



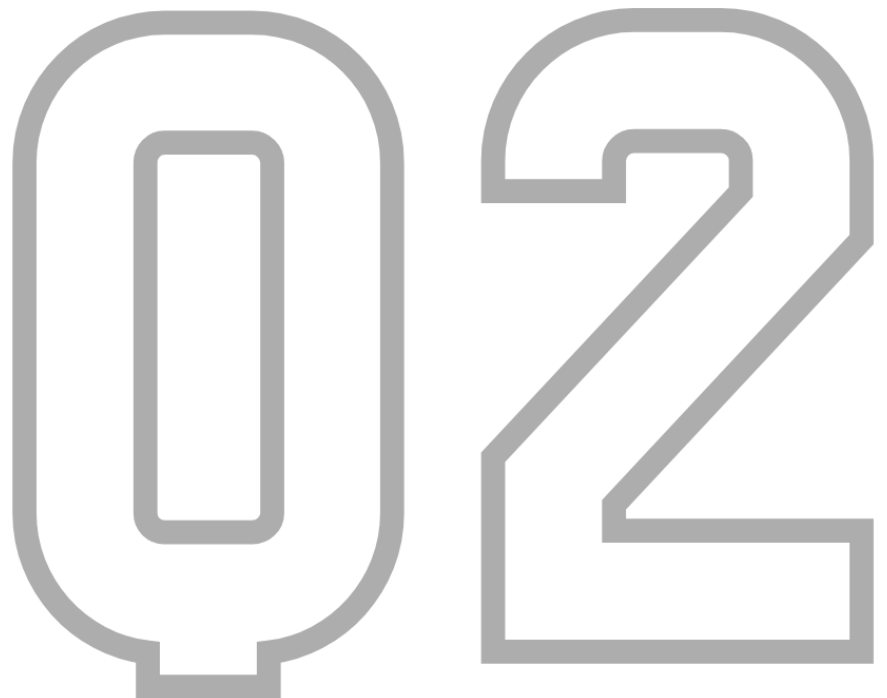
INDEPENDENT COMMISSION OF INVESTIGATIONS

INDECOM QUARTERLY 2023

**A REVIEW OF DEATHS IN
CUSTODY IN JCF LOCK UPS -
2021 - 2022**



APRIL - JUNE 2023



“Honour your commitments with integrity”

Les Brown

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COMPACT DISC

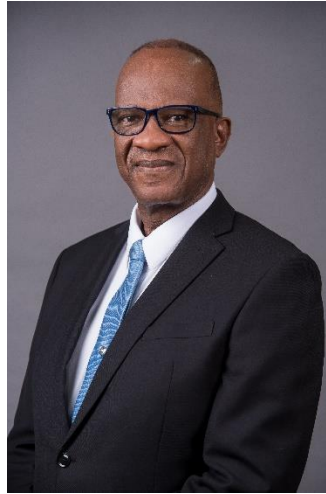
2nd Quarterly Report: April - June 2023

New Complaints: April - June 2023

Commission's Reports Completed: April - June 2023

(In compliance with Section 17(3) (c) of the INDECOM Act)

COMMISSIONER'S REMARKS



Welcome to INDECOM's 2nd Quarterly Report for 2023, which presents the data for the months of April to June 2023.

During the second quarter of 2023, fifty-three (53) citizens were either shot and killed or shot and injured; of which thirty-six (36) were killed and seventeen (17) were injured. Of the 53 persons, eight (8) persons were identified as mentally ill. Of continued concern, is the lack of inadequate distribution of body worn cameras, for both planned and unplanned operations, where death or injury occurs. The Commission continues to monitor and ascertain from concerned officers, whether they were issued with a body worn camera. No body worn cameras were reported as used, in fatal and non-fatal shooting incidents, during the second quarter of 2023.

Through this review of deaths in police custody, it reinforces the Commission's position that greater intervention is required with regard to the suitable location of ill persons currently in State custody. The continued detention of persons with illnesses, in police lock ups, is not suitable.

Another area which requires immediate attention is the inadequate resourcing of the Institute of Forensic Science and Legal Medicine (IFSLM). INDECOM is significantly hampered in concluding investigations due to the current delays in receiving scientific reports (especially ballistic reports). These inordinately long delays, from the Government Laboratory, directly affects the concerned officers when their matters with INDECOM remain pending. Additionally, advancement of an investigation to the Office of the Director of Public Prosecutions (ODPP) and or to the Special Coroner (in cases of fatal shootings) are hampered by the non-receipt of reports or certificates concerning ballistic exhibits. The Commission continues to liaise with the IFSLM to consider solutions. It is projected that the Commission will have over one thousand (1000) scientific reports outstanding by the end of this year.

Hugh B. Faulkner

Commissioner – INDECOM

IN THIS EDITION OF THE IQ

A REVIEW OF DEATHS IN CUSTODY IN JCF LOCK UPS: 2021 - 2022

This report examines fourteen (14) deaths in police custody during the period 2021-2022. The cases are analysed under the three primary categories of cause of death, namely: **Illness, Suicide and Murder**.

The report highlights the ages, location, length of time in custody, types of illnesses, and the reason for the detention of each prisoner. Further, the report outlines short and long term changes that will improve the care and detention of prisoners in State care and also the working conditions of the custodial officers.

PART ONE: NEW COMPLAINTS

For the period, April to June 2023, the Commission received 346 categories of complaints from 267 incidents reported for the period. The top five categories of complaints include: assault (114), discharge of firearm (56), fatal shooting (32)* [see page 18], threat (26), and shooting injury (15).

The Commission's Forensic Unit responded to 74 incident scenes during the period, April to June 2023. There were four deaths in custody for the period.

Incident reports were received for all parishes, with Kingston and St. Andrew recording the highest with 74 complaints. Portland recorded the least with three (3) reports.

PART TWO: THE LEGAL DEPARTMENT

The Legal Department, completed and distributed 212 Commission's Reports during the second quarter, April to June 2023. An overview of the reports completed, lists the recommendations for unsubstantiated (185 cases) and disciplinary action (27 cases; 51 officers). There were no cases with recommendations for a charge during the period. Recommendations from fatal shooting incidents, where Commission's Reports were completed, as well as rulings received from the Office of the Director of Public Prosecutions (ODPP) during the quarter are also listed. One (1) member of the Jamaica Constabulary Force was charged during the period, for an incident investigated by INDECOM.

The Commissioner's Office closed 87 cases on initial intervention, following INDECOM investigations.

PART THREE: PUBLIC INFORMATION

The Commission participated in sensitization sessions equalling a total of 2571.8 man hours for the second quarter in 2023.

A REVIEW OF DEATHS IN CUSTODY IN JCF LOCK UPS: 2021 - 2022

Deaths in police custody will unfortunately, but inevitably, occur in almost every police jurisdiction. Each death requires an independent investigation to ensure that such deaths are not attributable, as far as is reasonably possible, to mishandling, ill treatment, neglect, violence by agents of the State, or other features which may abrogate the detainees' right to life, whilst in State detention.

INDECOM's second quarterly report examines the deaths in custody which occurred within the Jamaica Constabulary Force (JCF) Police Station Lock Up environment, over the two year period 2021 and 2022. The number of police deaths in custody in the two year period was relatively low, with just fourteen (14) deaths. This report examines the circumstances of those deaths, the data and facts surrounding them and provides further observation and analysis on the incidents.

INDECOM has submitted previous reports on matters concerning the conditions and issues affecting the care and detention of prisoners held by both the JCF and Department of Correctional Services (DCS). A schedule of those reports are shown at Appendix I. Of particular relevance is the Commission's 2013 report, **Safeguarding the Right to Life**, which examined the data for JCF deaths in custody during the period 2005 – 2012. [\[Read report\]](#)

That 2013 report highlighted a range of issues which still pertain in 2023, over a decade later. Further remedial action is required to address aspects of the medical and environmental conditions which still exist in a great number of police station lock ups.

DEFINING DEATH IN CUSTODY

The United Kingdom's Independent Office for Police Conduct (previously the IPCC) defines death in custody as:

“Deaths of persons who have been arrested or otherwise detained by the police; it includes deaths which occur whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle”.

This includes deaths in situations where deaths happen:

- i) During or following police custody where injuries resulting in the death of the person happened during the period of investigation;
- ii) Deaths which occur in or on the way to hospital (or other medical premises) following or during transfer from police custody; and
- iii) Deaths which occur as a result of injuries or other medical problems which are identified or developed while a person is in custody.

[Independent Police Complaints Commission 2009]

Such a definition is purposely broad and ensures that each person's life, within the custody, control or care of agents of the State is correctly accounted for. The Commission regards this definition as a precise determination of those cases for which INDECOM is to be informed of. Section 11 of the **Independent Commission of Investigations Act, 2010** directs that the Commission be informed forthwith when such a death occurs, and for the death to be independently investigated.

This report addresses the issues under the three primary categories of deaths in police custody, namely: **Illness, Suicide and Murder**. The report also discusses the physical conditions of the Police Lock Ups, and references the recent inspections of some police stations in 2022 by the Police Civilian Oversight Agency (PCOA).

THE DATA

Fourteen (14) people died in the custody of the JCF in the two years 2021 and 2022. The deaths occurred either within the Lock Up facility at the police station, or, following the transfer of the prisoner from the police station to a hospital, the prisoner subsequently died at hospital. The years 2021 and 2022 witnessed a somewhat elevated number of deaths in custody when compared to the previous two years, 2019 & 2020, (a total of five). The majority of deaths were attributed to illness rather than violence and occurred, it will be recalled, at a time of the COVID 19 pandemic.

In examining the data more broadly for the five years 2018 - 2022, there were twenty-five (25) deaths in police custody.

2018	2019	2020	2021	2022	Total
6	2	3	7	7	25

Table 1 shows the annual deaths in JCF custody for the period 2018 – 2022.

