Fiosrú

Oifig an Ombudsman Póilíneachta

Office of the Police Ombudsman

Incidents of Death and Serious Harm 2024

Contents

Acknowledgments

This report was developed and analysed by Aisling Montgomery of the research team at Fiosrú, Office of the Police Ombudsman. We would like to express our appreciation to all colleagues who assisted in gathering, reviewing and verifying the information contained in this report, and to those who contributed to its publication. Fiosrú would also like to thank the research team in the Independent Office for Police Conduct (IOPC), who provided information and support.

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List of Abbreviations

DIU	Digital Investigations Unit
DMR	Dublin Metropolitan Region
DPP	Office of the Director of Public Prosecutions
ECHR	European Convention on Human Rights
GSOC	Garda Síochána Ombudsman Commission
FLO	Family Liaison Officer
PULSE	An Garda Síochána's information management system
RTI	Road Traffic Incident
SIO	Senior Investigating Officer
SSU	Specialist Services Unit

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Foreword

I am pleased to introduce this inaugural thematic report by Fiosrú, Office of the Police Ombudsman, on incidents involving contact with gardaí where a member of the public has died or been seriously injured.

By law, all such incidents are investigated by Fiosrú following their referral by An Garda Síochána. By their nature, these incidents generally require the rapid response of our on-call investigative teams countrywide, and also often our family liaison specialists who are trained in trauma-informed practice.

Where necessary, Fiosrú's specialists attend incident scenes to gather forensic evidence, interview witnesses and injured parties, provide specialist support to families and vulnerable people, and liaise with other state officials including Coroners.

As this report documents, during 2024 Fiosrú received a total of 37 statutory referrals of incidents of death or serious harm. These referrals involved a total of 42 people. Of these, sadly, 21 people lost their lives and a further 21 suffered serious injuries.

From the outset, I wish to acknowledge that the incidents documented in this report are by their nature often tragic, complex and sensitive. In many cases, grieving families have been left behind, people have been deeply affected by injuries and trauma, and lives have been potentially changed forever.

Indeed, this report starkly illustrates the range of very challenging and difficult scenarios which gardaí can face in their important role as the first line of response for such people at risk.

Just over a third of the referrals related to road traffic incidents, while a high number related to apparent and attempted suicides. Six of the people involved in the incidents described in this report were young males under the age of 25, while several were homeless.

One of the statutory functions of An Garda Síochána is preventing harm to individuals, in particular individuals who are vulnerable or at risk. Underlying factors in many of the incidents involving tragic loss of life in 2024 include mental health difficulties, self-harm and alcohol and drug issues. My thoughts are with all of those affected by these sad events.

Where deaths have occurred, this office's role is to respond and investigate in an independent, thorough and transparent way. This is an important element in ensuring that the State fulfils its obligations under the European Convention on Human Rights.

At the conclusion of our investigations, our role is to either make recommendations to the Garda Commissioner for potential internal disciplinary proceedings or to send files to the Office of the Director of Public Prosecutions to consider criminal prosecutions.

As this report details, out of the 37 referrals of incidents of death or serious harm received in 2024, five Fiosrú investigations remain ongoing. A further 23 were discontinued for a range of reasons, including the lack of any apparent disciplinary breach or criminal offence. Such decisions are taken following detailed analysis of a range of evidence including pathology reports, toxicology test results and reviews of CCTV footage and witness statements.

In two referrals, this office identified possible breaches of Garda discipline and sent files to the Garda Commissioner for his consideration. Two Fiosrú investigations identified an apparent criminal offence, resulting in files being sent to the Office of the Director of Public Prosecutions for its consideration.

As these outcomes show, the majority of Fiosrú's investigations concerning referrals of incidents of death or serious harm in 2024 found no evidence of wrongdoing on the part of individual gardaí.

The report should nevertheless provide reassurance from the perspective of public confidence in the oversight process that each of these serious incidents was subject to an immediate and independent investigation by Fiosrú's dedicated and skilled on-call response teams.

The incidents documented in this report are exceptional and represent but a small fraction of the investigations which Fiosrú carries out each year. The often challenging and complex circumstances behind these referrals provide real opportunities for learning with the objective of minimising harm and preventing deaths in the future.

The investigatory process itself often sheds important light on procedural or organisational issues that may warrant intervention to help improve policing policy and practice, safeguard public trust in our policing services, and ensure accountability.

As an independent civilian oversight agency, Fiosrú, through all of its investigations, seeks to contribute where it can to fostering capacity and resilience among frontline gardaí in responding to challenging scenarios.

My hope is that the yearly publication of this statistical data and analysis will facilitate better understanding of systemic issues and areas for improvement for consideration by the Garda Commissioner.

We know that our national policing service does not operate in isolation, and that multi-agency collaboration is required to ensure that people in need receive appropriate services from the relevant agencies at the right time.

I hope too that the statistical analysis and insights in this annual research will contribute positively to the work of social service and public health agencies which play an important role in interrogating the root causes of some of the serious and sad circumstances behind these incidents.

Emily Logan
Police Ombudsman

Executive Summary

Introduction

Section 102 of the Garda Síochána Act 2005 provides for the independent investigation of referrals from An Garda Síochána relating to incidents where the conduct of a Garda member may have resulted in the death or serious harm of a person. This statutory provision was replaced by section 203 of the Policing, Security and Community Safety Act 2024 which entered into force in April 2025.

This report sets out the statistics and key findings relating to an analysis of the referrals received under section 102 of the Garda Síochána Act 2005 by Fiosrú in 2024.

This is Fiosrú's first annual report on this subject, and covers the period 1 January to 31 December 2024.

The following chapters present demographic information about those who were injured or died following garda contact, along with details about the incidents that led to their death or serious harm, and their reasons for contact with the gardaí and detention.

Key Findings

Incidents and referrals

In 2024, An Garda Síochána made a total of 37 referrals to Fiosrú of incidents of death or serious harm involving garda contact. These incidents resulted in the death of 21 people. A further 21 people were injured.

The incidents of death or serious harm are examined and categorised by Fiosrú on the basis of the circumstances in which they happened.

Of the 37 referrals received in 2024:

- Thirteen related to road traffic incidents
- Eight involved death or serious harm in or following Garda custody
- Ten related to apparent or attempted suicides
- Six involved death or serious harm following garda contact

Demographics

Out of a total number of 42 deceased or injured people involved in incidents which led to referrals:

- Thirty-seven (88%) were male
- Five (12%) were female
- Six were aged under 25 years old
- Seventeen were aged between 31-40 years old

Vulnerable individuals and people at risk

Many of the people involved in the incidents which led to referrals were vulnerable or at risk. Of the 37 referrals:

- 49% involved people identified as having mental health difficulties
- 51% involved people with links to alcohol
- 38% involved people with links to drugs
- 11% involved people who are currently experiencing, or have a history of periods of homelessness

Two referrals related to gardaí dealing with alleged sexual offences and a further two referrals related to gardaí responding to alleged domestic violence offences.

Fiosrú investigations

- Fifteen preliminary examinations discontinued
- Fourteen disciplinary investigations:
  - Three ongoing
  - Six discontinued
  - Three concluded and no breach of discipline identified
  - Two recommendations were sent to the Garda Commissioner for disciplinary proceedings
- Eight criminal investigations:
  - Two ongoing
  - Two discontinued
  - Two concluded and no criminal offence identified
  - Two referred to the Office of the Director of Public Prosecutions (DPP)

GSOC to Fiosrú

On 2 April 2025, the Garda Síochána Ombudsman Commission (GSOC) became Fiosrú - Oifig an Ombudsman Póilíneachta (Office of the Police Ombudsman) with the commencement of the Policing, Security and Community Safety Act 2024.

This law provides for the continuation of GSOC as Fiosrú. This means that Fiosrú continues to investigate those cases which were already underway in GSOC under the Garda Síochána Act 2005.

It should be noted that the referrals included in this report were received by GSOC in 2024 and investigated under the Garda Síochána Act 2005. The report, however, refers throughout to Fiosrú ("Fiosrú investigations", "Fiosrú investigators", etc), as we are now known.

1. Introduction

Fiosrú - Oifig an Ombudsman Póilíneachta (Office of the Police Ombudsman), is the independent statutory agency responsible for investigating garda conduct.

In addition to investigating complaints from the public concerning Garda members, Fiosrú is responsible for independently investigating referrals from An Garda Síochána where it appears that the conduct of a Garda member(s) may have resulted in the death or serious harm to a person. Fiosrú may also undertake investigations in the public interest outside of the usual complaints or referrals processes.

Under the Policing, Security and Community Safety Act 2024, the objectives of the Police Ombudsman are:

- to promote confidence in the processes for resolving and investigating complaints made by members of the public;
- to improve public understanding of Fiosrú's role;
- to ensure that its functions are performed in a timely, efficient and effective manner, and in accordance with fair procedures.

This report presents the data on all referrals of incidents of deaths or serious harm involving Garda members received by Fiosrú in 2024. This is the first report on this subject published by Fiosrú.

This report provides a range of data for referrals received between 1 January and 31 December 2024. This includes an overview of the nature and circumstances in which these incidents of deaths or serious harm occurred and details of any patterns that have been identified.

The referrals included in this report were received by GSOC in 2024 under section 102 of the Garda Síochána Act 2005. These referrals continue under section 203 of the Policing, Security and Community Safety Act 2024.

The definition of "serious harm" is outlined in section 82 of the Garda Síochána Act 2005 to mean injury that:

(a) creates a substantial risk of death,

(b) causes serious disfigurement, or

(c) causes substantial loss or impairment of mobility of the body as a whole or of the function of any particular bodily member or organ.

