report on *"Delivering Custody Services" (July 2021),* that An Garda Síochána develop a mandatory training and development programme for all those who undertake member in charge and gaoler roles. The training and development programme should:

    - Incorporate all aspects of custody including law and policy, human rights, risk management, vulnerability, diversity and mental health awareness, first aid, use of force in custody and de-escalation techniques;
    - Be informed by lessons learned and good practice;
    - Involve key stakeholders in its design and delivery; and
    - Be accompanied by regular refresher training and information-sharing events.

- As per the Garda Inspectorate Report on *"Delivering Custody Services" (July 2021),* that pending the implementation of the above recommendation, An Garda Síochána improve the supervision of Garda members who perform the role of member in charge by ensuring sergeants comply with their responsibilities under the Garda Code.

In reference to the above recommendations, please note that previous similar recommendations have been made by GSOC to An Garda Síochána. These include:

- On 8 September 2015 GSOC recommended Garda Commissioner consider revisiting the regulations and guidelines relating to treatment of detained persons, with particular regard to the risks of intoxication. In relation to a death in custody, GSOC recommended that AGS consider the training of dedicated custody officers.

- On 3 May 2013 GSOC issued a systemic recommendation to An Garda Síochána stating "Consider amending guidance to Custody Regulations, asking that added consideration be given to obtaining a formal medical opinion as to whether medical treatment is needed, when arrests are solely for S4 Criminal Justice (Public Order) Act 1994 or S25 Licensing (Ireland) Act 1874".

- 3 May, 2013, GSOC issued a systemic recommendation that training in relation to intoxicated prisoners and those who may be suffering from brain injuries be provided to members. It was recommended that members be given clearer guidance about rousing, and that they should need to get a coherent response from a prisoner, not just a response. It was recommended that further awareness training be delivered to members to alert them to potential risks to persons in custody who may be under the influence of different intoxicants.

- On 8 April 2014, GSOC made a systemic recommendation in relation to a death. This followed queries raised by a jury as to whether the deceased person should have been brought to a hospital for immediate medical attention rather than being brought to a Garda station.

- On 29 September 2014, GSOC issued a systemic recommendation to An Garda Síochána in relation to a death in custody. GSOC recommended that a specialist Custody Officer role is created, separate from the role of Member in Charge, and that the Custody Officer should be an Occupational First Aider and of supervisory rank.

- On 29 September 2014, GSOC issued a systemic recommendation that a specific course is created for the role of Custody Officer, with specific emphasis on First Aid Training and the hazards that arise where detainees are severely intoxicated.

- On 30 March 2015, GSOC issued a systemic recommendation to AGS asking that AGS advise members of importance of updating custody records and adhering to the Treatment of Persons in Custody Regulations.

- On 8 September 2015, GSOC issued a systemic recommendation in relation to a death in custody. It was recommended that the Garda Commissioner consider revisiting the regulations and guidelines as they relate to the treatment of detained persons, with particular regard to the risks of intoxication.

- On 3 March, 2016, GSOC recommended that AGS should consider amending the guidance to the Custody Regulations, asking that additional consideration should be given to obtaining a formal medical opinion as to whether treatment is required, where the person has been arrested solely for Section 4 of the Criminal Justice (Public Order) Act 1994 and Section 25 of the Licensing (Ireland) Act 1874. The recommendation was made following an investigation pursuant to a S.102 referral received following the arrest and detention of a person who was subsequently transported to hospital and died.

- On 3 March 2016, GSOC recommended that that all Gardaí are given refresher first aid training, and specific training in dealing with heavily intoxicated persons. The recommendation was made following an investigation pursuant to a S.102 referral received following the arrest and detention of a person who was subsequently transported to hospital and died. During the investigation it transpired the members had no specific training, and the family raised queries in relation to whether the deceased should have been brought to a hospital for immediate medical attention rather than brought to a Garda Station.

RESPONSE RECEIVED: -

Letter of acknowledgment received from An Garda Síochána on 3/1/23.

