Hereafter is a summary of the State Attorney Office's decision regarding the investigation into the cause of death of the late Prisoner X (hereinafter: "the deceased").

On 16th December 2010, the day following the tragic suicide of the deceased, the Honorable Court ordered an investigation into the circumstances of his death, at the request of the Israeli Police. The investigation was led by the Unit of International Crime Investigations, as instructed by the Court, with the assistance of the Central District Attorney's Office.

On 19th December 2012, the Court gave its decision, in which it determined, *inter alia*, that "the investigation conducted was thorough, comprehensive and extensive, carefully examined all relevant issues, and provided a proper basis for concluding the investigation into the deceased's cause of death, as required by law".

The Court rejected the possibility that an external actor contributed to the death of the deceased, and determined that "the willing act of the deceased is that which caused his death, by suicide."

Furthermore, the Court found that, while in general, the guidelines for the supervision of the deceased were "implemented strictly", nevertheless a specific error, reflected by faulty supervision on the day of the suicide, was the result of negligence, and therefore concluded that there was *prima facie* evidence to implicate Israel Prison Service ("IPS") officials in the negligent cause of death of the deceased.

However, the Court refrained from exercising its authority to order the public prosecution to indict any of the IPS officials who were involved in the supervision of the deceased. Instead, **the Court chose to refer the investigation file for our review, as it found that "the matter of indictment is subject to additional considerations as to the strength of the evidence and the enforcement policy regarding the offence" of causing death by negligence.**

The assessment of the evidence and its strength, which was conducted by the State Attorney and the Deputy State Attorney (Special Assignments), with the assistance of a team of attorneys at the State Attorney's Office, led to the conclusion that these were insufficient to establish charges against the IPS officials, according to the level which is required by criminal law.

Foreseeability of the act of suicide

The prosecution of any of the individuals involved in the treatment of the deceased, requires, among others, proof beyond reasonable doubt, that the person could have and should have foreseen an act of suicide.

The evidence suggests that the deceased's mental condition was continuously monitored and that the supervision included multiple periodic tests, in light of his personal circumstances and the conditions of imprisonment.

In total, the deceased had examined 14 times, by three different psychiatrists during the first nine months of his detention, after which all psychiatrists stated that the deceased denied suicidal intent. The psychiatric reports state among other things:

"There is no danger of suicide" (Examination dated 7.3.10); "not suicidal ... also denies suicidal intent" (Examination dated 15.3.10); "he denies intention or plan to commit suicide" (Examination dated 26.4.10); "feels better… no psychosis, does not seem depressed" (Examination dated 3.5.10); "strongly denies suicidal thoughts" (Examination dated 16.5.10); "denies suicidal thoughts" (Examination dated 24.5.10); "no suicidal thoughts, no signs of depression" (Examination dated 7.6.10); "strongly denies suicidal thoughts" (Examination of 17.6.10); "strongly denies suicidal thoughts" (Examination dated 1.8.10); "denies suicidal thoughts" (Examination dated 19.9.10); "denies any intention to harm himself now... There is no need for monitoring on a psychiatric basis" (Examination dated 14.11.10); "denies suicidal thoughts" (Examination dated 28.11.10).

The investigative material also indicates that during this period of time the deceased met social workers on 57 different occasions and that also in these meetings there was no content of a suicidal nature.

One exception to all of the above appears in the report of the IPS Chief Medical Officer (CMO) - a doctor specialized in internal medicine, that noted in her report dated 29.11.10: "mental state - abnormal findings ... depression, deteriorated mood. Has trouble sleeping. Wakes up early. Poor appetite. Dispirited. Tearfulness." Neither did this doctor of internal medicine mention suicidal thoughts. Nevertheless, following the CMO's report, the deceased was examined by a psychiatrist on 5.12.10 (ten days prior to the suicide). At the end of his examination the psychiatrist concluded in his report: "denies suicidal thoughts and without evidence of psychosis or major depression", and ordered to continue routine treatment.

According to a social worker who had accompanied the deceased at the time, two days prior to the suicide she formed the impression that his mental condition was improving and that it might be taken into consideration to terminate his classification as a "Prisoner Under Supervision".