The referrals of incidents of death and serious harm are separated by Fiosrú into the following four categories that align with those used by other police oversight bodies:

- Road traffic incidents;
- Death or serious harm in or following Garda custody (garda custody);
- Apparent or attempted suicides;
- Death or serious harm following garda contact (garda contact).

For more detailed definitions and information about how incidents are categorised and recorded, please see Appendix B.

Anonymised summaries of the circumstances of a number of incidents which led to referrals are included in this report. Only summaries of incidents in which the Fiosrú investigation has concluded have been included.

This report also includes incidents involving the death or serious harm of Garda members, as well as incidents involving off-duty Garda members.

In future annual reports, Fiosrú will report on an expanded range of referrals as the definition of serious harm was expanded under section 193 of the Policing, Security and Community Safety Act 2024 to also include incidents in which a person has been the victim of a sexual offence or has been the victim of an abuse of power for a sexual purpose.

Fiosrú's On Call Teams – Round the Clock Response

Fiosrú has an on-call team of investigators available 24 hours a day, 7 days a week, 365 days a year. These investigators are ready to attend incident scenes at any time of the day or night anywhere in Ireland. Working primarily from three office locations in Dublin, Cork and Longford, Fiosrú investigators are based around the country and are dispatched to and remain present at incident locations until all immediate investigative actions are completed. These teams are each headed by a Senior Investigating Officer who has overall responsibility for this urgent response supported by multiple teams in areas such as witness appeals, technical support and specialist equipment. Fiosrú investigators are trained in such areas as critical incident response and the strategic management of complex cases to ensure they provide the highest standards of investigation. A number of Fiosrú investigators have also undertaken further study and training to enable them to operate in highly specialised roles such as advanced-level interviewing and victim support.

Section 102, Garda Síochána Act 2005

102 (1) The Garda Commissioner shall refer to the Ombudsman Commission any matter that appears to the Garda Commissioner to indicate that the conduct of a member of the Garda Síochána may have resulted in the death of, or serious harm to, a person.

Section 203, Policing, Security and Community Safety Act 2024

203 (1) The Garda Commissioner shall, subject to subsection (2), without delay, refer to the Police Ombudsman any matter that appears to the Garda Commissioner to indicate that the act or omission of a member of garda personnel may have resulted in the death of, or serious harm to, a person.

European Convention on Human Rights

Article 2
Right to life

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection.

Article 3
Prohibition of torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

1.1 Upholding Human Rights

Fiosrú and An Garda Síochána, as actors of the State, have an obligation to uphold and protect the rights of all people.

Article 40.3.2 of Bunreacht na hÉireann, the Irish Constitution, sets out to protect the life of every citizen through the law while Article 40.3.1 guarantees the protection of the personal rights of citizens.

Article 2 of the European Convention on Human Rights (ECHR), sets out the right to life of all people.

Article 3 of the ECHR prohibits torture and inhuman or degrading treatment of all people.

The European Convention on Human Rights Act 2003 gives further effect to the ECHR in Ireland. This law requires that Irish state bodies, including Fiosrú and An Garda Síochána, perform their functions in a manner that meets the State's obligations under the ECHR.

In order to comply with Article 2 of the ECHR, investigations into any death following police contact should adhere to five principles developed by the European Court of Human Rights. These five principles are:

- Independence
- Effectiveness
- Promptness
- Public scrutiny
- Family involvement

These principles are at the heart of all Fiosrú's investigations into deaths.

Fiosrú's investigations into referrals of death or serious harm form an important element of the State's framework for compliance with its obligations under Articles 2 and 3 of the ECHR. This aspect of policing oversight contributes to a human rights approach to policing.

Referrals of death and serious harm were provided for under section 102 of the Garda Síochána Act 2005 and continue under section 203 of the Policing, Security and Community Safety Act 2024 which repeals and replaces the earlier statute.

1.2 Referrals of Death and Serious Harm

When it appears to the Garda Commissioner that the behaviour of a Garda member may have resulted in the death of, or serious harm to, a person, the Garda Commissioner is obliged to make a referral to Fiosrú, informing it of the details and circumstances. A referral does not necessarily mean a Garda member or members have been accused of wrongdoing. Instead it means that the incident should be investigated independently by Fiosrú to ascertain whether or not the conduct of the Garda member contributed to the death of, or serious harm to, a person.

In practice, the Garda Commissioner delegates the decision to refer incidents which may have resulted in death or serious harm to Garda Superintendents at district level. Once the Superintendent decides that the conduct of a Garda member may have resulted in death or serious harm, they must refer the matter to Fiosrú. As soon as the referral is made, the Fiosrú on-call Senior Investigating Officer (SIO) contacts the Superintendent immediately to obtain further information and establish the circumstances of the referral known at the time. For referrals requiring an urgent response, the Superintendent contacts Fiosrú through a dedicated on-call telephone number which is monitored 24 hours a day, 365 days a year.

1.3 Investigations of Referrals

Once Fiosrú receives a referral from An Garda Síochána under section 102 of the Garda Síochána Act 2005, it must initiate an immediate preliminary examination. This is an independent investigation that establishes the facts of the incident that has been referred, what happened, and whether the garda or gardaí involved have acted appropriately. The purpose of the preliminary examination is to make a recommendation as to whether a criminal or disciplinary investigation should be commenced.

It is sometimes the case that, following a preliminary examination, it is clear that there is no evidence of a breach of discipline or a criminal offence. For example, post mortem and toxicology reports may show that a deceased person passed away from medical reasons or reasons unrelated to any garda action. In such cases, Fiosrú will discontinue the referral. This means that further investigation will no longer be pursued and the case is closed.

In other cases, it is appropriate to undertake a full investigation. The preliminary examination determines whether a full investigation will be criminal and/or disciplinary.

1.3.1 Criminal Investigations

In a criminal investigation, Fiosrú investigators have full policing powers, equivalent to all the powers, immunities and privileges conferred and all the duties imposed on members of An Garda Síochána.

It is sometimes the case that no evidence of criminality is found and Fiosrú will discontinue the investigation. In other cases, where the evidence indicates that the conduct of a Garda member may constitute a criminal offence, Fiosrú sends a report to the Office of the Director of Public Prosecutions (DPP).

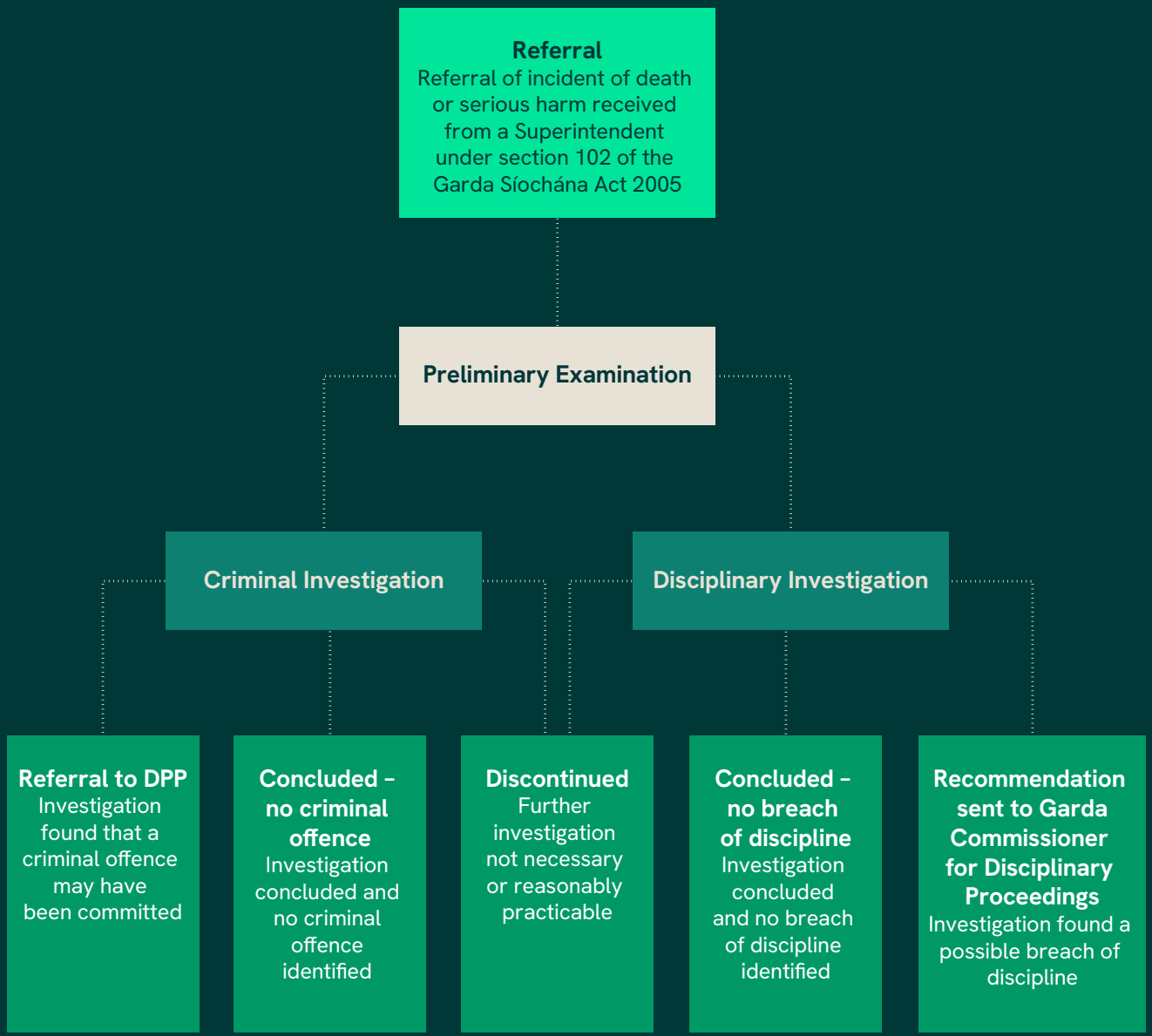
1.3.2 Disciplinary Investigations

If it becomes evident that a referral may have involved a breach of discipline, a disciplinary investigation is initiated.