SYSTEMIC RECOMMENDATION

GSOC-SR6-22
Issued to An Garda Síochána: 22/12/2022

BACKGROUND: -

In 2018, GSOC received a referral under section 102(1) of the Garda Síochána Act from a Superintendent, concerning the death of a person following their release from custody.

GSOC investigators attended the scene and conducted an examination of the circumstances of the referral, as required by section 91 of the Garda Síochána Act 2005.

The person was found deceased at their home, after family members alerted Gardaí. Once the scene was examined, it was determined that there was no trauma or suspicious circumstances relating to the death. Prescription medication was found near the deceased, and the post-mortem established that drugs in the person's system had contributed to their death.

It transpired that the person had crashed their vehicle the evening before. Gardaí and paramedics had attended the scene following the crash, and arrested the person on suspicion of driving a mechanically propelled vehicle whilst unfit to do so.

As part of the investigation, it was established that a witness to the arrival of Gardaí noted that the person had told Gardaí that they were fine. A paramedic who attended the scene stated that the person was upset, saying they were going to lose their licence, their job and their family.

The person was taken to the Garda station, where a doctor was called to obtain an evidential blood sample. Whilst in custody, the person informed Gardaí that they were on anti-depressants and attending mental health services.

No PULSE check was conducted on the person. (There is no clear Garda instruction requiring one to be completed by the Member in Charge when a person who has been arrested arrives at a Garda Station.)

PULSE data revealed old and recent entries regarding the person's mental health and concerns over their safety.

Enquiries with the doctor who attended the Garda Station revealed that they were not informed of the mental health information on PULSE, nor had they been told that the person had recently been in a road traffic incident.

GSOC conducted an investigation under section 95 of the Act, as there was no appearance of an offence on the part of Garda members. Following the investigation, a report was sent to the Garda Síochána in accordance with Section 97 of the Act, and no disciplinary proceedings were recommended.

ISSUE IDENTIFIED: -

While it must be highlighted that there was no fault attributed to individual Gardaí, a number of issues were identified by GSOC in the course of this investigation which, if addressed, may assist in more effective risk assessment in similar cases in the future.

There appears to be no explicit requirement to conduct a PULSE check on a prisoner upon their arrival into custody. The conduct of a PULSE check as standard would be beneficial for the purposes of making an informed risk assessment as per the Garda Decision Making Model.

While the doctor attended for the purpose of obtaining an evidential blood sample, they were not informed more broadly of the circumstances of the person's arrest, or of any relevant information regarding the person stored on PULSE. There does not appear to be any requirement to provide such information to an attending doctor. A process to ensure that such information is furnished to an attending doctor may assist in identifying potential risks.

More generally, there is currently no requirement for An Garda Síochána to conduct a risk assessment in advance of releasing a detainee from custody. Recommendation 40 of the Garda Inspectorate 2022 report *Delivering Custody Services* recommends a structured process for the release of transfer of persons in custody. As part of that process, the Inspectorate recommended that the process should include "reviewing and updating the risk assessment prior to release and where there is a risk of self-harm, ensuring that appropriate support is in place"[1] (p127).

RECOMMENDATION: -

The Commission recommends that:

- The Garda Síochána review its procedure, and introduce an explicit requirement that PULSE checks are conducted on all prisoners upon their arrival into custody at a Garda Station, so that an informed risk assessment can be carried out and any relevant information taken into consideration in order to safeguard the welfare of a person in custody.
- The Garda Síochána consider introducing a requirement that an attending medical practitioner is informed of all relevant information on PULSE concerning the detainee's health, no matter the reason for the medical practitioner's attendance.
- The Garda Síochána introduce the practice of risk assessments prior to the release of persons from custody and adopt the Garda Inspectorate's Recommendation 40.

RESPONSE RECEIVED: -

Letter of acknowledgment received from An Garda Síochána on 11/4/23.