The twenty-five (25) deaths in custody occurred over a period of sixty (60) months - an 'average' of five deaths per annum. In the preceding four year period, 2014 - 2017, (48 months) there were twenty (20) deaths in custody, again an average of five deaths in custody per annum. The total deaths in police custody over the nine years 2014 - 2022, was forty-five (45), which remains a consistent average of five deaths in custody per annum. It is recognised that these deaths in custody are a very low number when juxtaposed with the many thousands of persons detained in police lock ups during a near decade.

ANALYSIS OF THE FOURTEEN DEATHS IN CUSTODY IN 2021 AND 2022

- All of the deaths in custody related to adult male prisoners.
- No juveniles or females died in custody during this period. Only one female has died in custody since 2014.

The death incidents in this report are defined by one of three categories: **Illness**, **Suicide** or **Murder**. Of the fourteen (14) deaths, ten (10) were attributed to *illness*, three were identified as *suicide* and one case of *murder* - caused by another detainee.

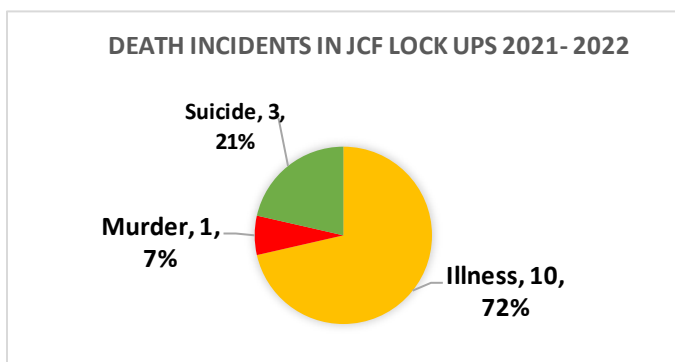


Chart 1 shows the category of death per detainee in JCF lock up during the period 2021-2022

At the time of death, twelve (12) of the prisoners were not convicted and two were convicted. In this report, persons who were not convicted refers to prisoners who have

been arrested and were not yet charged or charged prisoners who were awaiting trial.

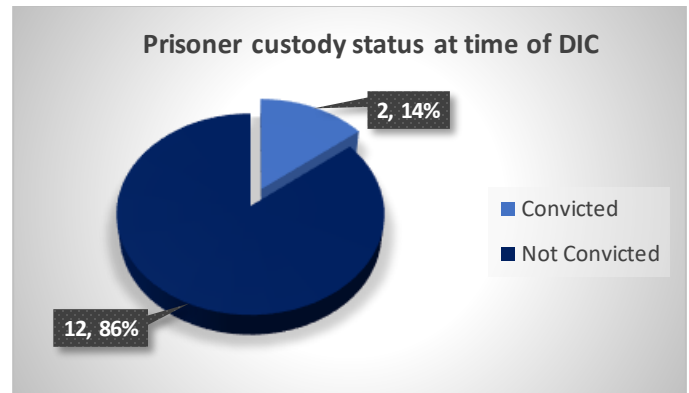


Chart 2 shows the custody status of each prisoner at the time of the death in custody in 2021 and 2022

The men's ages ranged from 20 - 56, of which six (43%) were in their early to mid-fifties.

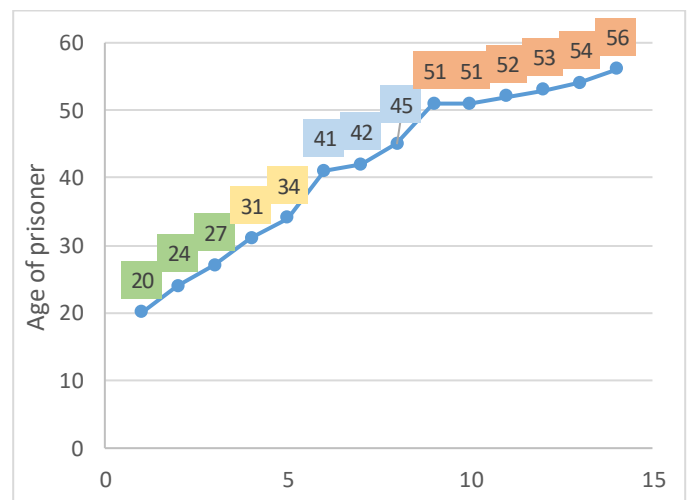


Chart 3 shows the ages for each of the fourteen prisoners who died in police custody during the period 2021-2022

Six of the fourteen (14) prisoners had been arrested for an offence of murder, four for non-fatal assaults/violence (viz rape, indecent assault/wounding), two for acquisitive offences and two for malicious destruction of property offences (damage).

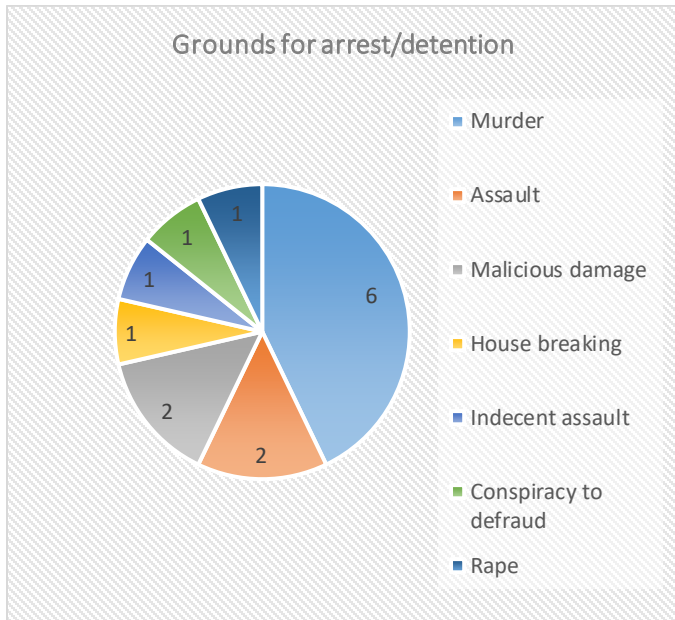


Chart 4 shows the initial reason for the arrest/ detention of each prisoner that died in police custody

The fourteen prisoners were held at twelve (12) different police stations. The two police stations, Hanover and Kingston Central Lock Ups, each experienced two deaths in custody in this study period.

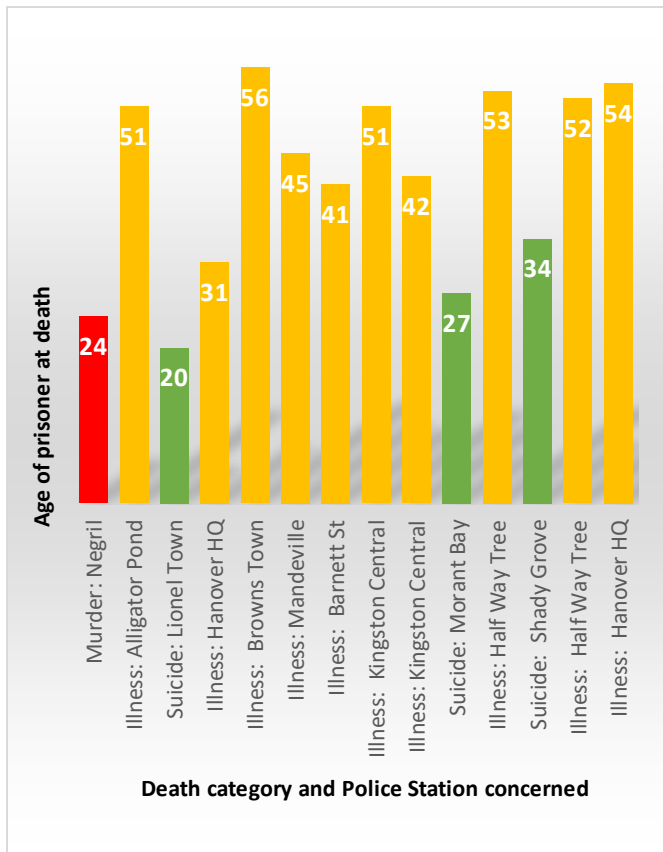


Chart 5 shows the police station where each prisoner was held at the time of his death in police custody in 2021 and 2022.

Table 2 shows the correlation between offence for which the prisoner was arrested, the death incident category, number of days spent in custody before death, and their ages. It is notable that the detainees in the three suicide incidents were in custody for the shortest period of time, before taking their own life.

Little can be readily determined from those in the 'illness' category, but in some instances it is observed that some prisoners were detained for extremely long periods, without bail being addressed by the court or police station, for relatively low level, non-violent offences, (see numbers 10, 12, 14 in table 2).

	Detention Offence	Death Category	Days in custody	Age of Prisoner
1	Murder	Suicide	1	20
2	Rape	Suicide	1	27
3	Assault	Suicide	9	34
4	Murder	Illness	9	54
5	Malicious damage	Illness	10	51
6	Murder	Illness	12	52
7	Indecent assault	Illness	14	41
8	Assault	Murder	46	24
9	Murder	Illness	49	31
10	Malicious damage	Illness	121	53
11	Murder	Illness	176	56
12	House breaking	Illness	254	45
13	Murder	Illness	443	42
14	Conspiracy to defraud	Illness	1460	51

Table 2 shows the correlation between the detention offence, death incident category, number of days in custody and age of each prisoner who died in police custody during the period 2021-22

ILLNESS

The Commission's view is that police stations are not the appropriate location for sick or very sick people, some of whom are held in custody for a considerable period of time. The JCF is not equipped to host detainees who require immediate or prolonged medical attention. Alternatively, these persons should be detained in remand facilities, where medical support and identification of illness may be better recognised and administered.

This observation has been made frequently, by the JCF, the PCOA, INDECOM and within the Government's own 2014 report 'The Review of the Detention System in Jamaica'.

All ten prisoners, suffering an illness or injury were pronounced dead at the hospital, following their transfer

from the police station, albeit a few were found unresponsive in their cells and conveyed to hospital in that state. The other four died in the police station, which concerned the one murder and three suicide incidents. Of the ten prisoners who succumbed to illness and death, the majority were part of the older cohort of detainees.

