DEATHS IN MERU PRISONS

A report by the Independent Medico-Legal Unit (IMLU)

The Inside Story

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Executive Summary

This report documents the findings of investigations carried out by IMLU on the deaths in Meru G.K. Prisons. The investigations were occasioned by reports of five deaths that occurred on a single night within one cell on 27/9/04. Death-in-custody is an area of interest for IMLU because it may constitute Human Rights violations. This independent report is necessary because investigations by Government agencies may be clouded by fears of lack of impartiality and cover-up. This report contains details of the circumstances surrounding the deaths, an analysis of the events that followed, and results of medico-legal investigations by IMLU, including a detailed summary of the autopsy findings and medico-legal inferences. The report also highlights responses by authorities and makes recommendations for a proper and thorough investigation to be conducted by the Government, to the fullest conclusion.

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IMLU EXECUTIVE DIRECTOR

Table of Contents

About IMLU

Independent Medico Legal Unit (IMLU) is an NGO comprised of a secretariat led by a Board of Directors, co-coordinating a network of professionals that includes doctors and lawyers. The organization and the professionals, with which whom it works, are dedicated to a torture-free Kenya, where Human Rights and the rule of law are observed.

Our vision is to transform social paradigms on torture and related Human Rights abuses. Our mission is to promote and protect Human Rights in Kenya and promote the rule of law, and see to it that Kenya adheres to the international treaties and conventions it has ratified.

Our core business includes:

- Documentation of torture and related Human Rights violations
- Rehabilitation of torture victims and their relations
- Increasing public awareness of torture and contributing to public outcry against it
- Training of professionals on identification and documentation of torture

IMLU is independent of any government, political persuasion or religious creed. IMLU does not support or oppose any government or political system. IMLU is concerned solely with the impartial protection of Human Rights and upholding the rule of law.

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I. Introduction to Events Surrounding the Deaths in Meru Prisons

An exclusive front-page story was published by the Daily Nation Newspaper on 28/9/2004, under the headline 'Five prisoners found dead in jail'. The story revealed that five prisoners had died in Meru prisons the previous day, and 23 others had been taken to hospital. The story further reported that the five were among 12 men who had been crammed into a cell measuring only 6ft by 3ft, "barely enough to take one single bed". According to the story, initial reports from officials said they had died of suffocation, but the Police were investigating how three of the bodies bore marks of injury. Prisons officials are reported to have said that the five, who were jailed for chang'aa offences, had died of drink-related illnesses. However, it was reported that these claims were refuted by the area's Medical Officer of Health, who thought the five might have suffocated to death because of over-congestion in the cell. All five men said to be in their early thirties, had been in the cells for less than a week. The Eastern provincial police boss was reported to have said the bodies of the five bore physical injuries and police were investigating.

Immediately upon receiving this news, IMLU dispatched a team to investigate the situation on the ground, with the intention of pursuing an impartial and independent reporting. This is in line with IMLU's mandate[1], and also in line with Principle 7 provided in the *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment.* As our investigating team was gathering information to shed objective light on the tragedy, more information was emerging in the news media.

A story titled 'Prisoners beaten to death, say cellmates', published in the Nation on 29/29/2004, reported claims that the five prisoners were beaten to death by warders and their fellow inmates. According to those claims, prisoners who were interviewed, said the five victims were beaten by warders when they refused to enter the 6ft by 3ft cell, which already contained 12 inmates. The story gave a detailed account of the events, including a report that the five who died had been seen on the day prior to their death at the prisons dispensary, where they had been treated for minor ailments. The area medical officer was quoted as saying, "They complained of chest problems and were returned to their cells after treatment". Asked about the nature of their injuries, the medical officer said he had never seen anything that would suggest there was any kind of physical beating. On their return to the prisons cells, the five were held for the rest of the day and night in a 14ft by 4ft corridor, running the length of one of the cell blocks, which was holding 80 to 100 prisoners. The following afternoon, the five were ordered to enter a tiny 6ft by 3ft cell, which is at the other end of the corridor. Allegedly they refused to comply and were set upon by the warders with *rungus*, forcing them into the tiny room having the 12 other inmates.