1 https://www.gsinsp.ie/wp-content/uploads/2022/06/Garda-Inspectorate-Delivering-Custody-Services.pdf p. 127

SYSTEMIC RECOMMENDATION

GSOC-SR7-22
ISSUED TO AN GARDA SÍOCHÁNA: 22/12/2022

BACKGROUND: -

An investigation was initiated by GSOC following receipt of a complaint relating to the alleged behaviour of a Garda member.

In 2018, a member of the public called to a Garda Station and requested information in relation to allegations of historic sexual abuse perpetrated by a family member against her. The alleged abuse had originally been reported in 2000.

She initially spoke with a Garda member in the reception area and later in a private interview room.

The member of the public alleged in her complaint that the Garda did not carry out proper enquiries, had a very 'casual attitude' towards the seriousness of the allegations, failed to provide any victim support, and did not subsequently contact her as he had agreed.

A GSOC-led disciplinary investigation was conducted. It established that the Garda member carried out adequate enquiries in respect of the request for information relating to the historical abuse, and that the victim was kept informed throughout his enquiries. GSOC found that no offence or disciplinary breaches were committed by the Garda member.

However, a separate issue emerged during the investigation. In the course of its inquiries, GSOC was informed by An Garda Síochána that all investigation files relating to the original complaint received in 2000 had been removed for safe-keeping to a container located in a local Garda station. GSOC was further informed that the files contained in the storage container had been damaged by water and that they were subsequently destroyed.

ISSUES IDENTIFIED: -

1. GSOC's investigation established that the original investigation file from 2000 detailing the allegation of sexual assault had been destroyed due to water damage. The destruction or loss of any Garda investigation files is an issue of major concern. The correct retention and careful storage of investigation reports and materials after an investigation has been completed is a vital process that requires particular attention.
2. Enquiries conducted by GSOC found that the incident reported by the complainant to the Garda Síochána in 2000 was not recorded on the Garda PULSE IT system. The Garda member in receipt of the original report is no longer a serving garda member and is therefore no longer subject to any disciplinary proceedings, however GSOC wishes to highlight this as an issue of concern.

RECOMMENDATION: -

The Ombudsman Commission recommends that:

- A review is conducted in relation to the storage and retention of Garda investigation files following the finalisation of an investigation. Consideration should be given to establishing a standardised system for the filing of investigation files and that digital scans of files be maintained. In this regard, GSOC wishes to highlight a previous systemic recommendation made to the Garda Síochána by the Ombudsman Commission concerning the loss of a Garda investigation file regarding an alleged sexual assault on 22nd January 2020 (GSOC Case reference 730015-11-17 / Garda HRM Ref B2/OC 1260/2017).
- The issues surrounding the missing Garda file are brought to the attention of the Garda Commissioner.
- The existing Garda file management systems are reviewed to establish ways to mitigate the risk of similar losses of investigation files reoccurring in the future.
- The importance of safekeeping of all files is emphasised to all Gardaí, in particular when allegations of historic sexual abuse relate to a child.

RESPONSE RECEIVED: -

Letter of acknowledgment received from An Garda Síochána on 11/4/23.

SYSTEMIC RECOMMENDATION

GSOC-SR8-22
Issued to an Garda Síochána 19/12/2022

BACKGROUND: -

An emerging body of research indicates that child sex abuse offenders are at high risk of suicide when their offences come to light. Those accused of accessing indecent images of children are noted as being at particular risk[1]. The Independent Office for Police Conduct (IOPC) reported apparent suicides following police contact occurring between April 2020 and March 2021 in England & Wales. This includes incidents that happen within two days of release from police custody, as well as those beyond that time period. Twenty-six of those who appeared to have died by suicide had been arrested for a sexual offence. Of these, twenty-one related to sexual offences or indecent images involving children, representing 39% of all apparent suicides during that time[2]

ISSUE IDENTIFIED: -

In 2021, GSOC received four referrals made by different Garda Superintendents in accordance with Section 102 of the Act, following instances where Gardaí had interacted with members of the public due to suspicions over inappropriate contact with children or in relation to investigations into the sexual abuse of children. In each of the referrals, the member of the public had died by suicide after Gardaí searched their homes or spoke with them regarding these matters.