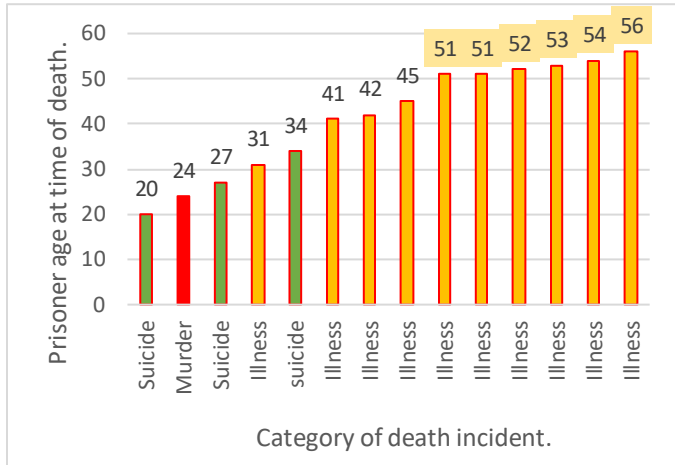


Chart 6 shows the age of the prisoner correlated with the category of death incident

Table 3 below shows the cause of death, as recorded in the pathologist's post mortem report, juxtaposed with the number of days the prisoner survived following transfer to hospital. It is apparent that the majority of the ten 'illness' category prisoners were evidently suffering from long term (and occasionally hidden) health conditions. The issue for the JCF Lock Up staff is to be able to respond in a timely manner to those prisoners who present as sufficiently unwell and to recognise and render medical treatment or enable access to medical intervention.

Table 3 shows the cause of death, death category, prisoner age, days survived on transfer to hospital during the period 2021-2022

Cause of Death	Death Category/ Prisoner age	Days in hospital following transfer
Bilateral pulmonary thrombo-embolism & Right deep venous thrombosis	Illness 51 yrs	5 days
Acute hypertensive encephalopathy. (High blood pressure)	Illness 31 yrs	0 days
Epileptic sufferer. Acute cardiac failure. (Heart attack) (High blood pressure)	Illness 56 years	0 days
Epileptic sufferer. (Heart attack)	Illness 45 yrs	0 days
Hypoxic encephalopathy (Lack of oxygen)	Illness 41 yrs	1 day
Kidney failure	Illness 51 yrs	1 day
HIV. Wasting syndrome	Illness 42 yrs	0 days
Heart disease	Illness 53 yrs	5 days
Acute Peritonitis, Perforated ulcer	Illness 52 yrs	1 day
Subject to assault in cells. Multiple broken ribs, lung contusion. Lung infection.	Illness 54 yrs	5 days

Chart 7 below shows the total number of days the prisoner was in custody at the JCF Lock Up and the survival days following transfer to hospital.

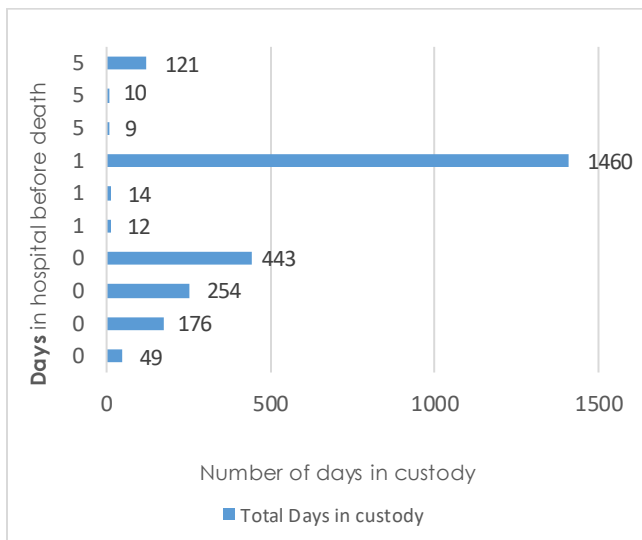


Chart 7 shows the total days in police custody before death for the prisoners who were transferred to the hospital due to illness in 2021-2022

Five of the ten (10) sick prisoners had been detained in police custody for over 100 days, yet following their transfer they died very quickly (Chart 8). Seven of the ten (70%) died upon arrival or within the first day (24 hours), four died on the same day as their transfer, and three the following day. A further three died on the fifth day following their transfer; all the transferees died within a week of their transfer. Nine of the ten ill prisoners were on remand, awaiting trial proceedings.

In both this current and previous study, it is observed that all the sick prisoners died within, or less than, a week of their transfer to hospital. In INDECOM's 2013 report, for the period 2005-2012, 27 of the 36 prisoners transferred to hospital, all had died within a week, arising from illness or unresponsiveness.

The transference of prisoners from the police Lock Up to a hospital can demonstrate a recognition of illness amongst the detainee population. However, it appears, upon a review of these figures, that recognition and action to medical aid is too late or delayed.

This may be indicative of a failure to recognise some of the illness cases sufficiently quickly. It is apparent that some of the prisoners were evidently already very unwell at the time of their transfer.

However, it is recognised that police officers are not medically trained and the ability to monitor multiple prisoners, frequently in overcrowded cells, can make

such observations difficult; especially if insufficient custody staff are on duty or they are inexperienced in their critical role. Nevertheless, as illustrated below, in some cases it was very apparent to some senior JCF custody officers, that prisoners were very unwell and they did intervene to try and alleviate the situation.

NB: This report looked specifically at deaths that occurred in police lock ups. Some persons who die in correctional facilities could also have had their prior remand at a police station, and medical access shortcomings within the lock up, may be a contributory factor to a death in a correctional facility.

Two cases illustrate the issue affecting the JCF managing long term chronic sickness of prisoners in police custody - a role which is not suitable for police officers.

• **ILLNESS - CASE STUDY I**

The longest serving detainee (BT) had been in the police Lock Up for over four years (this subject shown as >1460 days), since 2017, but precise custody records were unobtainable - a set of circumstances which is difficult to comprehend. This prisoner had in fact pleaded guilty to his charges on 4th June 2021, but three court dates for sentencing (July, October and November 2021) were each adjourned, and the fourth, listed for 11th February 2022, never occurred as the prisoner died on 1st February 2022.

BT had begun to present with health issues in December 2020, and had been treated as an outpatient, from the police Lock Up, in December 2020 and February 2021. He was subsequently placed on medication throughout 2021. His health deteriorated and he became an inpatient at Kingston Public hospital for ten days in January 2022 but was discharged back to the police lock up, on 21st January, despite clearly being very ill. Ten days later he was again returned to hospital, having been found unresponsive in the cell. The prisoner died at hospital the following day.

The level and duty of care required by the JCF towards such ill patients is an arduous one and the Commission considers there is an undue burden upon their other duties. In this particular case, the convicted prisoner should have been detained within the Department of Correctional Services (DCS) - who may have been better able to meet the needs of this detainee. The JCF are unable to prevent the 'return' of such sick prisoners from hospital, where they are discharged without recourse to debate. The Police Lock up cannot be a substitute to a hospital or other medical institution.

- **ILLNESS - CASE STUDY II**

The prisoner FM was a similar case of chronic illness and in fact more serious. A 42 year old man charged with murder and awaiting trial, having been detained since November 16, 2020. Concerns over the prisoner's deteriorating health, by the Station's long serving custody Inspector, resulted in FM being sent to the Windward Road Health Centre on January 26, 2022. FM was returned to the Health Centre on 27th of January and admitted to Kingston Public hospital (KPH) on the same day, where he remained for six weeks. FM was discharged from the KPH on 11th of March, with multiple medications and still evidently very unwell. Post mortem photographs depict an extremely emaciated man and was described as such by the pathologist.

Of note, and commendably, the same custody Inspector recognised the critical illness and futility of police detention and arranged for an emergency bail application to be heard, having contacted FM's lawyers. The bail application was listed for 14th March but adjourned by the court until 16th March as the hospital medical report was not available. FM was found collapsed and unresponsive in the cells on 15th March and died at hospital the same day.

A number of issues arise from these two cases, and are replicated in many other deaths in custody. The Police Lock up is not the location for the sick. The Commission recognises that the JCF, in such situations, are seeking to manage critical illness but seemingly without the resources or ability to re-locate such unwell prisoners or without a coordinated response from other State agencies. Both prisoners BT and FM should have been detained at the State's high security Remand Centre with adequate medical access.

Photo 1 shows the cell environment to which FM was returned, in stark contrast from the hospital environment where he had been for six weeks. The conditions depicted are typical of the general Police Lock Up infrastructure and are not conducive for any person, yet alone those who are seriously sick, where washing facilities, sanitation and hygiene are critical.



Photo 1. Cell to which prisoner FM was returned.

The Commission finds that the JCF Lock Up infrastructure is still being utilised as a long-term prison environment, when the Horizon Remand Centre, via the courts, is where such prisoners should be detained.

The conditions at the Lock Ups remains, unfortunately, woeful. They are frequently overcrowded, unsanitary, lacking in sufficient airflow and affected by other issues, all of which can be contributory causes to prisoners, who are already perhaps suffering from illness, experiencing to a greater degree the ill effects of such conditions.

SUICIDE

There were three suicides in the 24-month period 2021 & 2022, all of which were by hanging. This was 21% of the total deaths in custody. Within the previous three years, (2018 - 2020) there was only one suicide, also by hanging.

The Commission's 2013 report, **Safeguarding the Right to Life**, examined JCF deaths in custody for the years 2005 - 2012, which comprised a total of 36 deaths. In that period there were nine (9) deaths by hanging, which accounted for 25% of the total.

Despite these relatively low numbers, suicide remains a high risk incident within State detention institutions and the vigilance required to identify and monitor detainees who present as a suicide risk remains a challenge for State custodians. All custodians must be aware of the risk factors that present for each and every prisoner, and senior personnel made aware of those risks. But equally important, the custodial environment must, as far as reasonably practicable, reduce the opportunities for suicide to occur.