The story further stated that inmates who were also in the 'death cell' said that at about 6pm that evening, they shouted to the warders for help on realising that three of the five men had died. The warders are said to have refused to come until the next change of shift at 6am. It is only when they were taking the morning roll call, that they discovered five of the prisoners were dead.

[1] Thompson K. and Gifford C. *Reporting Killings as Human Rights Violations: How to Document and Respond to Potential Violations of the Right to Life within the International System for the Protection of Human Rights.* Human Rights Centre, University of Essex, 2002.

II. Conclusive summary of investigations done by IMLU

IMLU's personnel who were in Meru corroborated most of the account given in the press reports above, through observations and interviews which are recorded on tape.

The following were some pertinent findings by IMLU:

1) That the five who died on the material day are namely:
    1.1. Festus Ntombura
    1.2. Barfa Gitonga Joshua
    1.3. Joseph Thuku
    1.4. George Kimathi
    1.5. Patrick Muriungi
2) That on the material day, the following inmates were also in the cell with the victims:
    2.1. Lawrence Kirimi
    2.2. Harrison Mutembei
    2.3. David Mungela
    2.4. Mutembei Karima
    2.5. Francis Mwelu
    2.6. Francis Mworia
    2.7. Pauel Mutembei
    2.8. Jeremiah Karenya
    2.9. Mberitu Mwenda
    2.10. Julius Mwetu
    2.11. Fredrick Igado
    2.12. Bakari Abdalla
    2.13.
3) That inmates who claimed to be witnesses, reported that around 6.00pm on 26/9/04, during the change of warders shift at counting time, the five were beaten by the warders because they were unable to follow orders to squat on the ground.
4) That the five prisoners were new in the prisons.
5) That the duty officers at the time of the change of shifts were day-duty officer Inspector Samuel Thirata and night-duty officer Senior Sergeant David Maingi respectively.
6) That the two duty officers led the beating of the victims in the company of other officers, an event witnessed by the inmates.
7) That the beatings, lasting 15 to 20 minutes, were executed using truncheons, kicks and blows.
8) That the beaten inmates, who were two convicts and three remandees, had to be carried back to the cells by their fellow inmates, as they could not support themselves.
9) That these already beaten inmates were then crammed with 12 others in a cell 6ft by 3ft, ideally meant for one prisoner.
10) That during the night of 27/9/04, commotion broke out in the cell as the inmates were jostling for every inch of space and struggling for air in the over-congested cell.
11) That the occupants of the cell screamed for water, banging the doors to attract the warders attention, but their cries were ignored by the warders who belted out a string of verbal insults at them.
12) That the five victims were only discovered to be dead by the warders at 6.00am during the next change of shift on 28/7/04.
13) That instead of following the appropriate procedures of informing the investigative authorities as stipulated by law, the prisons officials attempted to cover-up and conceal evidence.