If Fiosrú considers that the behaviour of a Garda member may have amounted to a breach of discipline, it makes a recommendation to the Garda Commissioner that internal disciplinary proceedings should be instituted.

Disciplinary investigations by Fiosrú may be escalated to criminal investigations if evidence of criminality is found.

Chart 1: Referral Journey



1.3.3 What Happens During an Investigation?

Fiosrú has a total of seven teams available to investigate referrals of incidents of death or serious harm. One team, led by a Senior Investigating Officer (SIO), is on call at all times with the capacity to respond to an incident anywhere in the country and to conduct an independent investigation. Depending on the circumstances of the incident, other investigators are assigned to assist the on-call team in the investigation.

The investigation team, led by a SIO, may take a number of the following actions depending on the circumstances. The investigation team may:

- Attend the scene of a death or injury;
- Preserve the scene of a death or injury for forensic examination;
- Submit material for forensic examination;
- Send vehicles for forensic examination;
- Collect and analyse CCTV footage and other sources of digital evidence;
- Gather witness details and statements;
- Interview injured people, gardaí and other people involved;
- Gather further evidence, including Garda reports;
- Notify the Coroner of a death and provide the Coroner with a briefing on the circumstances of the death;
- Notify the Coroner of preliminary post mortem findings and toxicology findings, if Fiosrú has primacy of the case;
- Recommend a State post mortem by the State Pathologist and provide the State Pathologist with a briefing on the circumstances of the death;
- Attend the post mortem;
- Meet with the family of a deceased person to provide updates on the investigation;
- Deploy a dedicated Family Liaison Officer to engage with and support the family of a deceased person.

2. Overall Findings

Fiosrú received 37 referrals of incidents of death or serious harm involving garda contact in 2024. This compares to 35 referrals in 2023 and 41 referrals in 2022. Out of the 37 referrals, 21 related to deaths and 16 related to serious harm.

A referral may include more than one person. The 37 referrals in 2024 involved a total of 42 people of whom 21 were deceased and 21 were injured.

The referrals of death or serious harm are separated by Fiosrú into the following four categories that align with those used by other police oversight bodies:

- Road traffic incidents;
- Death or serious harm in or following Garda custody (Garda custody);
- Apparent or attempted suicides;
- Death or serious harm following garda contact (garda contact).

For more detailed definitions and information about how incidents are categorised and recorded, please see Appendix B.

During 2024, there were:

- Thirteen referrals of road traffic incidents;
- Eight referrals of death or serious harm in or following Garda custody;
- Ten referrals relating to apparent or attempted suicides;
- Six referrals of death or serious harm following garda contact.

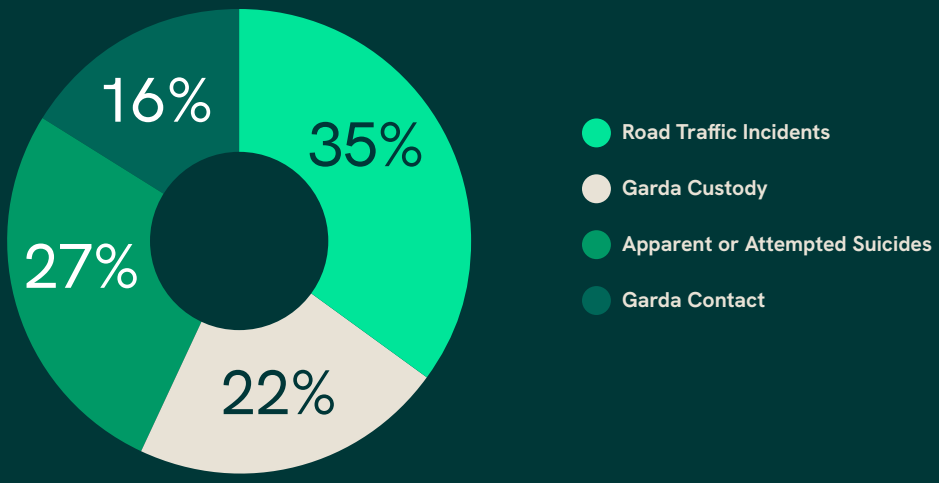
The category of death or serious harm following garda contact includes one referral relating to a Garda member accidentally discharging a firearm during official training exercises which resulted in an injury to themselves. In 2024, there were no referrals relating to fatal or non-fatal shootings of members of the public by gardaí.

The figures in Table 1 show the number of referrals relating to deaths and serious harm in 2024 across each category.

Table 1: Deaths and Serious Harm by Category

Category of Death and Serious Harm	Death	Serious Harm	Total
1. Road Traffic Incidents	3	10	13
2. Garda Custody	5	3	8
3. Apparent or Attempted Suicides	9	1	10
4. Garda Contact	4	2	6
Total	**21**	**16**	**37**

Chart 2: Category of Death and Serious Harm



The findings summarised in this chapter are broken down per category in the following chapters.

Demographic information about those who died or were seriously harmed is also presented in the following chapters, along with details of the circumstances of the incidents which led to referrals to Fiosrú in 2024.

Also documented are the reasons captured for the deceased or injured person's contact with gardaí and, where relevant, the reasons for their detention by gardaí.

This data highlights a range of social issues and personal hardships including mental health difficulties, alcohol and drug addiction and homelessness.

2.1 Investigations

In the case of 23 referrals (62%), Fiosrú immediately sent investigators to the scenes of incidents of death or serious harm. Not all referrals require an urgent response. For example, there may be no need to immediately secure evidence or conduct enquiries due to the nature of the referral.

The quickest response time from referral to attendance at the scene of the incident by on-call investigators was just over an hour. The average response time was 3 hours and 43 minutes. The location of the incident and the distance that the Fiosrú on-call team is required to travel influences the overall response time to an incident. Fiosrú has offices in Dublin, Cork and Longford and can respond to incidents across the country.

154 Garda members were involved in the 37 incidents of death or serious harm that were referred to Fiosrú for investigation. This includes 77 Garda members investigated for a potential breach of discipline or criminal offence, 73 Garda members who provided reports or statements and four Garda members who were interviewed by Fiosrú investigators.

Stage of Investigations

Some of the investigations into referrals of death and serious harm recorded in this report are ongoing at the time of writing. The data used for this report is based on the information available at the point of analysis in November 2025.

The stage of the investigations for each of the 37 referrals received in 2024 as of November 2025 are detailed below:

- Three disciplinary investigations were ongoing.
- Two criminal investigations were ongoing.
- Fifteen referrals were subject to a preliminary examination which was discontinued. The preliminary examination found there to be no apparent breach of discipline or criminal offences.
- Eight referrals included the initiation of disciplinary and criminal investigations that were discontinued as further investigation was found to be not necessary or reasonably practicable. The reasons for these decisions were:
  - One investigation led by An Garda Síochána was already underway and a Fiosrú investigation was not necessary;
  - In one investigation the injured person(s) would not engage, or could not be contacted;
  - In one investigation the injured person requested there was no further investigation of the incident;
  - In one investigation there was insufficient information available to continue;
  - Four disciplinary investigations did not identify any evidence of an apparent breach of discipline.

- Three referrals involved a disciplinary investigation that was concluded and identified no breaches of discipline.
- Two referrals involved a disciplinary investigation that identified a breach of discipline and a recommendation for disciplinary proceedings was sent to the Garda Commissioner.
- Two referrals involved criminal investigations where, following detailed investigation, no criminal offence was identified.
- Two referrals involved a criminal investigation that identified an apparent criminal offence. Fiosrú referred these matters to the Office of the Director of Public Prosecutions (DPP).
  - The DPP decided to initiate a prosecution in relation to one referral.
  - The DPP's decision is pending in relation to one referral.

2.2 Demographics

2.2.1 Age

Of the 42 people involved in incidents which led to referrals to Fiosrú in 2024, four were under 18 years of age and a further two were under 25 years of age. These people were all involved in road traffic incidents. No young people under 25 were involved in any of the remaining categories.

A total of 17 deceased or injured people between the ages of 31 and 40 years were involved in incidents that led to a referral, making this the largest age group. Tables 2 and 3 below show the breakdown of the age ranges by category and in percentages.