It is noted that all three prisoners were placed in cells on their own. A unique feature of police detention, since single cell occupancy is rare within the JCF Lock Up

system, the opposite more frequently the case. Full or overfull cells, is a factor which actually makes suicide attempts less likely - primarily because observation and monitoring is occurring by the detainees.

The three men, who committed suicide, were in the younger age cohort, 20, 27 and 34 (see table 4 below). Two of the three committed suicide within one day of their detention - the third case within nine days. One had been arrested for the alleged murder of his girlfriend, an incident to which he had confessed, the second arrested for an allegation of rape, and the third an assault upon his father.

Cause of Death	Death Category/ Prisoner age	Days in hospital following transfer
Hanging by neck	Suicide 20 yrs	n/a Died at PSTN
Hanging by neck	Suicide 27 yrs	n/a Died at PSTN
Hanging by neck	Suicide 34 yrs	n/a Died at PSTN

Table 4 shows the cause of death, death category, prisoner age for the prisoners who committed suicide during the period 2021-2022

In each of these deaths there were circumstances which were either avoidable or preventable and if addressed could reduce further the risk of suicide in the police Lock Up.

• **SUICIDE - CASE STUDY I**

Suicide at Lionel Town in 2021. Death of MH - 20 years of age. This prisoner had killed his girlfriend and upon arrest had admitted to the crime. Officers had taken MH back to the murder scene, which resulted in considerable community anger, during which stones had been thrown, resulting in a head injury to MH, for which he received medical treatment.

MH was placed in a cell on his own, believed both for his own safety and because of his recent head injury. He was reportedly checked upon, along with other prisoners, at 8.30am. He was next visited at 11.00am, for delivery of his breakfast meal and discovered hanged - this was less than twenty-four hours after his detention.

MH had hung himself by use of the toilet flush wire (electric cord) which protruded through from outside the cell block, and was being used to flush the toilet cistern. This was a temporary apparatus for the flush mechanism and deployed in all the cells. Such a system resulted in a length of line being available for anybody who wished to either self-harm, or injure another.

Of note is the police Inspector's testimony in this case who had previously identified the inadequacy of such a system to higher command. The Inspector's statement reported that the of length of wire passed through each cell is, *'...an antiquated method...used in all six toilets... which were installed in 2018'*. The Inspector further reported that the original cord suffered dry rot and broke and *'.. several reports were written on the conditions of the cells and request made for repairs to be effected and the cords changed'*. It further reports that *'No remedial works has been done on the toilet to date'*, and clearly had not been at the time of the death in 2021.

The Commission's report into this death recommended that the wires should be removed in order to prevent the possibility of a similar event. INDECOM made enquiry of the Lionel Town police station in March 2023 to follow up on this recommendation. It was observed that the wires had been removed from all the toilets and replaced with a very short piece of cord to enable flushing, but prevent hanging.

Whether this suicide could have been prevented will be unknown, but the broader issue of poor cell conditions, and failure to undertake maintenance is apparent. This issue is referenced further below.

• **SUICIDE CASE STUDY II**

The prisoner SA was detained at Morant Bay police station in 2022. A 27 year old man, who had surrendered himself to custody following an investigation into a rape allegation. He was to be interviewed about the offence that same day, but the interview was postponed for a day, due to the unavailability of a lawyer. It was reported that SA used his own T-shirt which he anchored to the metal lattice grill wall, which extended one entire length of the cell structure (see photo 2).

The police station was equipped with CCTV cameras, one of which was within the cell area, pointing directly towards the large holding cell in which SA died. However, upon investigation it was discovered that the cell camera was not working. The Commission was unable to establish who precisely was responsible for ensuring that non-functioning CCTV equipment is reported and for repairs to be expedited immediately. Of note is that other cameras within the CCTV network at the police station, which did not monitor the cells, were working. Further, the CCTV monitors were located within the Superintendent's office, thus they were not, in any event, subject to any effective live time monitoring and prisoner observation.

Defective CCTV equipment is a regular feature within the JCF lock up environment and an issue commented upon in previous reports, concerning both fatal and non-fatal incidents. Failure to maintain, report and secure immediate repairs borders on neglect, and it is extraordinary that death and serious assault complaints appear to be the occasion when such matters are identified and acted upon, post event.

This same issue was identified during the 2022 PCOA inspections of the Westmoreland, Trelawny and St James divisions. They report that the CCTV cameras, at the time of their inspection in March 2022, were either 'not working', 'non-operational' or 'out of use' at Negril, Falmouth and Barnett Street police stations respectively.

In this case, (and Case study 3 below), family members of the deceased refute claims of suicide. The absence of working CCTV (especially where it is already installed) only adds to a suspicion of unaccountability by the JCF and an absence of trust in the accounts provided by the security forces. Immediate repairs to defective CCTV equipment is a critical part of demonstrating re-assurance to the public regarding events in police stations and allaying such beliefs and perceptions even arising.

Photo 2. This photo shows the nature of the standard/typical grill door or wall within the JCF Lock Up - which enables multiple anchor points for suicide. The non-operational CCTV camera is visible in the top left corner of the picture.



Photo 2

- **SUICIDE - CASE STUDY III**

Prisoner AL was detained at Shady Grove police station in 2022. A 34 year old man who had been arrested for assaulting his father with a bladed weapon, causing injury. AL was a previous patient of Bellevue Hospital and evidently suffered from mental health issues. The assault

upon his father in fact arose from a failure by AL to take the medication he required.

During AL's detention he was in a cell with another detainee. A fight occurred between AL and the other prisoner, during which the other prisoner was assaulted by AL, requiring that prisoner's attendance at hospital for a medical check-up.

Following this altercation AL was detained in the cell on his own. A few hours after the assault incident AL hung himself, in a similar manner to that of prisoner SA in Case study 2, with his own shirt top, and affixing it to the metal lattice grill of the cell door.

This case presents as a mentally unwell man, who did not appear to have access to any medication during his detention and whose behaviour (in addition to the assault on the other prisoner) presented a risk of self-harm. In addition, the feature of the JCF lockup, where open grill doors and walls form a large part of the cell estate, provides a continuing access point from which prisoners can hang themselves.

The three suicide incidents reveal a number of factors, all of which have been previously reported on by INDECOM and there are features to the death which indicate that a greater duty of care is required. The absence of operational CCTV where it is already installed, the inability to monitor single cell occupancy, the recognition of the mentally unwell prisoners who present a risk to themselves or others, and the inaction to remedy infrastructure defects, all contribute to such outcomes.

Long term infrastructure planning should consider the removal of open grill structures while still ensuring properly ventilated facilities to improve the lock up environment. Additionally, consideration should be given to not placing single prisoners in such environments with open grills.

MURDER

The deaths in police custody of Kamoza Clarke (2013) and Mario Deane (2014) resulted in much media attention and raised public interest questions regarding the safety of persons detained by the police. In both those cases criminal prosecutions still await to be heard, with police officers accused of the death of Kamoza Clarke, and in respect of the death of Mario Deane, both prisoners and police officers are separately indicted, regarding aspects of Deane's death.

Since the death of Kamoza Clarke in 2013 it is to be noted that there has not been any reported incident or allegation of a death in police custody, allegedly caused

by police officers. This is significant. However, there continues to be a number of deaths in which prisoners have allegedly been killed at the hands of other prisoners - a feature of the Mario Deane incident. Equally, there continues to be serious assault cases in the police lock ups amongst prisoners.

Two prisoners were subject of assault and injury from the study group. One prisoner, a 24 year old was killed at the police station; the cause of death described as a stab wound to the chest/ injury to the heart. The second was the victim of a serious assault in a multiple occupancy cell, from which he suffered multiple broken ribs and lung contusion. The prisoner died at hospital and his death recorded as a lung infection, however the post mortem report reveals a causation and requires the JCF to continue their investigations.

As with the suicide cases it is upon closer examination of the circumstances of these violent death incidents that identify issues which if acted upon may have prevented the incidents occurring.

- **MURDER - CASE STUDY I**

Prisoner RB was 24 years old, having been arrested for assaulting his girlfriend. RB was detained at Negril police station and after 42 days in Lock Up was convicted on 15 March 2021 and sentenced to six months imprisonment - suspended for 2 years. However, unexplainably, he was not released from State custody and remained in the police lock up. Had RB been released his death would more than likely not have occurred.

Four days after sentencing RB and another prisoner became involved in a disturbance in the cell they shared. The conflict came to the attention of the police guards, the result of which the two men were separated and placed in different cells. This was the correct intervention action.

However, the incident was not recorded in the Station diary, nor was the matter reported to the Sub Officer or new incoming shift - a requirement under Section 5(12) of the JCF Lock Up Administration Policy & Procedures. This critical failure led to the new shift officers being unaware of the risk and permitting both prisoners out of their cells at the same time to use the bathroom facility. Whilst the two men were unattended, the officers having returned to the Guard room, their fighting resumed, resulting in RB's murder – he being stabbed in the chest.

This death was a likely preventable one, had the correct protocols been adopted and the new Shift Officers been made aware of the risk presented and the prior action

already taken. The two prisoners should not have been afforded the opportunity to be together, unsupervised in the shower/toilet area.

A second feature which compounded this incident was that of the six cells at Negril police station, each of which was equipped with a toilet, quote; '*...not one was operational*'. It was for this reason that all prisoners had to be released from their cells to use the single toilet located in the shower area.

RB was killed in March 2021. A year later, in March 2022, the PCOA inspected the Negril police station. Their inspection reported that, quote; '*..the toilet and shower facilities in the cell area were deplorable*.' It is clear that within the year March 2021-March 2022, nothing had been undertaken to remedy the situation, to enable prisoners to utilise the cell toilet, instead of multiple prisoners all required to use a single toilet.