14) That one inmate is on record having been asked to remove and wash blood stains from the cell and the beddings
15) That the prisons authorities attempted to contact a single police officer to secretly visit the scene, but the attempt was thwarted by the OCS in Meru, who got wind of this apparent suspicious and irregular behaviour of the prisons officials.
16) That the police then insisted on having the right procedure followed and investigating officers were sent in.
17) That the 12 inmates who shared a cell with the victims claimed that they were ordered by prisons officers to clean up blood from the cells and removed blood-soaked mattresses before any one else (i.e. the police), could come and see.
18) That 10 inmates were allegedly given cash (1,000/= each) by Senior Sergeant Maingi to conceal the truth of what they saw.
19) That the inmates were persistently threatened by the prisons warders as they were being interviewed by a flurry of Human Rights investigators, journalists and others.
20) That the threats made some of them retract or change their stories under fear of reprisal.
21) That the bodies of the victims was lying at the Meru District Hospital Mortuary
22) That at least 45 other inmates had died in Meru Prisons over the preceding 9 months.
23) That the prisons officers had asked some of the families of the victims to acquire an affidavit requesting to bury the bodies without autopsy being done.
24) That the bodies of some additional inmates were discovered to be lying at the mortuary, including the following six, five of whom died at the Meru District Hospital while undergoing treatment for physical injuries:
    24.1. Martin Muriuki
    24.2. Robert Gatobu
    24.3. John Gitonga
    24.4. Henry Baithirwa
    24.5. Jacob Thine
    24.6. Loyford Kimathi
25) That the five who died in hospital are claimed by the prisons authorities to have been admitted to the prisons with injuries, having been victims of mob-justice immediately prior to their arrests.
26) That according to the prisons authorities, the five were referred to the hospital through the prisons dispensary immediately upon their admission to the prisons.
27) That there were no definite arrangements by the State for post-mortem examinations of the bodies of the inmates who had died in Meru prisons, including those who had died long before 27/9/04.

The matter of the deaths at Meru Prisons immediately gained considerable public attention and was being extensively covered in the media. It became clear that the public had very little confidence in the ongoing official investigation; especially when there were implied indications that the prisons authorities did not believe that any wrongdoing has been committed.

Despite the early public outcry, the prisons officers suspected of carrying out or abetting these Human Rights violations were not promptly suspended. The impunity enjoyed by the suspected prisons officers raised concerns that the prisons authorities were acting improperly, even as results of independent investigations were being released. The Vice-President of Kenya, who is also the Minister of Home Affairs under whose docket the Prisons Department falls, commented to journalists on 29/9/04 that that prisons authorities were investigating the Meru deaths, and pleaded with the public not to speculate. However, his pleas could not quell the public outrage, and eventually the officer-in-charge of the Meru Prisons as well as his deputy were sent on compulsory leave.

III. Forensic findings including autopsy results

Paragraph 9 of the *United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*, adopted on 24 May 1989 by the Economic and Social Council Resolution 1989/65, (UN Principles on Extra-Legal Executions) provides, *inter alia*, "There shall be a thorough, prompt and impartial investigation of all suspected cases of extra legal, arbitrary and summary executions, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances ..."

Paragraph 17 provides, *inter alia*, "A written report shall be made within a reasonable time on the methods and findings of such investigations. The report shall be made public immediately and shall include the scope of the inquiry, procedures, methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law..."

Unfortunately in the Meru deaths, there was no prompt or effective investigation into the allegations of torture or beatings as contributory to the deaths in custody. It was not until the five simultaneous deaths had been reported that some semblance of an investigation was instituted. In fact, it wasn't until the Vice-President issued an order that investigations began in earnest. In any case, the information that emerged from the prisons seem to suggest a cover-up and conspiracy to defeat justice by the prisons officials.

No valid explanation as to the reasons for the decision by the prisons authorities to dismiss the deaths as not related to physical injuries. It is not simply IMLU's opinion that the authorities should adopt specific methods for the proper examination of killings in which State agents may be implicated, such as these cases of death-in-custody. It is our Kenyan law that clearly stipulates the procedures to be followed as laid down in CAP.75 s.386-387. The principles for such investigations are also well laid out in various international rules and standards such as the *United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions.* Sadly, the authorities initially dilly dallied in their response and failed to adhere to the respective laws and international standards until media pressure and public opinion persuaded them.