Table 2: Age Range of Deceased or Injured People by Category

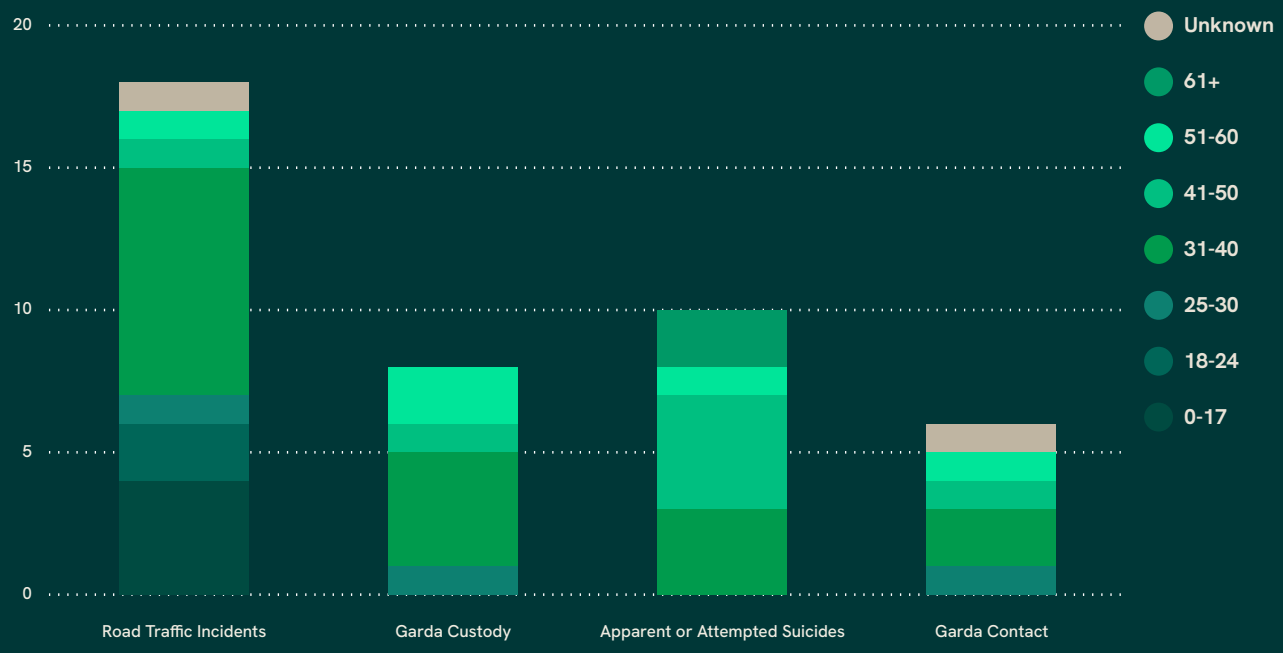
Category of Death and Serious Harm	0-17	18-24	25-30	31-40	41-50	51-60	61+	Unknown	Total
1. Road Traffic Incidents	4	2	1	8	1	1		1	18
2. Garda Custody			1	4	1	2			8
3. Apparent or Attempted Suicides				3	4	1	2		10
4. Garda Contact			1	2	1	1		1	6
Total	**4**	**2**	**3**	**17**	**7**	**5**	**2**	**2**	**42**

Table 3: Age Range of Deceased or Injured People

0-17	18-24	25-30	31-40	41-50	51-60	61+	Unknown
10%	5%	7%	40%	17%	12%	5%	5%

Chart 3 highlights that while the 31 to 40 years age group is the largest across all 37 referrals, the 41 to 50 years age group is higher in the category of apparent and attempted suicides.

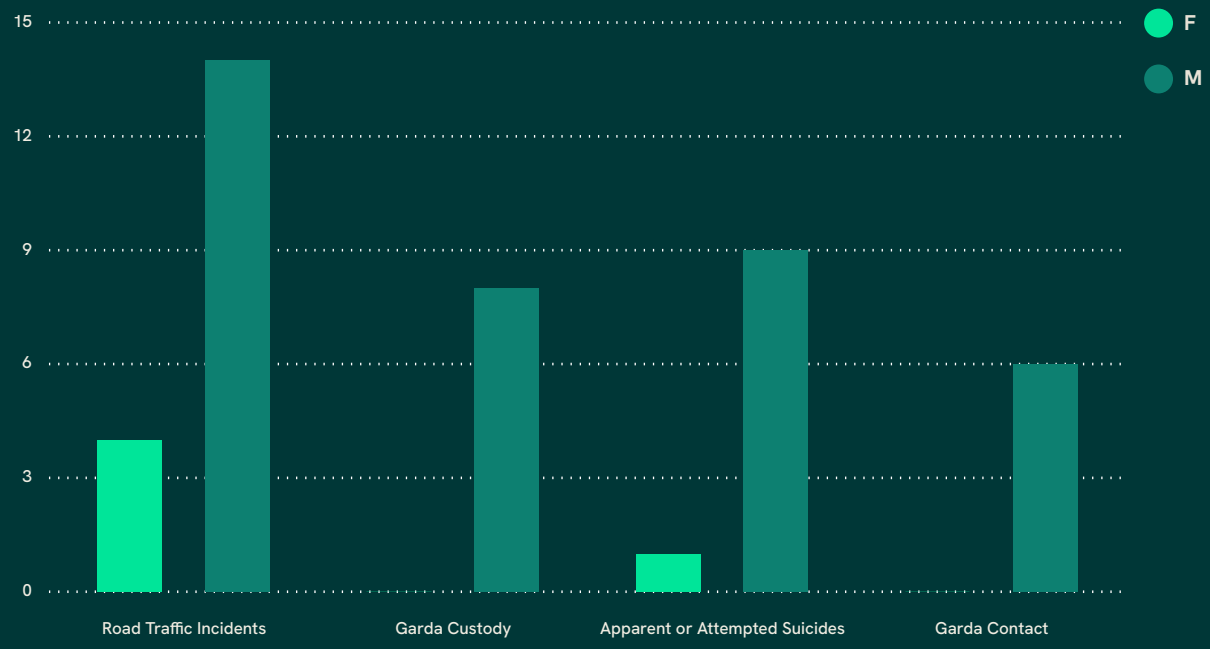
Chart 3: Age by Category



2.2.2 Gender

Of the 42 deceased or injured people included in referrals, 37 (88%) were male and five (12%) were female. Chart 4 shows the breakdown of gender by category. Only males were involved in the incidents of death and serious harm which came under the two categories of Garda custody and garda contact.

Chart 4: Gender by Category



2.3 Reason for Contact with Gardaí

For all 37 referrals, the initial reason for the deceased or injured person's contact with gardaí was recorded by Fiosrú from an analysis of the circumstances of the referral. The deceased or injured person may have come into contact with gardaí for allegedly committing an offence or due to circumstances in life that left them vulnerable or in crisis.

Table 4 outlines the reasons captured for the deceased or injured person's contact with gardaí per referral. The most common reason for contact with gardaí was intoxication, followed by mental health difficulties or suicide risks, dangerous driving and road traffic incidents involving off duty Garda members.

Table 4: Reason for Contact with Gardaí - All Referrals

Reason for Contact	
Intoxication	5
Mental health / suicide risk	4
Dangerous driving	4
Off duty garda[1]	4
Public disturbance	3
Stolen car	3
Other	2
Search for suspected possession of drugs	2
Suspicious activity	2
Arrest for suspicion of serious child sexual assault	1
Domestic incident	1
Breach of safety order	1
Criminal damage	1
Noise disturbance	1
Road traffic incident	1
Search warrant for suspicion of possession of child pornography	1
Theft	1
Total	**37**

1. All referrals that have a reason for contact recorded as "off duty garda" relate to road traffic incidents involving an off duty garda member.

2.4 Vulnerable Individuals and People at Risk

The data shows the prevalence of mental health difficulties, and the usage of alcohol and drugs in the incidents that led to the referrals of death and serious harm received in 2024. This highlights the challenging and complex situations, crises and vulnerable individuals that gardaí come into contact with.

For each referral included in this report, it is recorded whether mental health difficulties, alcohol or drugs is relevant to the deceased or injured person. For more detailed information on how these factors are selected, please see Appendix B.

Mental health difficulties, or the usage of alcohol or drugs were factors in 29 referrals (78%).

Out of 37 referrals, 18 (49%) involved people with mental health difficulties. The type of mental health difficulties recorded included bipolar disorder, depression, psychosis, post-traumatic stress disorder, self-harm, suicidal ideation and history of suicide attempts. Four individuals involved in an incident that was referred for investigation were detained under section 12 of the Mental Health Act 2001.

In 19 referrals (51%) alcohol was a factor and in 13 referrals (35%) drugs was a factor. These factors were selected if the deceased or injured person was intoxicated by alcohol or drugs at the time of the incident, or if alcohol or drugs featured heavily in their lives.

Some referrals have multiple factors. The intersection of these social issues, whereby an individual is dealing with two or more of these factors, is important to note. In five referrals, mental health and alcohol were co-existing factors. In six referrals (16%), mental health difficulties were noted with co-existing factors of alcohol and drugs.

Chart 5 highlights the prevalence and co-existence of mental health, alcohol and drugs in the referrals of death and serious harm received in 2024.

Chart 5: Referrals Involving Mental Health, Alcohol and/or Drugs

Additional Information

Four referrals (11%) included homelessness as a factor. These referrals included two individuals who were homeless at the time of the incident and two individuals who had a history of periods of homelessness.

Domestic violence was noted in two referrals. In these cases, the gardaí were responding to calls of an alleged domestic incident and an alleged breach of a safety order.

Family Liaison Officers – Supporting Relatives

Fiosrú sends its Family Liaison Officers (FLOs) to support a family where there has been a death, the circumstances of an incident are complex, or to support a family through the court or coronial process.

The FLO serves as the main point of contact between Fiosrú and the family of the deceased person during an investigation. These highly trained staff are an essential part of the investigation team.

A FLO may also be appointed to the family by An Garda Síochána. In such circumstances, Fiosrú's FLO will liaise with their Garda Síochána counterpart where it is appropriate.

Fiosrú's FLOs have all completed specialist training to develop their knowledge and skills in supporting people in crisis or bereavement. They receive specialist training on emotional support, trauma-informed practices and supporting families through the criminal justice system.

FLOs ensure a human rights-based approach to Fiosrú's work by supporting the principle of family involvement in police complaint investigations under Article 2 of the European Human Rights Convention.

3. Category One: Road Traffic Incidents

The category of road traffic incidents (RTIs) includes referrals of death or serious harm of drivers, passengers, pedestrians or other road users arising from garda pursuits and other Garda traffic-related activity.

This does not include:

- Deaths or serious harm that happen following a RTI where gardaí attend immediately after the event as an emergency service; or
- Death or serious harm from RTIs where gardaí had no involvement in the RTI but happened to be in contact with the deceased or injured person a short time prior to the incident.

In 2024, there were 13 referrals of death or serious harm related to RTIs. These referrals involved three deceased people and 15 injured people.