The PCOA recommendation was for the Negril cell and bathroom facilities be sanitized and repaired. Further, as reported above, and similar to the Suicide Case Study II, the CCTV in the Negril Lock up area was malfunctioning and thus served no purpose. At the time of the murder the CCTV was not operating and a year later it remained defective.

Insufficient urgency and an apparent lack of concern appears to be one factor for these health, safety and duty of care matters not being addressed in the manner they should be. The PCOA recommendation again iterates the matters are to be reported and remedied by the Custody Officer(s) or Station Commanders [see PCOA report dated 14 March 2022].

In this case a man has been charged with the murder of prisoner RB.

- **CASE STUDY II**

This case is the second of the two in which death arose following direct violence in the Lock Up. Prisoner EC was a 54 year old man detained at Hanover Lock Up. It was alleged that he had committed a murder in 2013 but was only arrested for the crime on 13th December 2022.

EC was placed in a cell with twenty-three other inmates - a space of 196 sq ft. The seven cells at Hanover were grossly overcrowded by 51%. The maximum of 35 inmates was exceeded, with 53 prisoners being held. Between the 13th and 15th EC was severely assaulted by (according to his evidence) at least six other prisoners. He reported the matter to his interviewing officers on the 15th and presented with some injuries. The Station diary records the observation: '*..which he (EC) reported that*

men in cell #7 where he was housed beat him and stepped on him - his injuries are not life threatening'.

Despite his complaint EC was not medically examined by a Doctor, but simply moved to another cell. The non-medical observation of EC's condition could not have been more wrong. The following day EC complained of chest pains and breathing difficulty and was conveyed to the Cornwall Regional Hospital. EC died at hospital on 21st December. The post-mortem showed he had seven broken ribs, four on one side, three on the other and contusion of the lungs.

Each of these deaths reveal features which demonstrate a failure to adhere to policy and practice across a spectrum of issues. EC's complaint was not treated with the care required. A doctor should have been called to examine him, following his report of assault, and for a proper medical assessment to be made. It was clear to the interviewing officers that he had been assaulted - since they enquired about his well-being, which was observed and reported. It was not appropriate for non-medical personnel to determine the severity of such injuries and delay medical treatment and assessment.

Whilst the death outcome may not have been any different, medical speculation is not within the remit of the duties assigned, but rather compliance with policy. The duty of care, ensuring a safe environment for all prisoners in State custody, and managing and lessening the risk of injury or death whilst detained by the State remain a critical element of the State's role. The State has a special responsibility to ensure that lives are secure and they must take the necessary and reasonable preventative operational measures to protect individuals, whose life may be at risk, whether by their own hands or another inmate.

This incident further highlights the gross overcrowding of the Lock Up capacity, a feature which, it is recognised, is often out of the control of the operational custodians of the JCF. That twenty-three prisoners were all crowded in to a 14'x 14' cell is not compatible with the management of safety, health, hygiene or control of the detainees. An explanation was provided for the overcrowding that the exceptional circumstances of the pre-Christmas period and the Court list. However, the PCOA had conducted their inspection some ten months earlier (March) and reported then that Hanover Lock Up was 'over full', in fact by the same number as in December.

The PCOA recommendation that '*... measures are to put in place to address current overcrowding in the lock ups*' was not achieved.

CONCLUSION

In August 2021, the outgoing Chief Executive of the UK's Howard League for Penal Reform, Ms Frances Crook, when commenting on the parlous state of the UK prisons, stated;

"But prisons matter. It matters who goes into them. It matters what happens inside them. And it matters how much they cost. Although prisons too often function like black holes into which society banishes those it deems problematic, the state of our prisons tells a story about all of us. Prisons reflect society back to itself: they embody the ways we have failed, the people we have failed, and the policies that have failed, all at immense human – and economic – cost".

[UK Guardian. 10 August 2021]

The above commentary has resonance with the JCF Lock Up environment, especially the conditions of the Lock Up. INDECOM's review of these fourteen deaths in custody within the JCF Lock Up aims to ensure a securing of accountability and change by the State agencies responsible for safeguarding the right to life whilst detained by the State.

A pattern emerges from both the current and previous death investigations which require action to address the issues concerning CCTV, monitoring, record keeping, medical aid and cell conditions. Such a pattern and similarity is all the more remarkable when one recognises that so many different police stations and personnel are involved, yet the features are repetitively similar. It is these repetitive circumstances which present as institutionalised and have not been sufficiently addressed, despite being identified and highlighted by both INDECOM, the Police Civilian Oversight Agency and other Panels on previous occasions.

It is pertinent to reference and quote from the September 2014 PCOA report, which, at that time was addressing the general status of the JCF Lock Ups. It reported that the gazetted capacity of police cell accommodation was expected to give an indication as to the number of persons '*...who can hold comfortably in a specified space...*' so that prisoners are, at the very least, physically comfortable.

The PCOA identified that the Person in Custody (PIC) population at the lock-ups, '*... tends to present a myriad of human and material resource complications for the JCF. Often times, this leads to the stripping of the stations of much needed manpower for other critical policing functions. We are confident that holistic treatment of the overcrowding at these stations and the attendant*

infrastructural and logistical improvements required, will solve a major part of the problem as pertaining to PIC lock-ups'.

INDECOM's investigation of deaths in custody incidents are the occasions that identify where infrastructural and logistical improvements have not been achieved, particularly as it relates to environmental health, safety, sanitation, and cleanliness. It is unclear why such conditions persist, and who is responsible for effecting the changes required.

The standard of attention required is not impossible or disproportionate. Where authorities know, or ought to have known, of a real and immediate risk then they ought to take such reasonable and expected measures that are within their scope of powers to avoid the risk.

The observations are not intended as criticism of the JCF, where many officers, junior and front line leaders, are acutely aware of the issues and work hard to alleviate some of the conditions within which they themselves have to operate, but rather to raise awareness of the need for urgent reform. The JCF perform a critical safeguarding function in an operating environment for which other stakeholders and bodies are responsible for the **structural and funding** changes necessary. The issues that exist within the JCF Lock Up infrastructure are far wider than what the JCF are directly able to influence or affect change.

RECOMMENDATIONS

These recommendations are not new or revelatory, but require restating. They are either long term, strategic issues, outside the scope of the JCF to address directly, or short term and tactical - frequently the ones which can make an immediate difference. It is intended that such recommendations, individually or collectively, will address and lessen the circumstances in which deaths in police Lock Ups can occur.

Long term

- Overcrowding requires intervention at a strategic level. The JCF cannot address the issue in isolation. Overcrowding creates the 'deplorable' conditions identified by the PCOA, and in which many Lock Up prisoners are detained. Funding should be made available to ensure bathroom and toilet facilities are repaired, fully operational and regularly cleaned.
- The JCF Lock Up should not be utilised to detain a prisoner long term. Where prisoners are remanded by the Courts, and are awaiting trial,

their detention should be within the State's purpose-built remand institutions. The JCF is ill-equipped to manage long term detention, in the numbers they currently do. The human resources which are required by the JCF to secure and manage the detainees, exceeds their current capacity.

- The JCF Lock Up should not be utilised to detain prisoners who are sick or very sick. There are, self-evidently, many more prisoners who are unwell, but do not die, and thus remain unseen by medical personnel. The Lock Ups are not conducive to administering effective medical care or ensuring recovery.
- The return of seriously ill prisoners to the police station (who, in many instances are quite incapable to being a threat to any person) should be re-considered. Either bail or retention in hospital for such ill prisoners is to be considered.
- Greater record keeping and recording of the decision making in such critical cases should be utilised.
- Consideration should be given to utilising non-police personnel in permanent custody roles, who are trained across a spectrum of disciplines to manage the short-term detention of prisoners. This would release law enforcement officers to conduct priority police functions.

Short term

- Greater use of station bail and court bail would alleviate some aspects of overcrowding - an issue previously stated by PCOA and the Government's 2014 review. Low level, non-violent offenders should be afforded bail. The overly long detention of prisoners, many exceeding a year or more, in unhealthy environments can only exacerbate sickness and contributes to the overcrowding at Lock Ups.
- Enhance medical training and awareness by Custody staff of prisoners in their care. It should be a requirement that medical attention by a Doctor, or other medical aid, is sought as a priority, for any prisoner complaining of or suffering from a visible injury. Each intervention should be properly recorded by the staff on duty.
- Compliance with all the PCOA recommendations in a timely manner. Clearer accountability and responsibility for ensuring remedial works are attended to by a nominated senior officer within a clear timeframe. Reasons

as to why sanitation, toilets, basins, showers are not working or repaired should be recorded and reported to the Area Commander on a monthly basis until remedied.

- All CCTV systems, where installed, must be checked to ensure that the cameras are operable and function correctly.

The responsibility to ensure their utility should rest with a specific officer, thus allowing a focal point at each station, where equipment is installed.