The information gathered shows that at no time during the period of the deceased's detention and up to his suicide did the professionals - psychiatrists and social workers - establish concerns regarding suicide. On the contrary, their findings and evaluations ruled out such concerns. It is therefore doubtful whether it is possible to determine, according to the level required by criminal law that the officials responsible for the deceased's detention should have assumed that suicide is likely, and adopted enhanced supervision methods in addition to those proposed by the mental health professionals.

The unanimity of opinion between prison officials and mental health officials throughout the deceased's entire detention in prison, disproves the theory that they erred in their evaluation and professional conclusion regarding the state of the

prisoner during the period leading up to the day of the suicide, or at least casts significant doubt in that regard. It is obvious that this doubt (at the least) is to the advantage of anyone who might supposedly be attributed with personal criminal responsibility for the death of the deceased.

The evidence indicates that the supervisory instruction provided by the social workers, that defined the deceased as a "Prisoner Under Supervision Level B", provided for stricter supervision than the assessments of the psychiatrists, who did not see fit to define the deceased as a "Prisoner Under Supervision". In this respect, the degree of supervision over the deceased was stricter than that which was determined by psychiatric assessments.

Unusual event on day of the incident

The decision of the Honorable Court notes that on the day of the incident, several hours prior to the time of suicide, the deceased met with family members. The Court describes the said event in paragraph 23.2.

An examination of the evidence in the investigation file, which was not mentioned in the decision of the Court, raises the possibility that the content of the meeting and "the difficult message to the deceased" had a severe impact on his state of mind. The content of the conversations of the deceased with his family members are known today, yet they were not known to IPS officials at the time and, thus, a reassessment of the deceased's suicide risk at the time was unattainable.

IPS officials were indeed exposed to the deceased's "turmoil" after the visit and yet, as the Court noted, according to them they did not regard this as an unusual event in the behavior of the deceased following family visits.

Considering that IPS officials were unaware of the content of the conversations between the deceased and his family members, IPS officials conducted themselves, including at the time of suicide, in accordance with the supervision instructions applied from the time of the deceased's arrival at Ayalon Prison.

Conditions of Supervision

From the day of his arrival at Ayalon Prison, the deceased was defined as a "Prisoner Under Supervision" and a procedure was set for his visual monitoring every 30 minutes, despite that, the psychiatrists who examined him from time to time did not so categorize him.

As the Honorable Court determined, the defects that were found in the IPS' supervision, formed an exception to the otherwise proper supervision by all those officials responsible for supervising the deceased. The investigation material shows that IPS officials took notice of their duty to safeguard the life of the deceased, with special regard to his conditions of confinement.

The details of the supervision are superfluous, as we have come to the conclusion that it is doubtful whether the act of suicide was foreseeable and given the absence of a causal link between the conditions of supervision and the fatal result, as detailed below.

The evidentiary material indicates that it is doubtful that the conditions of supervision set for the deceased were intended to prevent an immediate suicidal act. The deceased was defined as a "Prisoner Under Supervision Level B" – which is the lowest supervision level – and was placed in a regular prison cell, which contained a shower column, anchor points for the walls and ceiling, a high bed, etc. The deceased held in his possession many different items which enabled suicide – shaving razor, means for tying and hanging and so forth.

In order to prevent an inmate's suicide the IPS is required to define him as "Prisoner Under Supervision Level A" or "Prisoner Under Supervision Level A+", a definition which allows drastic supervision methods such as: assigning a personal guard, cuffing, placing in a supervision cell (defined as a bare cell in which the walls and floor are padded and equipped with a camera that covers the entire cell, severely infringing upon the privacy of the inmate), and so forth.

It is understood that a decision by a competent official to place an inmate in such extraordinary conditions is taken by balancing an inmate's risk of self-harm and the interest in maintaining his privacy and welfare as much as possible.

Any attempt to thwart an inmate's resolute decision to commit suicide is very difficult to attain and naturally entails the imposition of severe limitations, causing suffering to the inmate, and further narrowing the little freedom and privacy he has left.