3.1 Demographics

Of the 18 deceased or injured people, 14 were male and four were female.

This was the only category to include young people, with four injured people under 18 years of age and a further two under 25 years of age. The most common age group was 31 to 40 year olds, making up 47% of referrals related to RTIs.

Of the 18 people involved in referrals related to RTIs:

- Six were drivers of vehicles pursued by the gardaí;
- Six were passengers;
- Four were pedestrians;
- One was a driver of an unrelated vehicle;
- One was a rider of an e-scooter.

Of the three people who died, two were pedestrians and one was a passenger in a vehicle.

3.2 Reason for Contact with Gardaí

The most common reason for garda contact recorded was dangerous driving which was recorded in four referrals relating to RTIs. This was followed by stolen cars which were recorded in three referrals. Suspicious activity and an incidental road traffic incident were recorded in the remaining two referrals.

Four referrals related to off duty Garda members involved in RTIs.

Chart 6 highlights the reason for contact with gardaí recorded for referrals relating to road traffic incidents.

Chart 6: Reason for Contact with Gardaí in Referrals relating to Road Traffic Incidents

Gardaí Attempt to Stop E-Scooters

Incident

Gardaí on patrol spotted two men with their faces covered, riding e-scooters with no lights on and not wearing helmets. The gardaí used hand signals to indicate to the men to stop. When they did not stop the gardaí activated the emergency blue lights on their Garda patrol vehicle. The e-scooter riders did not stop and diverted down an alley. The gardaí did not pursue them.

Approximately 40 minutes later, a member of the public reported a man lying injured and unconscious on the road. One of the Garda members attended the scene and identified the man as one of the e-scooter riders who had failed to stop earlier in the evening. The man was brought to hospital where it was established he had sustained a head injury and fractures to his left eye socket and his cheek.

Investigation

Two Fiosrú Investigators attended the scene of the incident. The investigators photographed the incident scene, obtained Garda PULSE records and took accounts from the gardaí involved. The Investigating Officers then attended the hospital to speak with the injured man. While at the hospital, the Investigating Officers also met with the second male involved in the incident and took an account from him.

Outcome

Fiosrú found no breach of discipline or criminal behaviour by gardaí and determined that further investigation was not necessary. On this basis, the investigation was discontinued.

3.3 Pursuit Related Incidents

Referrals are classified as 'pursuit-related' for the purpose of this report if they:

- involved a pursuit by gardaí;
- gardaí began to follow a pursued vehicle which failed to stop;
- there was a collision involving a vehicle that was recently pursued by gardaí but the gardaí lost sight of the vehicle;
- gardaí were driving in the direction of a vehicle before notifying the Regional Control Centre and obtaining authorisation for a pursuit.

Out of the 13 referrals related to road traffic incidents, seven were pursuit-related.
These involved one deceased person and 11 injured people.

In the referrals that were pursuit-related the reasons for pursuit being initiated included dangerous driving, stolen cars and suspicious activity.

Road Traffic Incident Following Garda Pursuit

Incident

A Garda car on patrol stopped a car with three occupants driving dangerously in the middle of the night. When gardaí approached the car, it took off at speed. The gardaí pursued the car for approximately two minutes while objects, including a glass bottle, were thrown at the Garda car by occupants of the vehicle. During the pursuit, the driver of the car lost control and the car crashed into a ditch. All three occupants, two men and one woman, were taken to hospital. Two of the three occupants obtained injuries in the crash including fractured vertebrae and a fractured eye socket.

Investigation

Fiosrú Investigating Officers attended the scene and inspected the Garda car and the car that had crashed following the pursuit. Fiosrú Investigators established that the Garda car had not been damaged. Statements were taken from all gardaí involved in the incident. Fiosrú Investigators spoke with two of the three occupants of the crashed vehicles in the hospital. The injured parties did not engage with the Fiosrú investigation and declined to make statements.

Outcome

As the Fiosrú investigation did not find evidence of a breach of discipline or any criminal behaviour by gardaí, the investigation was discontinued.

Road Traffic Incident following Garda Response

Incident

Gardaí responded to reports of men breaking into cars. On arrival at the scene, the men entered a car and drove at the Garda patrol car before leaving the area at speed. Gardaí followed the car which failed to take a turn and crashed into a ditch.

The three occupants of the pursued vehicle were all minors. Gardaí removed them from the vehicle and arrested them. The young people had cuts and bruising from the accident. Once in custody in the Garda station, the young people were seen by a doctor, who advised that they should be further assessed in hospital. The young people were released into the care of their parents. The parents were advised to seek assessment and treatment as necessary and they were transported to hospital by ambulance.

Investigation

The investigations team obtained and reviewed statements from gardaí involved in the incident. They also reviewed CCTV footage, custody records, photos of the scene and recordings of a 999 call made after the vehicle crashed into the ditch. The Senior Investigating Officer met with one of the injured young people and took a statement from them.

Outcome

Fiosrú did not find evidence of a breach of discipline or criminal behaviour by gardaí. On this basis, the investigation was discontinued.

Young People, Stolen Cars and Dangerous Driving

Out of the 13 referrals relating to Road Traffic Incidents (RTIs), four involved young people under 18 years of age. The young people were all males.

All four referrals were related to garda pursuits. This represents 11% of referrals received in 2024, or 31% of the total referrals relating to RTIs.

These referrals all resulted in serious harm. There were no deaths of young people in the referrals received in 2024.

The reason for contact with gardaí in three of these referrals was because of reports of a stolen car being driven dangerously. One referral was due to an incident of dangerous driving.

These four referrals involved a total of ten young people, all males. Four of these young people were the injured people named in the referral on the basis that these were the injured party. These young people were either the driver of or a passenger in the vehicle involved. In addition, there were six other young males involved in the incidents referred.

4. Category Two: Death or Serious Harm in or following Garda Custody

The category of "Garda Custody" includes incidents of death or serious harm that happen while a person is being arrested or taken into custody, is in custody, or that happen following a period in custody. This category includes incidents involving the death or serious harm of people who have been detained by gardaí under section 12 of the Mental Health Act 2001. The death or serious harm may have taken place on Garda or private premises, in a public place, or in a Garda car or another vehicle.

This does not include:

- Apparent suicides that occur during or after a person is released from Garda custody. These are included in the apparent and attempted suicides category.

In 2024, there were eight referrals relating to incidents of death or serious harm in or following custody involving eight people. These referrals involved five deceased people and three injured people.

4.1 Demographics and Other Factors

All eight deceased or injured people were male.

There were no young people under 25 in this category. There was also no person over 60 years of age in this category. The most common age group was the 31 to 40 year olds group.

Six people were suffering from mental health difficulties. The types of mental health difficulties included bipolar disorder, depression, psychosis, history of suicide attempts and post-traumatic stress disorder. Bipolar disorder was recorded in three referrals.

In five referrals, alcohol was a factor. In four referrals, mental health and alcohol were co-existing factors. In three referrals, drugs were a factor. This means that at the time of the arrest the deceased or injured person had recently consumed, were intoxicated by, in possession of, or had known issues with alcohol and/or drugs.

4.2 Preliminary Cause of Death

The preliminary cause of death as provided by the Pathologist is recorded by Fiosrú. This is taken from the post mortem report, where available to us. In some cases, this will have been provided verbally by the Pathologist to the investigator and recorded in case notes.

The preliminary cause of death was recorded by Fiosrú in four of the referrals. These were:

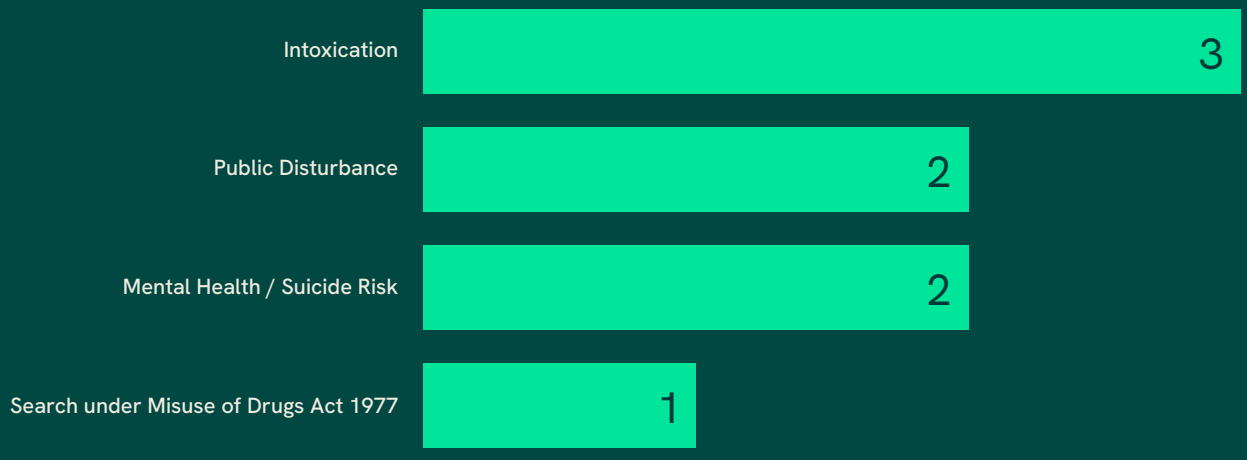
- Alcohol Intoxication
- Cardiac arrest from intake of fatal cocaine level in addition to alcohol toxicity
- Haemorrhage from fall two days prior to custody
- Pneumonia and sepsis

The preliminary cause of death in the one remaining death was recorded as “unknown”.

4.3 Reason for Contact with Gardaí

Intoxication was the most prevalent reason why gardaí initially came into contact with the deceased or injured people in the Custody referral category. This is followed by mental health and suicide risk and public disturbance. It should be noted that where a deceased or injured person came into contact with gardaí due to public disturbance, this was due to intoxication. Chart 7 shows the reasons for contact for referrals of death or serious harm in custody.