Critical letdowns by the Government in investigation of the Meru deaths include:

- Apparent absence of independent and impartial investigations
- Delays in the autopsies
- Apparent deficiency in the tracking, notification and involvement of the relatives of the victims
- Procedures falling short of local and international standards regarding investigations into deaths-in-custody
- Failure to arrest any suspects in the deaths

The authorities would be properly advised that the shortcomings in transparency and effectiveness pointed out in this case above, run counter to the purpose identified by the domestic courts of allaying suspicions and rumours. Proper procedures for ensuring the accountability of agents of the State are indispensable in maintaining public confidence and meeting the legitimate concerns that might arise in such cases. Otherwise, lack of such procedures will only add fuel to fears of sinister motivations.

The Five Concurrent Deaths Reported on 28/9/04

By the time of going to do the autopsies for these five concurrent deaths, the following issues had arisen from the information gathered:

- Claims that the victims had been deliberately and purposefully beaten by either the prisons warders, fellow inmates or both. These claims were made by prisons trustees and ordinary inmates.
- Claims that the victims had died as a result of congestion, contributed to by poor health and hygiene at the prisons. These claims were made by the Meru medical Officer of Health, and aptly accepted by the prisons authorities.
- Claims that the victims died during a brawl in the prisons among the inmates in the overcrowded cells and that those who died faired worst as a result of their alcoholism. These claims were made by prisons officials
- Claims that the victims died of natural illnesses, which could not be prevented or treated. These claims were made by the prisons officials.
- There were also claims by inmates and warders, that fights among the prisoners, specially for space, are an ordinary occurrence.
- The inmates and warders also claimed that sodomy is rampant in the cells. Some inmates claimed that the victims had been sodomized.

IMLU's mandate was then to gather material evidence that would confirm or refute the allegations, especially in view of the fact that the authorities were arguing that the detainees died of natural causes, without any mention of assault injuries. The aim was to obtain through forensic autopsies, hard evidence to corroborate the government's version or, alternatively, to prove that the detainees died from torture or cruel, inhuman or degrading treatment.

Our sources of information were confirmed to be reliable and most of the stories we gathered have been corroborated. Reports of the incident were consistent with our knowledge and experience on the patterns of incidents of death in custody in the country; whereby the victims often suffer blunt trauma injuries, which are then covered up as natural illnesses.

According to both local and international standards, autopsies for cases of death-in-custody should be done as soon as possible (CAP 75 s.386-7). As the events in Meru were unfolding, it was clear that there were no official arrangements for the autopsies to be done. In fact, there were no details from the police of when or by whom the autopsies were to be performed. Yet it is clear that the longer an autopsy is delayed, the higher the likelihood that deterioration of the body would cloud or destroy evidence. It must be pointed out that under Kenyan Law, forensic autopsies can be carried out irrespective of consent or presence of the victims' relatives. Nonetheless, it is standard practice to have representation by the relatives for the purpose of body identification as well as transparency. However, there were no clear indications that the relatives of the victims had been contacted about the autopsies.

On realizing that the authorities were dragging their feet regarding the autopsies, IMLU took the initiative to contact the victims' relatives as well as the Chief Government Pathologist, so that the autopsies could be done in a timely manner. Our field officers managed to get in touch with the relatives of the five, most of who were unaware that their sons had died. Majority were too financially constrained to even make the trip to Meru to attend the autopsies, and IMLU had to facilitate their travel and accommodation. All were very grateful for IMLU's involvement and support, and gave consent for IMLU to hire pathologists to stand-in for them during the autopsies.

As is the custom in such cases, IMLU contracts pathologists in its network to partner with the Government pathologist, on behalf of the families, in conducting the autopsy. This is to allow a second voice or opinion to document a proper forensic report. In this particular case, IMLU contracted two highly experienced pathologists who are vastly experienced in this area. Both pathologists are from Kenyatta National Hospital, the largest referral health institution in Kenya, and also teach at the University of Nairobi. Through IMLU's contacts, the Chief Government Pathologist also agreed to conduct the autopsy, particularly in view of the high profile the case had acquired. All these pathologists had to travel from Nairobi, as there was no qualified pathologist in Meru town capable of handling such a case. The date of autopsy had to be scheduled for Sunday 3rd October, because this was the only accommodative date for all the three pathologists travelling from Nairobi.