As stated, no factual or medical foundation was placed before IPS officials to justify the implementation of such severe methods, nor were the assessment and supervision officials, on the day of the incident, exposed to a change which might have reversed the conclusion reached by professional officials (psychiatrists and social workers) according to which the deceased did not show suicidal intent. Therefore, the overall facts which were available to the IPS did not justify enhancing the level of supervision and to hold the deceased cuffed, in a supervision cell or under continuous personal guard which would enable reaching his cell in a matter of seconds.

Causal Link

The criminal prosecution of any of the officials involved in the treatment of the deceased, for causing his death, entails a clear finding of a causal link between the alleged omissions and the unfortunate result – the death of the deceased.

The said pathological report, received into the investigative file after the decision of the Court, raises a strong doubt whether a causal link exists between the defects in supervision and the deceased's death. The pathological report establishes that the time period between the moment of hanging by neck and death lasts between 20 seconds

and three or four minutes – depending on the method of tightening the loop around the neck.

The evidence in this case illustrates that the tightening of the loop around the neck was extremely powerful, as the sheet was wet and wrapped, and therefore it is presumed that the deceased died in a matter of tens of seconds.

This fact indicates that even if the supervision had been conducted in accordance with supervision instructions and the MASHLAT [*Monitor & Control Center*] procedure – namely an optimal examination every 30 minutes, it cannot be said that it would have been possible to save the life of the deceased. Several tens of seconds (and no more than four minutes) were enough for him to die. With that consideration in mind, in order to prevent the deceased's death, it would have been necessary for an IPS guard to watch the suicidal act as it unfolded - something which is not certain at all when the supervision instruction is to watch the deceased every 30 minutes; and moreover, for the IPS guard to succeed in reaching the deceased and in acting to save him in this short period of time.

Due to the above, it is doubtful whether a causal link exists between the absence of strict supervision and the result.

Conclusion

The supervision of the deceased is the combined work of three elements: psychiatric doctors, social workers and prison guards.

Theoretically, it is possible to point to three junctures where a failure could have come about that would undermine the quality of the supervision of the deceased: (a) the assessments of the psychiatric doctors; (b) the compatibility of the psychiatric doctors' assessment with the supervision instructions derived therefrom by the social workers; (c) a deviation from the supervision instructions by the prison guards.

We fully agree with the conclusion of the Honorable Court that, in the Court's words: *"I have not found alleged evidence of violations of the duty of care of these officials (psychiatric doctors and social workers)". Indeed, nothing in the evidence suggests that defects have fallen in the consistent assessments of the psychiatric doctors, according to which the deceased did not show suicidal intent.*

The evidence also indicates that the supervision instruction of the social workers, which defined the deceased as a Prisoner Under Supervision Level B, exceeded that of the psychiatric assessments, which did not find it necessary to define the deceased as a "Prisoner Under Supervision."

This conclusion, that there was no defect in the assessment of the psychiatric doctors, and the supervision instruction derived therefrom, is a crucial starting point to examine the conduct of the prison guards, and the causal link between their alleged omissions and the death of the deceased. As stated, the duty of the prison guards to

foresee the suicidal act of the deceased, considering the assessments of the psychiatric doctors and social workers – is questionable, and most probably there is no causal link between the particular defect in their conduct and the death of the deceased.

In light of the aforesaid, and after considering all the additional factors which the Honorable Court in its decision, ordered to be considered, including the strength of the evidence and the enforcement policy regarding the offence of causing death by negligence, we have found it would not be possible to determine with the level of certainty required for criminal proceedings that IPS officials and others involved in the supervision of the deceased should have foreseen his suicide.

As for the supervision defects on the day of the suicide – the investigation material will be transferred to IPS disciplinary authorities in order to determine whether supervision officials committed a disciplinary offence by their conduct regarding the deceased or their alleged deviation from procedures.

Finally, the obvious should be stated – this decision involves only the question of criminal responsibility for the death of the deceased by officials responsible for his well-being. The conclusion of this examination, with a decision not to prosecute any of the persons involved, does not alleviate the difficult feelings accompanying them and us. However, it is clear that the responsibility for the well-being of a person in IPS custody does not, in and of itself, impose criminal responsibility on any IPS official, where an inmate succeeds in committing suicide.