Chart 7: Reason for Contact with Gardaí in Referrals relating to Garda Custody



4.4 Reason for Detention by Gardaí

The reason that gardaí initially came into contact with the deceased or injured person may differ from the reason for their detention. The reasons for contact are recorded by Fiosrú from the circumstances of the referrals, whereas the reasons for detention are grounded in statute.

Table 5 lists the statutory reasons why gardaí detained the eight people in custody. One person was detained for multiple offences. Two individuals were detained under section 12 of the Mental Health Act 2001. The most common reason for garda detention was public order offences for intoxication which was recorded in three referrals.

Table 5: Reason for Detention in Referrals relating to Garda Custody

Reason for Detention	
Public order offence/Intoxication – section 4 Criminal Justice (Public Order) Act 1994	3
Section 12 Mental Health Act 2001	2
Section 30 Offences Against the State Act 1939	1
Possession of pellet gun – section 11 Firearms and Offensive Weapons Act 1990	1
Assault – section 2 Non-Fatal Offences Against the Person Act 1997	1
Search under section 23 Misuse of Drugs Act 1977	1
Section 5 Road Traffic Act 2010	1

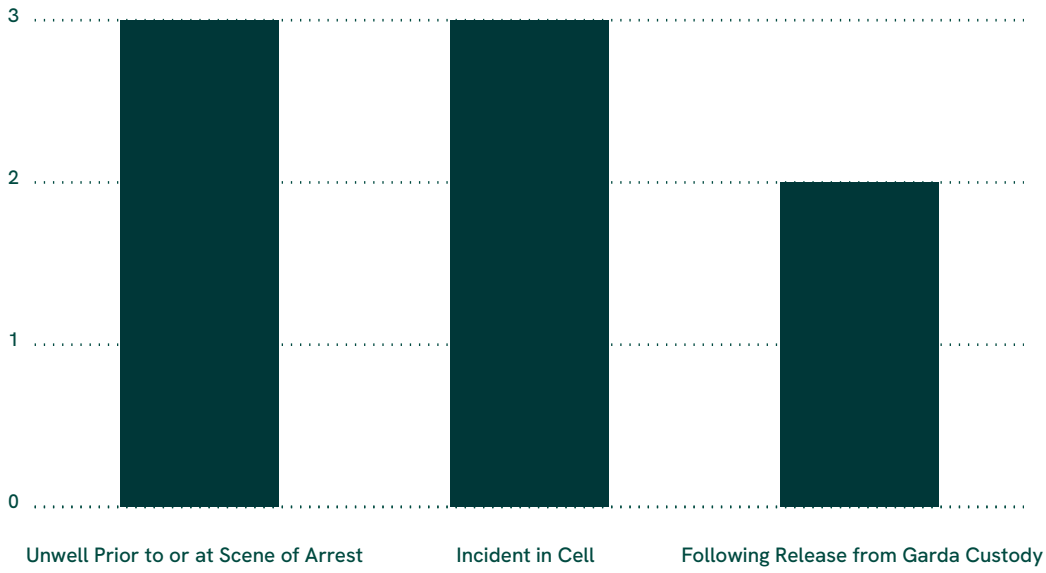
Circumstances of Death or Serious Harm

Of the eight referrals of death or serious harm during or following Garda custody, three incidents took place in a Garda cell. One person alleged a sexual assault in a cell, one person died in a cell from intoxication and one person became ill in a cell and was taken to hospital where they recovered.

A further three incidents involved a person who was unwell prior to or at the scene of arrest and custody. All three people were brought to a Garda station, seen by a doctor and then taken to hospital. Two of these people died in hospital, of which one died due to an illness and one died due to an injury sustained prior to contact with gardaí. One person was treated for non-fatal injuries sustained prior to contact with gardaí.

Two incidents took place following release from Garda custody. One person died from an alleged murder that was then investigated by An Garda Síochána and one person died of an apparent accidental overdose.

Chart 8: Circumstances of Death or Serious Harm in Referrals relating to Custody



Arrest and Detention for Public Intoxication

Incident

Gardaí were called to a disturbance outside a shop. A man was arrested for public intoxication for his own safety. The man was searched before being placed in a Garda cell. During routine checks, the man was found unresponsive in the cell. Gardaí administered CPR and the man was brought to hospital where he was put on a ventilator. The man recovered and was discharged from hospital. The Fiosrú investigation found that the man's medical condition was consistent with a possible overdose and it was probable that the man ingested drugs prior to or during his time in custody.

Investigation

Two Fiosrú Investigating Officers attended the Garda station to conduct enquiries and collect evidence from the scene. Fiosrú's actions included preserving the cell for investigation and reviewing CCTV footage, custody records, Garda PULSE records and notebook entries.

Outcome

Fiosrú's investigation found that custody checks were conducted appropriately and that the actions of gardaí contributed to saving the man's life. The man did not engage with the Fiosrú investigation and the investigation did not find evidence of a breach of discipline or criminal behaviour by gardaí. On this basis, the investigation was discontinued.

Arrest and Detention for Assault and Possession of Firearm

Incident

Gardaí attended a report of a taxi driver being attacked. When the gardaí arrived at the scene, a man pointed what appeared to be a firearm at the taxi driver and the gardaí. The gardaí restrained the man on the ground. The gardaí later confirmed that the suspected firearm was a pellet gun. The man was arrested and detained in a nearby Garda station where he was assessed by a doctor who referred him to hospital as he appeared to have injuries.

The man had minor cuts and scratches on his face consistent with being restrained on the ground, as well as broken ribs and an injury to his left wrist. The man also alleged that he was involved in a physical altercation with the taxi driver.

Investigation

Two Fiosrú Investigating Officers visited the hospital to speak with the injured man and photograph the injuries. They also spoke with witnesses and obtained and reviewed CCTV footage from the Garda station and phone footage of the incident. The Investigating Officers reviewed Garda PULSE records, custody records and notebook entries as well as medical records. They also collected written reports from the Garda members involved and took statements from the taxi driver and the injured man.

Outcome

From Fiosrú's investigation and the review of medical notes, there was sufficient information to indicate that these injuries were sustained weeks prior to the man's arrest during an unrelated incident for which he had previously been in hospital. The investigation found no evidence of misbehaviour by gardaí and the investigation was closed.

Forensic Evidence Gathering

Fiosrú investigators are trained and experienced in various levels of forensic and evidence gathering capability in such areas as fingerprints, DNA, photography, the investigation of serious and fatal road traffic collisions, firearms incidents and searches. If necessary, we can also call on additional resources to be provided to assist us in our work from organisations such as An Garda Síochána and other organisations thanks to agreements that have been put in place about how such supports will operate and be managed.

Arrest for Public Disturbance in Hospital

Incident

Gardaí responded to a call from hospital security that a man was highly intoxicated, causing a disturbance and refusing to leave a hospital emergency room. The man was experiencing homelessness at the time. The man was arrested for public disturbance and brought to the Garda station. While in custody, the Garda Member in Charge became concerned about the man's condition, given that he was highly intoxicated and not responding to questions. A doctor was called immediately. The man was examined by the doctor who instructed gardaí to call an ambulance and keep the man under constant surveillance. While in the Garda cell, the man was observed hitting his head off the cell door. The man was brought to hospital where he was transferred to intensive care unit, but died later that day. A State Post Mortem was conducted and the preliminary cause of death was found to be pneumonia and sepsis with meningitis being considered.

Investigation

Fiosrú investigators informed the Pathologist of the circumstances of the referral and communicated the preliminary cause of death to the Coroner. As the man's death was found to be due to medical causes, and the man's time in custody had no contribution to his death, the Coroner directed that the investigation into the death of this man be conducted by An Garda Síochána and not Fiosrú.

Outcome

As a result of the examination showing no evidence of a breach of discipline or a criminal offence, as well as the direction of the Coroner, this preliminary examination was discontinued.

Specialist Interviewing

To enhance the level of service we can provide to vulnerable people, some of our investigators are trained and experienced in specialist interview skills which can minimise the risk of victims of crime, young people or people with a mental health impairment being re-victimised or having to experience any further trauma. We are able to offer the use of a network of tailor-made interview suites across the country specifically aimed at providing all of the facilities that someone might need in a neutral, comfortable setting to help maximise the quality of the evidence that they are able to provide to our staff. In certain circumstances, this may lead to victims later being able to provide their evidence to a Court via either a pre-recorded or live video rather than attending in person. Other special measures are also available from the Courts Service depending on the specifics of the case and Fiosrú's investigators are able to advise on these when the circumstances arise. Fiosrú works with our partners to ensure, as fully as possible, there is a joined-up approach to the delivery of our services and that the needs of victims, complainants and their families are taken care of to the best of our ability.

5. Category Three: Apparent or Attempted Suicides

This category includes apparent or attempted suicides that happen while in Garda custody, following Garda custody where the time spent in custody may be relevant to the death or serious harm, or following garda contact.

The term 'suicide' does not necessarily relate to a Coroner's verdict as in some cases the investigation is ongoing or the inquest is still pending. If Fiosrú is not requested as the lead agency to investigate, it would not have the inquest verdict and therefore this would not be recorded. In this report, the case is only included in this category if, after considering the nature of the incident of death or serious harm, the circumstances suggest that the death or serious harm was the intended outcome of a self-inflicted act, for example, a hanging, or where there was some evidence of 'suicidal ideation', such as a suicide note or an expression of suicidal ideation, or an intent to act is recorded in custody records.

A total of ten referrals in 2024 involved apparent or attempted suicides. This included nine apparent suicides and one attempted suicide. This included one attempted suicide in Garda custody and three apparent suicides following Garda custody.