As part of the GSOC investigations, relevant Garda documentation was obtained and reviewed, and accounts obtained from the relevant Garda members. In each case, Gardaí stated that the member of the public said or did nothing that would have caused concern that they may harm themselves. In one instance, the Garda member informed the suspect of the services of "One in Four", who

[1] *Key et al (2020) Suicide Life Threat Behav. 2021;51:715–728*

2 *https://www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-202021*

provide support not just for victims of sexual abuse but also perpetrators. In those instances where the person left a "last letter" before taking their own life, none made allegations against Gardaí.

RECOMMENDATION: -

Risk assessments obtained for the execution of search warrants in these cases did not contain any section on the potential for self-harm, and therefore the Garda Síochána Ombudsman Commission recommends that all risk assessments/operational orders into matters such as these should include an appropriate mechanism for recording details of potential risk and details of support services. Additionally, it is recommended that An Garda Síochána provide training to all members regarding identifying potential vulnerabilities. A recommendation for such training was previously set out in the Garda Inspectorate report *Delivering Custody Services* (July 2021)[3]. This highlighted best practice in ensuring appropriate actions are taken when any utterances are made indicating the possible risk of self-harm during interview or during placement into custody. This includes:

- The recording of such utterances in the custody record
- Alerting the Member in Charge
- Recording the information and actions taken on the PULSE system.

RESPONSE RECEIVED: -

Letter of acknowledgment received from An Garda Síochána on 11/4/23.

3 https://www.gsinsp.ie/wp-content/uploads/2022/06/Garda-Inspectorate-Delivering-Custody-Services.pdf

SYSTEMIC RECOMMENDATION

GSOC-SR9-22
Issued to An Garda Síochána: 21/12/2022

BACKGROUND: -

In 2022, GSOC received two referrals from Garda Superintendents in accordance with Section 102 of the Garda Síochána Act 2005. Both related to the ingesting of hand sanitiser by members of the public.

In the first referral, a member of the public had been arrested under section 4 of the Criminal Justice (Public Order) Act 1994 (as amended) for being a danger to themselves. Following release from custody, the person remained in the public office area for a time. CCTV from the Garda Station shows the person ingesting hand sanitiser from a dispenser in the public office, before leaving the premises. They went on to ingest more hand sanitiser in another location.

The person concerned had known substance abuse issues.

They were subsequently found unconscious in a public space, and taken to hospital where they later died. There was no evidence that the sanitiser was the cause of death.

In the second referral, a member of the public was arrested for a number of serious offences. When taken to the Garda Station it was noted that the person had an IV medical line still in their arm, and was intoxicated. A doctor was called to the station to assess the person. During that assessment, the doctor formed the view that the person had ingested hand sanitiser in the medical examination room at the Garda Station. There was no Garda present in the medical examination room at the time for reasons of doctor-patient confidentiality

The incident was recorded in the custody record, and Gardaí maintained observations on the person. The person was later found to be unresponsive and taken to hospital. The person later regained consciousness and was discharged.

ISSUE IDENTIFIED: -

The presence of hand sanitiser containers in Garda Station poses a potential risk to members of the public. In the first incident, the member of the public was unattended at the time and was able to ingest the sanitiser without observation. In the second, no Garda was present but the person was in the care of a doctor.

RECOMMENDATION: -
The Ombudsman Commission recommends that: 1) The potential risk posed by the presence of hand sanitiser, particularly in public office areas which are often frequented by members of the public with substance abuse issues, is highlighted to all Garda members. 2) It further recommends that the potential risk posed by the presence of hand sanitiser in public areas of Garda Stations, and custody areas, is considered when conducting risk assessments, so that any possible mitigative action can be considered.
RESPONSE RECEIVED: -
Letter of acknowledgment received from An Garda Síochána on 11/4/23.