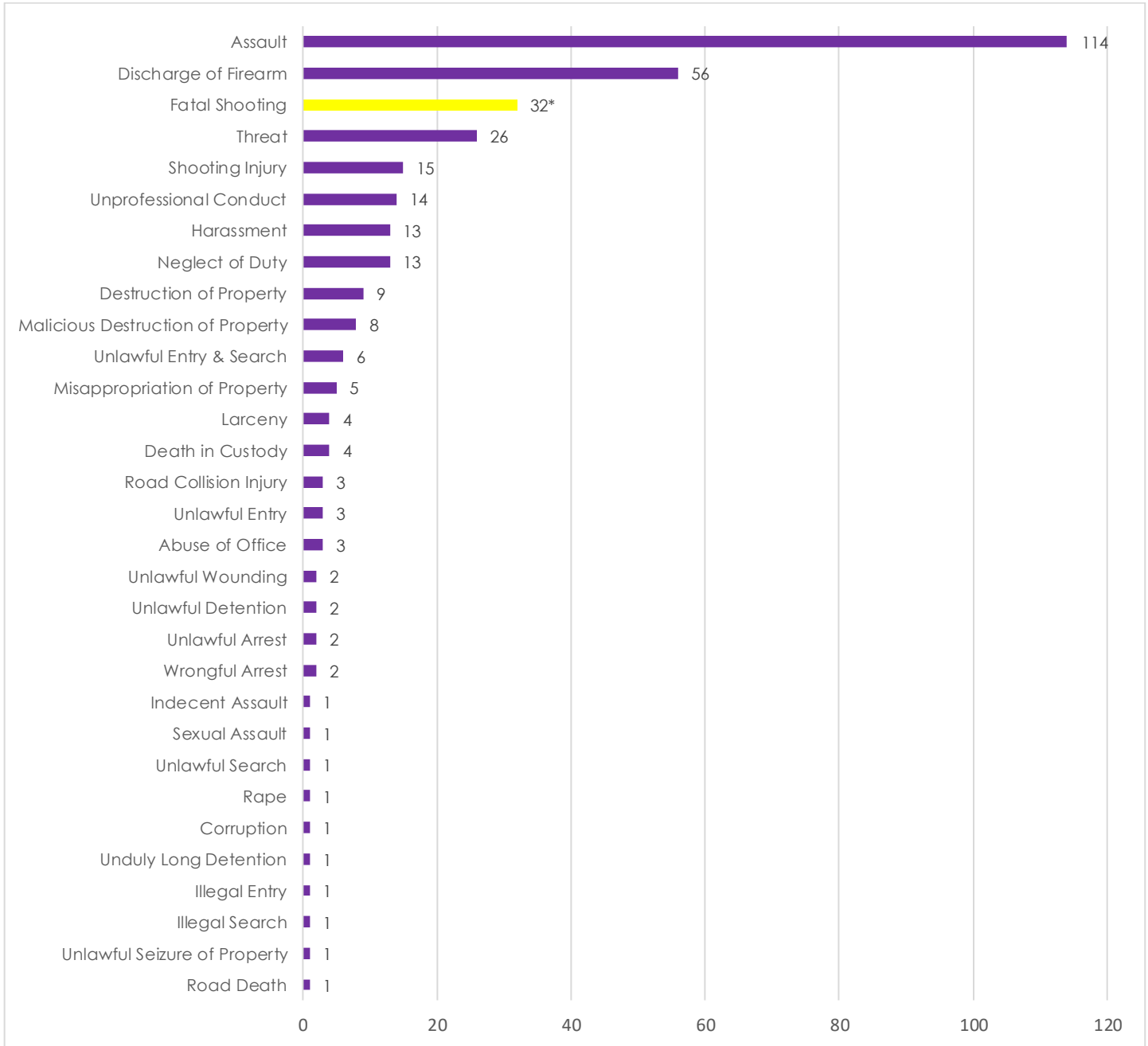
- The intake process into a lock-up facility should seek to ensure that relevant medical data is captured before detention. This will assist in safeguarding the medical access required – medication, diagnostic testing and possibly prevent deterioration.

APPENDIX 1Schedule of INDECOM reports on Detention

2013	Safeguarding the Right to Life
2017	Detention – Police Lock Ups
2018	Suicide in Custody. Vanessa Wint Re-visited
2020	i) Detained at Pleasure: Institutionalized Human Rights Breaches. ii) The State’s Treatment and Care of Inmates 60 years and over iii) Special Investigation: Rio Cobre Juvenile Correctional Centre.

PART ONE

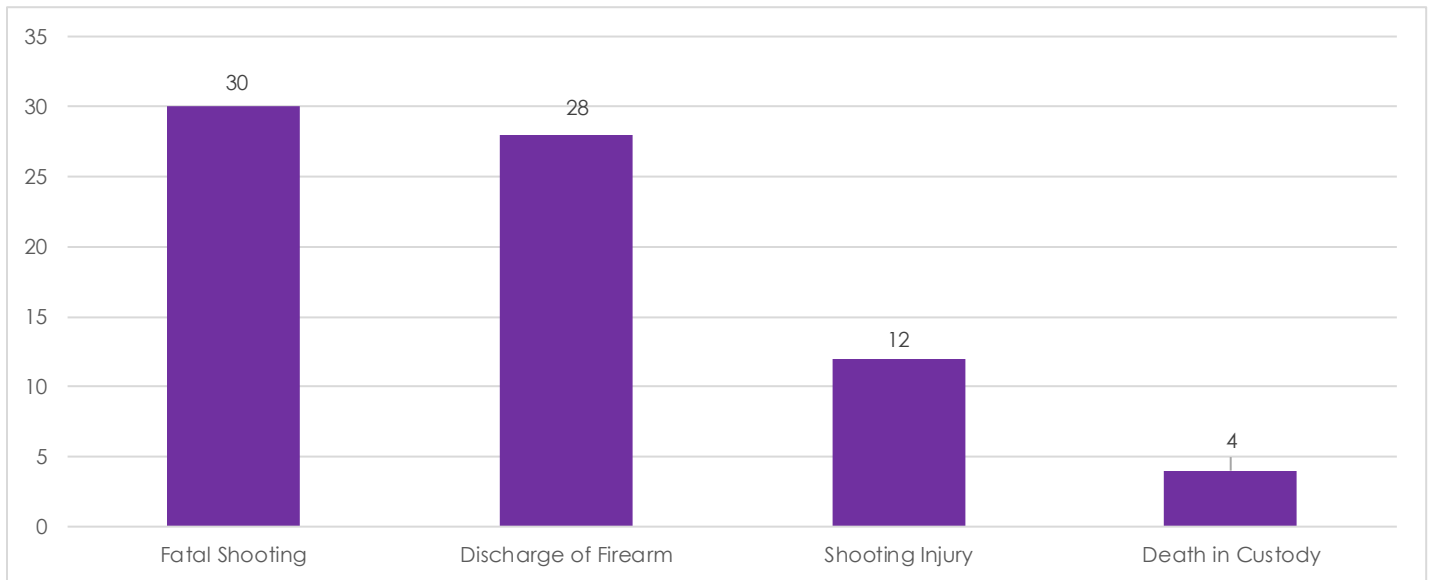
NEW INCIDENTS: APRIL – JUNE 2023



■ * There were 36 deaths from 32 Security Force fatal shooting incidents
 * Assault includes assault occasioning bodily harm and assault at common law

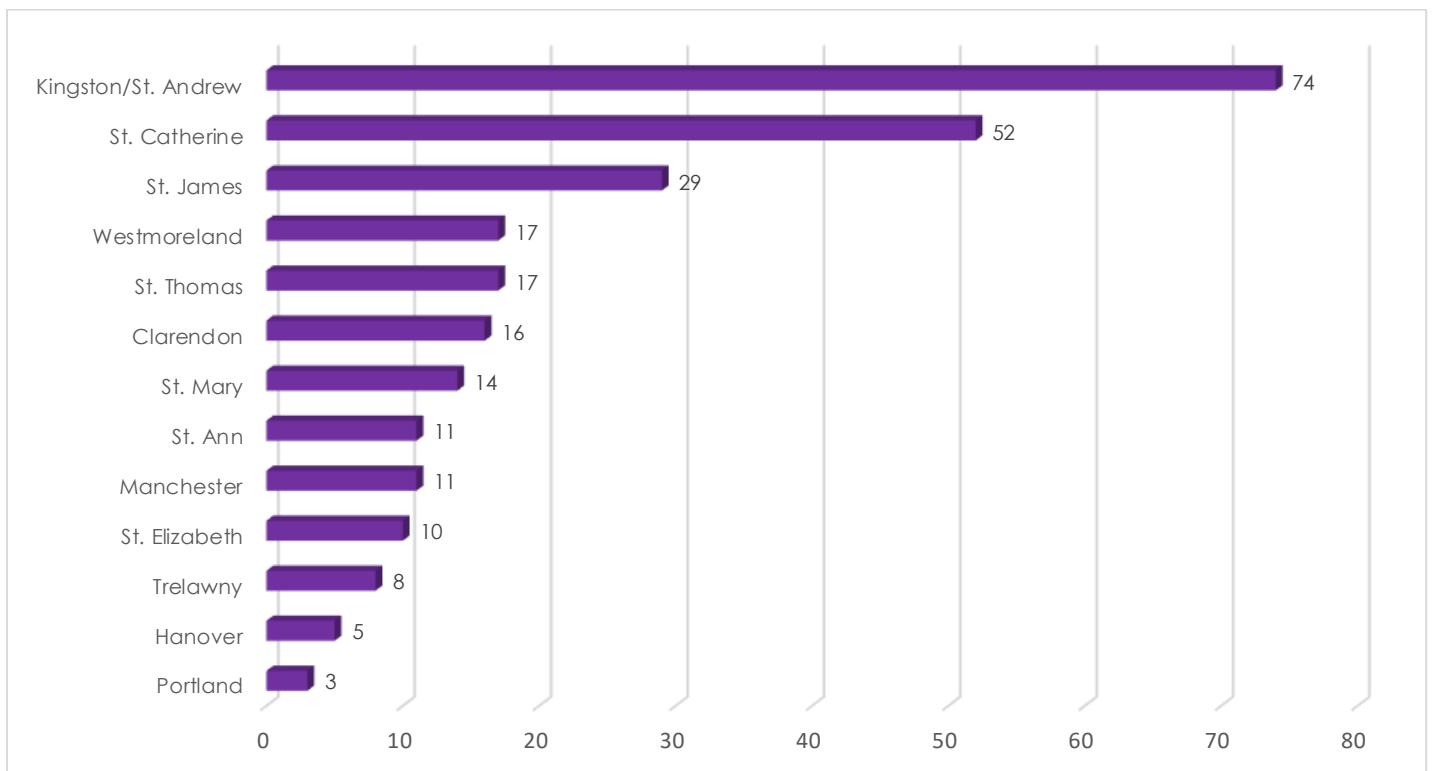
Graph 1 shows the 346 categories for the 267 new incidents for which complaints were received by the Commission during the period April to June 2023