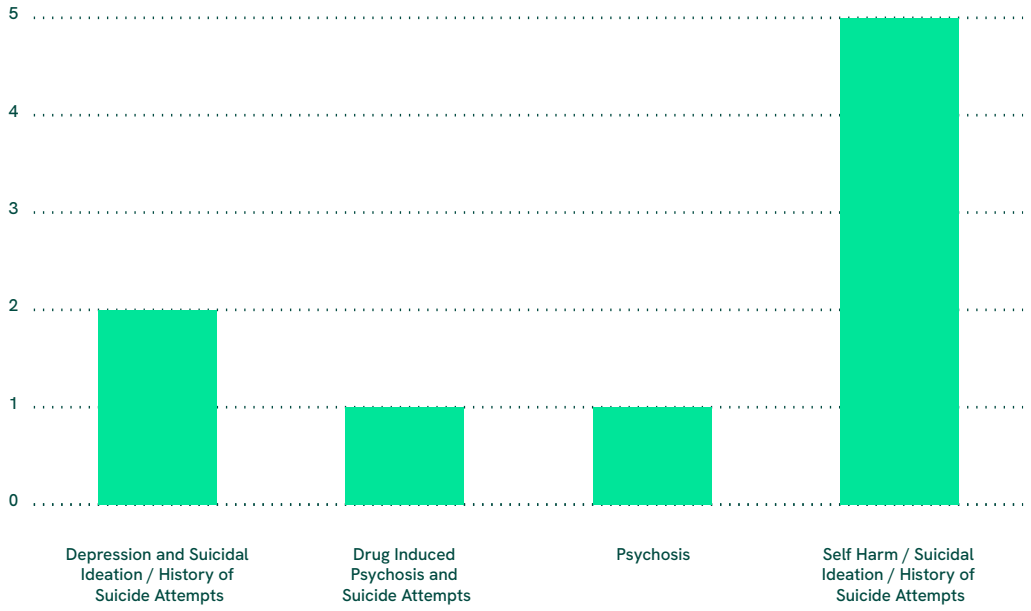
5.1 Demographics and Other Factors

Of the ten people involved, nine were men and one was a woman.

The most common age of those in this category was between 41 and 50 years (4 people), followed by 31 to 40 years (3 people). There were no people under 30 years of age in this category.

Nine of the people had known mental health difficulties. One person had no reported mental health difficulties. The types of mental health difficulties included depression, self-harm, suicidal ideation, history of suicide attempts, psychosis and drug induced psychosis.

Chart 9: Type of Mental Health Difficulty in Referrals relating to Apparent or Attempted Suicide



Alcohol was a factor in seven of the referrals and drugs were a factor in five of the referrals. This means that at the time of the deceased or injured person's interaction with gardaí, they had recently consumed, were intoxicated by, in possession of, or had known issues with alcohol and/or drugs.

In four referrals, mental health, alcohol and drugs were all co-existing factors.

Homelessness was a factor in two of the referrals. One person was experiencing homelessness at the time of their death and one person had a known history of periods of homelessness.

Digital Investigations Unit

Fiosrú's Digital Investigations Unit (DIU) provides specialist digital forensics for investigations. The DIU conducts and assists investigations where there are digital technology and data acquisition needs.

The digital forensic specialists in the DIU are experts in evidential recovery and the analysis of digital data from all devices, ranging from doorbell cameras and dashcams to mobile phones, tablets and laptops. Their work involves unlocking devices for information extractions, rebuilding corrupt files where damage or attempted deletion may have occurred and detection of material that may have been edited, AI generated or altered.

The DIU extracts data from CCTV and other security systems and can enhance, authenticate and preserve audio and video material for trials and inquests. The DIU also examines the underlying computer code of digital files for information of interest.

5.2 Reason for Contact with Gardaí

Table 6 shows the reason for the deceased or injured person's contact with gardaí.

Table 6: Reason for Contact in Referrals relating to Apparent or Attempted Suicides

Reason for Contact	
Mental health / suicide risk	2
Arrest for suspicion of serious child sexual assault	1
Breach of safety order	1
Domestic incident	1
Intoxication	1
Noise disturbance	1
Other	1
Search warrant for suspicion of possession of child pornography	1
Theft	1

Two of the above referrals were related to gardaí dealing with alleged child sexual offences and a further two of the above referrals were related to gardaí responding to alleged domestic violence offences.

5.3 Reason for Detention by Gardaí

Out of the ten referrals in this category, five involved arrest and detention by gardaí.

The reason that gardaí initially came into contact with the deceased or injured person may differ from the reason for their detention. The reasons for contact are recorded by Fiosrú from the circumstances of the referrals, whereby the reasons for detention are grounded in statute.

Where the deceased or injured person was arrested and detained by gardaí, the reason for detention was recorded. Table 10 outlines the statutory reasons why these people were placed into custody by the gardaí.

Two people were detained under section 12 of the Mental Health Act 2001 for their own safety. Both of these people died by apparent suicide.

Table 7: Reason for Detention in Referrals relating to Apparent or Attempted Suicides

Reason for Detention	
Section 12 Mental Health Act 2001	2
Breach of safety order - Domestic Violence Act 2018	1
Section 4 Criminal Justice (Theft and Fraud Offences) Act 2001	1
Section 4 Rape Criminal Law (Rape) (Amendment) Act 1990	1

5.4 Circumstances of Death or Serious Harm

Five of the apparent suicides happened in the home. Four happened in public places. These included five apparent suicides following garda contact and three apparent suicides following Garda custody.

One attempted suicide took place in a Garda station cell. In this instance, the gardaí intervened and were able to prevent the suicide.

Fiosrú's Role in the Coroner's Court

Coroners are independent judicial officers whose role is to determine the cause and circumstances of a death. Whenever the cause of someone's death is unknown, violent or unusual, the Coroner will order an inquest which is a legal enquiry into the death. The Coroner must hold an inquest if the death occurred in or following custody. Only a Coroner can order an inquest.

The Coroner will typically hold an inquest into any death involving gardaí and where there has been garda contact prior to the death, particularly if the death occurred under suspicious or violent circumstances.

While Fiosrú investigates the actions of the gardaí, the Coroner investigates the cause of death. Fiosrú's investigators liaise with the Coroner and provide information on investigations. This allows the Coroner to decide whether Fiosrú or An Garda Síochána will be the lead agency to investigate the death.

For inquest cases, Fiosrú investigators prepare an investigation report for the Coroner and share information. Statements taken by Fiosrú during an investigation into a death are transcribed in the form of depositions to be read into evidence at the inquest. In addition, Fiosrú assists the Coroner with the administration of the jury selection process.

Fiosrú investigators were involved in 18 inquests in 2024.

6. Category Four: Death or Serious Harm following Garda Contact

The category of "Garda Contact" comprises of incidents of deaths and serious harm that follow contact with the gardaí that did not involve arrest, or detention under section 12 of the Mental Health Act 2001.

There were six referrals of death or serious harm following garda contact, including four deceased people and two injured people.

6.1 Demographics and Other Factors

All six deceased or injured people were male. The most common age was 30 to 40 years. There were no young people under 25 or people over the age of 60 in this category.

One referral involved a mental health difficulty. The type of mental health difficulty was recorded as depression.

Alcohol was recorded as a factor in four of the referrals. Drugs were recorded as a factor in four of the referrals.

6.2 Preliminary Cause of Death

The preliminary cause of death as provided by the Pathologist is recorded by Fiosrú. This is taken from the post mortem report, where available to us. In some cases, this will have been provided verbally by the Pathologist to the investigator and recorded in case notes.

The preliminary cause of death was recorded by Fiosrú in two of the referrals. These were:

- Traumatic head injury from fall prior to garda contact
- Cranial and cerebral injuries consistent with an RTI.[2]

The preliminary cause of death in the two remaining deaths were recorded as "unknown".

2. Although this death was related to a road traffic incident, it has not been included in the road traffic incident category as it does not fit the definition for that category. The road traffic incident category includes deaths or serious harm of drivers, passengers, pedestrians or other road users arising from garda pursuits and other garda traffic-related activity. This referral did not involve a garda pursuit or other garda traffic-related activity. The referral involved a person who had come into garda contact earlier in the evening due to a public disturbance and, shortly after this contact, they happened to be involved in a road traffic incident, which did not involve any Gardaí.

6.3 Reason for Contact with Gardaí

Table 8 outlines the reasons captured for the deceased or injured person's contact with gardaí. The most common reason for contact with gardaí was intoxication, followed by mental health difficulties or suicide risks, dangerous driving and road traffic incidents involving off duty Garda members.

Table 8: Reason for Contact in Referrals relating to Garda Contact

Reason for Contact	
Criminal damage	1
Intoxication	1
Other	1
Public disturbance	1
Search for suspected possession of drugs	1
Suspicious activity	1

Search under Section 23 Misuse of Drugs Act 1977

Incident

Two detective gardaí stopped a man driving a vehicle which they had reason to believe to be carrying drugs. The gardaí engaged in a search of the vehicle under section 23 of the Misuse of Drugs Act 1977. During the search the man suffered a seizure. Gardaí administered CPR and the man was taken to hospital where he died shortly after.

Investigation

Two Fiosrú Investigating Officers were dispatched to the scene where they obtained and reviewed reports and CCTV footage, took witness statements and informed the family of Fiosrú's involvement. The Senior Investigating Officer notified the Coroner of the death and the Coroner ordered a local post mortem.

Outcome

Information gathered during the investigation suggested that the man had ingested drugs prior to the interaction with gardaí. The investigation did not find evidence of a breach of discipline or criminal behaviour by gardaí. On this basis, the investigation was discontinued.