There were various stumbling blocks and difficulties before and during the autopsy procedures. For example, the pathologists were initially barred from carrying out the autopsy examinations, by warders who claimed that the Chief Government pathologist was not who he claimed to be. It was up to the Meru Central police boss to prevail upon these warders to allow the pathologists to go on with their work. The autopsies were also delayed for several hours because the mortuary lacked certain basic facilities and materials, including gloves and other surgical kits to enable the pathologists conduct the examinations. Apparently relatives are the ones who are asked to purchase and provide them for their cases, but as previously stated, the relatives had no money. IMLU had to step in and provide these basic materials.

Another hitch was lack of forensic x-ray equipments, which are crucial in investigating fractures. The pathologists requested access to the hospitals X-ray room, but got resistance from the nurses and hospital orderlies who were unfamiliar with such procedures on the dead. The x-ray attendant was said to be absent, nevertheless the pathologists insisted and eventually the attendant opened the room for the pathologists to access the equipment.

That paved way for the autopsies to be done in the tiny, putrid and congested morgue under poor lighting and ventilation. The bodies were in appalling states owing to the poor storage and cooling facility at the morgue, which was filled beyond capacity. At one time, electricity went off for nearly three hours, and the pathologists had to work in even worse conditions of poor lighting and ventilation. Luckily, the power was restored just before dusk and this allowed the pathologists to complete their work. The entire exercise was completed at about 8.30pm.

The following are summaries of the autopsy results of the five deaths:

<u>George Kimanthi (MER/1172/04/SS)</u>
Multiple soft tissue injuries, rib fractures and head injuries
Cause of death was Head and Chest injuries

<u>Barfa Joshua Gitonga MER/2768/04/R</u>
Multiple extensive soft tissue injuries, and head injuries including diffuse bleeding in the brain (subarachnoid haemorrhage).
Cause of death was Head Injury (Subarachnoid haemorrhage)

<u>Patrick Muriungi (MER/1142/04/SS)</u>
Multiple extensive superficial and deep soft tissue injuries. Also had circumferential bruises and abrasions around both wrists suggestive of having been tied around the

wrists. However, none of the anatomical injuries were conclusive as to being the cause of death. The cause of death was still being analysed by the team of pathologists.

Joseph Thuku (MER/2992/04/R)
Multiple extensive soft tissue injuries, bleeding in the eyes (conjuctival haemorrhage), and evidence suggesting that he was strangled to death including fracture of the hyoid neck bone.
The cause of death was head and neck (strangulation) injuries

Festus Ntombura (MER/2991/04/R)
Multiple soft tissue injuries, deep bruising in some muscles, bleeding in the chest and the brain (subarachnoid haemorrhage). He also had circumferential bruises and abrasion around both wrists suggestive of having been tied around the wrists.
Cause of death: Chest and head injuries due to blunt force trauma

Specific tests that were done included:

- X-rays to check for fractures
- Rectal swabs for spermatozoa to assess possibility of sodomy
- Microbiological and serological studies to rule out infections
- Tissue samples for histological analysis

Conclusions made:

- ✓ Natural illnesses were ruled out as having caused deaths in these five cases
- ✓ All the victims had severe injuries in keeping with severe blunt force trauma, which caused their deaths.
- ✓ No evidence was found to suggest that the victims had been sodomized.
- ✓ An inquest must be opened to determine the person(s) responsible for the deaths of these inmates

The Other Deaths

As we were investigating the five deaths, it emerged that there had been several other mysterious deaths preceding these five. The bodies of some of them were still in the mortuary. Apparently these inmates died in Meru District Hospital, where they had been admitted with serious physical injuries, which the prisons officials attributed to mob justice by members of the public before the inmates admission to prisons. The prisons authorities were reporting that these inmates died consequent to injuries that they had sustained before arrival at the prisons, and that all were referred to Meru Hospital after being seen at the prisons dispensary, immediately upon their arrival in the prisons.