FORENSIC SCENE RESPONSE



Graph 2 shows the 74 incidents that the Commission's Forensic Unit responded to during the period April to June 2023

COMPLAINTS BY PARISH



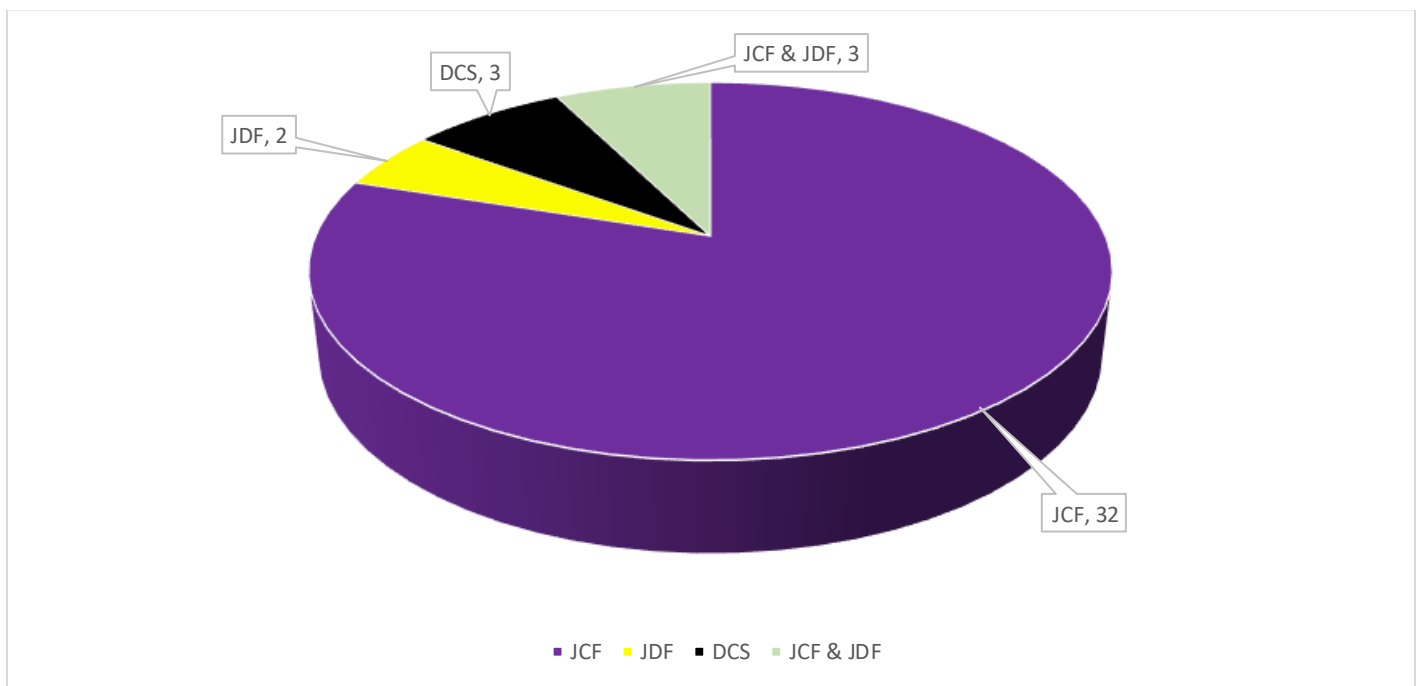
Graph 3 shows the breakdown per parish for the 267 new complaints received by the Commission during the period April to June 2023

COMPLAINTS PER ORGANISATION

STATE AGENCY	TOTAL COMPLAINTS	PERCENTAGE
Jamaica Constabulary Force (JCF)	220	82.4%
Department of Correctional Services (DCS)	29	10.9%
Jamaica Defence Force (JDF)	4	1.5%
Joint Police & Military (JCF & JDF)	13	4.9%
Other (Municipal Police)	1	0.4%

Table 5 shows the breakdown, per State agency, of the 267 new complaints received by the Commission during the period April to June 2023

FATALITIES PER ORGANISATION



Graph 4 illustrates the State agency to which the 40 fatalities (36 by fatal shootings, 4 deaths in custody), recorded for the period of April to June 2023 are related. See Table 2 below for the corresponding list with the specific incidents.

SECURITY FORCE-RELATED FATALITIES LIST

JCF – Jamaica Constabulary Force

JCF-OD: Jamaica Constabulary Force Off Duty Officer

■ JDF: Jamaica Defence Force

DCS: Department of Correctional Services

■ DIC: Death in Custody

RTC: Road Traffic Collision

Date	Name of Deceased	Location of Incident	Related State Agent
APRIL (9) (Fatal Shooting – 8; DIC – 1)			
4-Apr	Kenron TURNER Dwayne BAKER	Kingland, Manchester	JCF
5-Apr	Romain HAMBER	Cottage Salt Springs, St James	JCF
6-Apr	Lavanza BULGIN	Bobman Hill, Lilliput, St James	JCF
6-Apr	Albert KEEN DIC	SCACC to Spanish Town Hospital	DCS
14-Apr	Oshane R. CLARKE	Spanish Town, St Catherine	JCF
15-Apr	Olando DAVIS	Denbigh, Clarendon	JCF
15-Apr	Ripton E. JOHNSON	Seaside District, Port Morant, St Thomas	JCF
18-Apr	Nicholas DENTON	Race Course Lane, Denham Town, Kingston 14	JCF
MAY (14) (Fatal Shooting – 12; DIC - 2)			
1-May	Max FRANCIS	Eight Rivers Plaza, Ocho Rios, St Ann	JCF
3-May	Christopher LOCKE DIC	St Catherine Adult Correctional Centre	DCS
4-May	Fitzroy FRAY DIC	Negril Police Station	JCF
6-May	Romaine TUCKER	Nain, St Elizabeth	JCF
6-May	Avon S. FINDLATER	Lilliput, St James	JCF
8-May	Roger STERLING	New Road, Flankers, Montego Bay, St James	JCF
8-May	Andrea BROWN	River Road, Freetown, Clarendon	JCF
11-May	Denoby PRICHARD	Water Lane, Falmouth, Trelawny	JCF
13-May	Ricardo JONES	Brivate Lane, Fraser's Content, St Catherine	JDF
16-May	Shannon CAMPBELL	Hazlewood, Rickman Drive, Bamboo, St Ann	JCF
26-May	Otis EDWARDS	Tucker, Montego Bay, St James	JDF
27-May	Chadrick WILLIAMS	Penwood Road, Kingston 11	JCF
29-May	Dwayne CLARKE	Bethel Town, Westmoreland	JCF
31-May	Eric MORGAN	Olympic Way, Kingston 11	JCF – OD

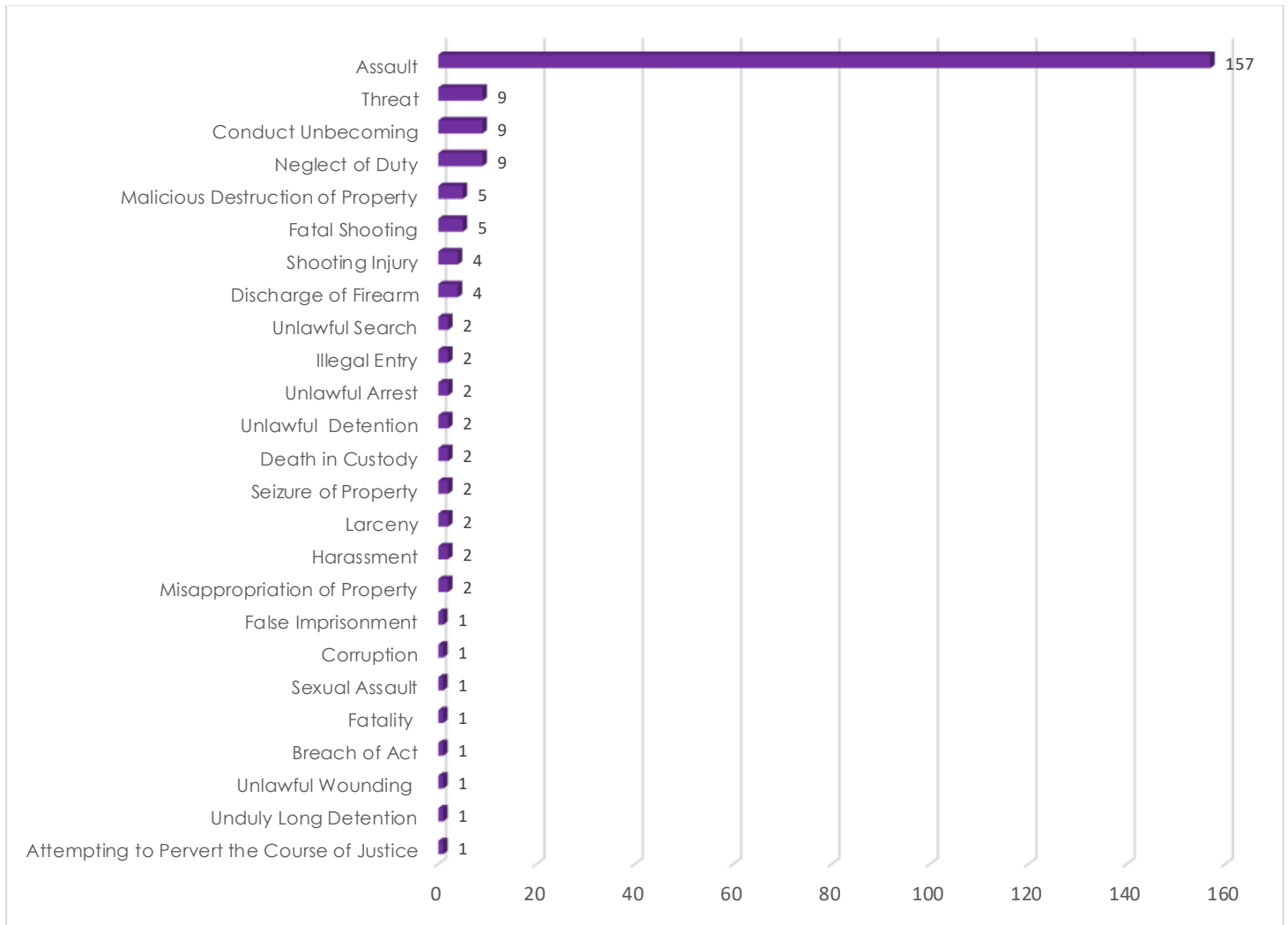
JUNE (17) (Fatal Shooting – 16; DIC – 1)			
3-Jun	Nester GALLIMORE Jedayne HENRY Javaughn HENRY	Compound, Barrett Town, St James	JCF & JDF
7-Jun	Jordan SMITH	Fort Clarence, Hellshire, St Catherine	JCF
9-Jun	Odaina H. LESTER	Windsor Heights, Central Village, Spanish Town, St Catherine	JCF
16-Jun	Melvin HALL DIC	Tower Street Adult Correctional Centre	DCS
16-Jun	Maurice JAMES	Burley Road, Kingston 10	JCF
16-Jun	Craig WILLIAMS	Blue Mahoe, St Thomas	JCF - OD
21-Jun	Delroy WILLIAMS	Maggoty Police Station, St Elizabeth	JCF
21-Jun	Jerraine BENT	Sligoville, near Bog Walk Gorge, St Catherine	JCF
22-Jun	Shevon DALEY	St Johns Road, Spanish Town, St Catherine	JCF
23-Jun	Gregory GRAHAM	Stewartfield, Seaforth, St Thomas	JCF
29-Jun	Wayne O'HARA	Market Road, Port Morant, St Thomas	JCF
29-Jun	Romaine MURRAY	Greenwood, Montego Bay, St James	JCF
30-Jun	Marcus JERVIS Allan BROOKS	Orange Street, Kingston	JCF
30-Jun	Cruise Palmer	Santa Cruz Car Park, Cecil Charlton Park, Mandeville	JCF