Response to Reports of Suspicious Activity

Incident

Gardaí responded to a report of a man acting suspiciously. Two gardaí in a patrol car and two gardaí on bicycles identified the man straddling a rear garden wall. The gardaí spoke with the man and helped him down off the wall. As gardaí searched the man he became unwell and fell to the ground. The man became unresponsive and the gardaí administered CPR until paramedics arrived. The man was brought to hospital where he was pronounced dead approximately one hour later.

Investigation

A Fiosrú investigator was deployed at the time of receipt of the referral. Fiosrú investigators obtained and reviewed CCTV footage and witness accounts, notified the Coroner and engaged with the man's family, the Garda members involved and the State Pathologist.

Outcome

The investigation found information to suggest that the man had a history of alcohol and drug dependency. A State post mortem took place which found no trauma to the body. The investigation did not find evidence of a breach of discipline or criminal behaviour by gardaí. On this basis, the investigation was discontinued.

7. Conclusion

This thematic report provides information and analysis on the incidents that led to referrals of death and serious harm involving contact with An Garda Síochána in 2024. By categorising the circumstances and examining patterns across referrals, the findings aim to contribute to a clearer understanding of the contexts in which these incidents arise. This report's aim is to promote and inform debate, discussion and policy to help prevent such incidents from happening again, where possible.

While each case reflects unique circumstances, the overall patterns highlight the prevalence of mental health difficulties and alcohol and drug use and dependency in incidents where death or serious harm has occurred. As well as this, the findings revealed ten apparent or attempted suicides.

This report raises questions not only about the capacity of our police to respond to these incidents, but also whether An Garda Síochána is the most appropriate public service response in all circumstances for people who are vulnerable or in crisis.

Policing, Security and Community Safety Act 2024

The referrals included in this report were received in 2024 and therefore were dealt with under the Garda Síochána Act 2005 and the respective definition of 'serious harm'. The Policing, Security and Community Safety Act 2024 at section 203 requires the Garda Commissioner to, without delay, refer to the Police Ombudsman any matter that appears to indicate to the Garda Commissioner that the act or omission of a member of garda personnel may have resulted in the death of, or serious harm to, a person. Section 193 of the Policing, Security and Community Safety Act 2024 expands the definition of 'serious harm' to include sexual offences and the abuse of power for sexual purpose. In future reports, Fiosrú will report on this expanded range of referrals and will include incidents in which a person has been the victim of a sexual offence or has been the victim of an abuse of power for a sexual purpose.

A key difference in how these referrals of incidents of death and serious harm will be handled under the new legislation is that there is no statutory requirement for a preliminary examination. Once a referral is received under section 203, an investigation is commenced immediately.

Annual Reporting

It is Fiosrú's intention to publish these findings on an annual basis as part of its new statutory research function under section 173 (2)(j) of the Policing, Security and Community Safety Act 2024. This law requires Fiosrú "to undertake research and analysis in order to identify trends and patterns arising from the performance of his or her functions".

Fiosrú's next annual report into incidents of death and serious harm involving contact with An Garda Síochána, covering data for 2025, will be published in autumn 2026.

Appendix A: Additional Tables

Table A1: Referring Garda Divisions and Total Referrals

Garda Division	Total Referrals
Clare/Tipperary	1
Cork City	1
Cork County	6
DMR North	2
DMR North Central	4
DMR Road Policing	1
DMR South Central	1
DMR West	3
Donegal	2
Kerry	2
Kildare	3
Kilkenny/Carlow	1
Limerick	2
Louth/Cavan/Monaghan	2
Meath/Westmeath	4
Waterford	1
Wexford/Wicklow	1
Total	**37**

Table A2: Gender of Deceased or Injured People by Category

Category	F	M	Total
1. Road Traffic Incidents	4	14	18
2. Garda Custody		8	8
3. Apparent or Attempted Suicides	1	9	10
4. Garda Contact		6	6
Total	**5**	**37**	**42**

Appendix B: Methodology and Definitions

This Appendix presents detailed information on how Fiosrú collates and categorises referrals of death and serious harm for inclusion in this report. There is also detailed information on the definitions used for this report.

Data Collation

A list of all cases of referrals of death and serious harm is extracted from Fiosrú's internal case management system (Perito). Each case is manually checked in order to ensure there are no duplications or incorrectly categorised cases. The research officer reviews each case manually and extracts the required data. The research officer then manually inputs the information required into Excel. A two-step validation process completed following the collection of the required data ensures that all data captured is accurate.

Categorising Data

Cases are categorised based on the information available from referral documents, investigation reports, statements and post mortems. Where information is unknown or unclear from the data available to the research officer, this is sought from the relevant Fiosrú investigator. The figures are based on the referrals received between 1 January 2024 and 31 December 2024. The date of referral is the reference point to determine the inclusion of the case in this report.

Definitions

Death and Serious Harm Categories

Referrals of incidents of death and serious harm are separated into the following four categories that align with those used by other police oversight bodies.

Road Traffic Incidents

The category of road traffic incidents includes referrals of death and serious harm of drivers, passengers, pedestrians or other road users arising from garda pursuits and other garda traffic-related activity.

This does not include:

- Deaths or serious harm that happen following a road traffic incident where the gardaí attend immediately after the event as an emergency service.
- Death or serious harm from road traffic incidents where the gardaí had no involvement in the road traffic incident but happened to be in contact with the deceased or injured person a short time prior to the incident.

Death or Serious Harm in or following Custody

This category includes deaths or serious harm that happen while a person is being arrested or taken into Garda custody or that happen following a period in custody. This category includes deaths or serious harm of people who have been detained by gardaí under section 12 of the Mental Health Act 2001. The death or serious harm may have taken place on Garda or private premises, in a public place, or in a Garda car or other vehicles.

This does not include:

- Apparent suicides that occur during or after a person is released from Garda custody. These are included in the apparent or attempted suicide category.

Apparent or Attempted Suicide

The category of apparent or attempted suicide includes apparent or attempted suicides that happen while in Garda custody, following Garda custody where the time spent in custody may be relevant to the death or serious harm, or following garda contact. The term 'suicide' does not necessarily relate to a Coroner's verdict as in most cases, inquest verdicts are still pending. In these instances, the case is only included if, after considering the nature of death or serious harm, the circumstances suggest that the death or serious harm was the intended outcome of a self-inflicted act, for example, a hanging, or where there was some evidence of 'suicidal ideation', such as a suicide note.

Death or Serious Harm following Garda Contact

The category of death or serious harm following garda contact includes deaths or serious harm that follow contact with the gardaí that did not involve arrest, or detention under s12 of the Mental Health Act 2001.

Reason for Contact

For each referral included in this report, the reason for contact with gardaí is recorded. The categories are defined to capture and convey the initial basis for the deceased or injured persons engagement with An Garda Síochána. This categorisation aims to reflect the primary circumstance that led to the deceased or injured persons contact with gardaí. Where multiple factors were present, the most immediate or initiating reason for contact is selected to ensure consistency and comparability across referrals. The categorisation process was guided by a review of the case files.

The deceased or injured person may have come into contact with gardaí for allegedly committing an offence (for example, the gardaí come across a vehicle being driven in a dangerous manner and they attempt to stop the driver) or due to life circumstances that have left them vulnerable or in crises (such as alcohol or drug dependency or domestic violence).

Mental Health

The mental health marker is selected on a case if the deceased or injured person has been detained under the Mental Health Act 2001, is a patient at a psychiatric hospital, or if the individual is reported as having current or historical mental health issues. If the person is known to have previously attempted suicide or is reported to be suffering from depression or another mental health illness, the mental health factor would also be selected. Information on mental health may be drawn from information received from the gardaí at the point of referral, self-reported information by the deceased or injured parties or evidence provided by the medical staff or close associates of the deceased.

The term "mental health difficulty" is used throughout this report and is taken from *Stand Up to Stigma: Changing the language we use when talking about mental health.* This guide was published by See Change, Ireland's National Mental Health Stigma Reduction Partnership, in 2020. It advises that:

> "Mental health difficulty may be used when we need to describe mental health issues or mental illness generally. We can have trouble defining a mental health issue or illness in everyday conversation. Using the term mental health difficulty helps bridge the gap and respects everyone's lived experience."

Alcohol

The alcohol factor is marked if the deceased or injured person had recently consumed or was intoxicated with alcohol at the time of arrest or contact with the gardaí. It is also marked if the cause of death or serious harm is linked to alcohol, or if the deceased or injured person has current or historical issues with alcohol. The relevance of alcohol may be deemed from information provided at the time of referral form from the gardaí or from information that is identified during the investigation.

Drugs

The drugs factor is applied to cases where the deceased or injured person had recently consumed drugs, was under the influence of drugs, had a history of drug abuse (either of illegal or prescription drugs, where they are abused), or was found to be in possession of illegal drugs at the time of arrest or contact with the gardaí. It is also selected if the cause of death or serious harm is related to drugs (either illegal or prescription drugs), including long-term misuse, overdose or where drug packages may have burst or are lodged in airways. The prevalence of drugs may be identified from information on the referral form from the gardaí or from the case description and investigation.

Homelessness

The homelessness marker is selected if the deceased or injured person is experiencing homelessness at the time of the incident referred for investigation, or has experienced homelessness or periods of homelessness in the past. This information may be taken from statements, case notes or investigation reports.

Preliminary Cause of Death

When a referral relates to a death, the preliminary cause of death is recorded, where available. This refers to the preliminary cause of death according to the Pathologist. This is taken from the post mortem report, where available to Fiosrú. In some cases, the preliminary cause of death will have been provided verbally by the Pathologist to the Investigator and recorded in case notes. In cases where it is decided that Fiosrú does not have primacy after initial investigation, the results of any post mortem would not be routinely provided to Fiosrú. In these cases, the cause of death is recorded as "Unknown".

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