Table 6 lists the names of the 40 civilians who died from Security Force-related incidents during the period April to June 2023

PART TWO

The Legal Department

COMPLETED COMMISSION'S REPORTS: APRIL – JUNE 2023



Graph 5 shows the categories of complaints for Commission's Reports completed during the period of April to June 2023

OVERVIEW: COMMISSION'S REPORTS RECOMMENDATIONS

Charge		Charge & Disciplinary Action		Disciplinary Action		Unsubstantiated
0 cases	0 officers	0 cases	0 officers	27 cases	51 officers	185 cases

Table 7 shows the recommendations made for the 212 Commission's Reports completed during the period April to June 2023

COMMISSION'S REPORTS RECOMMENDATIONS – FATAL SHOOTING INCIDENTS

No.	Date of Incident	Victim	Case Summary	INDECOM Recommendations
1.	May 16, 2017	Kenroy Murray & Kwame Richardson	On Tuesday May 16, 2017 about 3:45 p.m. members of the St. Elizabeth Operational Support Team were on a Vehicular Check Point operations along the New Market Main Road when they signaled a white Toyota Mark X motor car bearing registration number 6833 HJ to stop. Two of the four men who were aboard opened fire at the police team. The fire was returned by the police and two of the men were subsequently found suffering from gunshot wounds. They were rushed to the Black River Hospital where they were pronounced dead by Doctor. The other two men escaped in nearby bushes. One pistol bearing serial number CM 19850 with thirteen .40 live cartridges were taken from the motor car.	No Charge
2.	June 23, 2017	Rayon Creighton	On Friday the 23rd day of June 2017, it is alleged that whilst a team of five police officers were on patrol along Harris Street, in the Rose Town Community about 11:19 p.m. on reaching the vicinity of Harris and White Streets, they heard several explosions sounding like gun shots which seemed to be coming from the direction of Tewari Crescent. Shortly after they saw a group of men running towards them with guns in their hands. The men fired at the police, the police returned fire and the men ran in different directions. The area was searched and a man was seen suffering from gunshot wounds and a firearm seen beside him on the ground. He was taken to KPH where he succumbed to his injuries. No eye witness was identified from the witness canvass and the family members did not witness the actual incident.	No Charge
3.	January 4, 2021	Shawn D-White	On January 4, 2021 a team from the Independent Commission of Investigations (INDECOM) responded to and began investigations into the Fatal Shooting of Shawn D-White and Shooting Injury of SD along Warreika Road, Kingston 2. The police reported that on even date, that upon reaching the vicinity of St. Georges Road, several armed men opened gunfire at the team. They took cover and in fear for their lives returned fire. After the shooting subsided, Mr. White was seen suffering from gunshot wounds and a firearm was recovered from him. Mr. White was taken to the Kingston Public Hospital where he died while undergoing treatment. Accounts from eye witnesses SD and SW who placed themselves on the scene denied that the men were armed and asserted that the police party greeted them with gunfire. In fear for their lives they ran. Of importance, the Ballistics Report confirmed that the recovered firearm was fired on even date as six spent casings matched the firearm. Of equal	No Charge

			importance is the placement of these spent casings. Two were found on the verandah of the premises where it is agreed the incident started and where SD placed himself and SW placed both Shawn D White and SD. Of note, the other spent casings were found at the other scenes which spanned several houses. Further, the Chemistry Certificate revealed that Shawn D White's right hand revealed the presence of 2 particles characteristic of gunshot residue. SD's hands did not reveal the presence of particles characteristic of gunshot residue.	
4.	May 10, 2021	Leighton Thompson & Richard Green	On Monday, May 10, 2021 at about 12:30 p.m. New Kingston Police Team consisting of Constable and Woman Constable responded to radio of suspicious men said to be travelling in a white Toyota Axio motorcar, travelling along Trafalgar Road. Upon reaching the intersection of Waterloo, Trafalgar and Hope Road three (3) men alighted from the said Toyota Axio and fired on the police. The police engaged and returned fire. During the firefight the Matilda's Corner Quick Response Team consisting of three Constables, arrived at the location and were also engaged by the gunmen. Two (2) of the men from the white Toyota Axio exited the vehicle and ran into the Abbey Court Apartments. They were chased by the police and one of the two was apprehended, the other escaped. The male that was apprehended was found to be suffering injuries. The driver of the white Toyota Axio was also found to be suffering gunshot wounds. Both men were taken to the Kingston Public Hospital (KPH). In the vehicle the police recovered two (2) Glock pistols; one bearing serial ADFE 916 and the other with serial number not visible.	No Charge
5.	October 17, 2021	Kevaughn Plummer	Kevaughn Plummer was shot and killed by the police on October 17, 2021 on the compound of the Pathways International Church at 141 Albion Road where, on evidence, he unlawfully wounded CJ and PB on the instructions of Dr. Kevin Smith. In furtherance of instructions given by Dr. Smith, Plummer attempted to attack the police with a knife; expressing his intention to cause their death when he was struck down by bullets from M16 rifles. Having investigated the matter exhaustively, the Commission has found that there is no evidence to negative the police claim to self-defence.	No Charge

Table 8 represents recommendations by INDECOM's Legal Department for Commission's Reports completed, for fatal shooting incidents, during the period April to June 2023

CASES CLOSED ON INITIAL INTERVENTION ARISING FROM INDECOM INVESTIGATIONS

April	May	June	Total
27	34	26	87

Table 9 shows the total number of cases which were Closed on Initial Intervention (CII) during the period April to June 2023

RULINGS RECEIVED FROM THE ODPP ARISING FROM INDECOM INVESTIGATIONS

No.	Incident Date	Category of Incident	Date Referred to ODPP	Date ODPP Ruling Received
Ruling for Disciplinary Action				
1.	June 4, 2021	Discharge of Firearm	May 26, 2023	June 6, 2023

Table 10 shows all case rulings received from the Office of the Director of Public Prosecutions (ODPP) during the period April to June 2023

CHARGES LAID FROM INDECOM INVESTIGATIONS (APRIL – JUNE 2023)

Name and Rank	Incident Date	Charge	Date of Charge	State Agency
Corporal Deon Carr	August 19, 2022	Murder and Shooting with Intent	April 12, 2023	JCF

Table 11 shows any member of the Security Forces who was charged for various allegations during the period of April to June 2023

INDECOM INVESTIGATIONS COMPLETED IN COURT (APRIL – JUNE 2023)

There were no INDECOM investigations which were concluded in the court system during the period of April to June 2023.

PART THREE

PUBLIC INFORMATION

- **Outreach: Sensitization Sessions**

Unit/ Division/ Station	Group Size	Duration	Contact Hours
Horizon Remand Centre	22	2	44
Northern Caribbean University	300	7	2100
St. Andrew Central Division	15	3.42	51.3
Portland Police Division	36	2	72
St. Andrew North Division	16	2.5	40
Kingston West Division	29	2.5	72.5
Kingston West Division	26	2.5	65
Mobile Reserve	31	2	62
St. Andrew South Division	26	2.5	65

Table 13 shows the 2571.8 man hours for sensitization sessions conducted by INDECOM with members of the Agents of the State and the public during the period, April to June 2023

INDECOM OFFICES

Head Office

1 Dumfries Road
Kingston 10

Interview Centre

9 Dumfries Road
Kingston 10

Central Regional Office

1 A Brumalia Road
Cobblestone Professional Centre - Unit 10
Mandeville, Manchester

Western Regional Office

Praise Concourse Plaza
18 Queens Drive,
Montego Bay, St. James

Telephone Lines

876.968.1932	876.968.8875
876.961.4171	876.971.1672
876.979.3481	876.929.6719
876.971.1672	876.979.3481

Incident and Tip Lines

(F) 1.888.991.5555

Whatsapp

(876) 553 – 5555

Email us: info@indecocom.gov.jm

Website: www.indecom.gov.jm

Searching for Truth, Striving for Justice