Some of the issues that raised queries include the fact that autopsies hadn't been done despite a considerable lapse in time, that there did not seem to be any proper investigations of these deaths as required by law, and that the relatives had not been duly informed regarding these deaths.

Again, on realizing that the authorities were dragging their feet regarding the autopsies, IMLU took the initiative to contact the victims' relatives as well as the Chief Government Pathologist through the Director of Medical Services, so that the autopsies may be done as soon as possible.

IMLU attempted to contact all the relatives of eleven victims inmates whose bodies were still in the morgue. However, our officers only managed to contact and obtain consent from six of these relatives, none of whom had been contacted by the prisons authorities about their kin's death. This was in contrast to the information given by the prisons

officials that all the relatives of victims inmates had been informed of their deaths. By the time of going for the autopsies, there were actually 14 bodies of inmates from the prisons, over and above the five autopsied.

For these six autopsies, five of whom died in hospital, IMLU contracted the service of one of the two pathologists who participated in the other five autopsies. The autopsies were done on 22nd October 2004.

The following are summaries of the autopsy results of the six deaths:

Martin Muriuki
Multiple soft tissue injuries, traumatic loss of teeth, bleeding in the chest cavity, rib fractures and massive bleeding within the covering of the brain
Cause of death was head and chest injuries secondary to blunt force trauma.

Robert Gatobu
Multiple soft tissue injuries, pus in the chest cavity, rib fractures, bleeding around the right eye-orbit, and also bleeding within the covering of the brain
Cause of death was head and chest injuries secondary to blunt force trauma.

Loyford Kimathi MER/2251/03/CR
Massive collection of fluid in the lower limbs and chest cavity, with a collapsed right lung and enlarged liver due to heart failure. Also had multiple leg ulcers. There was no evidence of injury
Cause of death was Congestive Cardiac Failure (a natural manner death that could be augmented by poor health conditions)

Henry Baithirwa MER/2517/04/R
Multiple soft tissue injuries including the head, bleeding in the chest cavity and lung injuries.
Cause of death was head and chest injuries secondary to blunt force trauma.

Jacob Gitonga MER/855/04/LS
Extreme wasting (emaciation) with fluid collection in the lungs. No significant injuries were noted.
Cause of death was unascertained and the pathologist is yet to give a final analysis of the probable cause of death. However, the patient was noted to be in poor nutritional status, as physically manifested.

Jacob Thiane MER/2259/04/R
Multiple soft tissue injuries, bleeding in the chest cavity and bleeding in the skull within the brain covering.
Cause of death was head and chest injuries secondary to blunt force trauma.

Conclusions made:

- ✓ Natural illnesses were ruled out as having caused deaths in five of the six cases, and even for the one case whose manner could be concluded as natural, there is a strong possibility of other factors possibly contributing to the death.
- ✓ The five who died of injuries had severe injuries in keeping with severe blunt force trauma, which caused their deaths.
- ✓ An inquest must be opened to try and determine the person(s) responsible for the deaths of these inmates

IV. Expert Report on Conditions at the Meru Prisons

What was beyond speculation, the indisputable fact, was that the conditions at the Meru G.K. prisons were horrendous and probably contributed to the deaths.

As the events were unfolding, IMLU contracted a team of public health experts from the University of Nairobi to conduct a survey of the conditions at the Meru Prisons. The team did their work on 1/10/04, two days after news of the five deaths. Although it was common knowledge that prisons conditions in Kenya are generally appalling, the expert report documented shocking details that contravene all domestic and international codes and regulations on prisons conditions.

The following is a synopsis of the 6-page report titled 'Situation Analysis of the Meru GK Prisons Done on 1st October 2004':

1. Preamble

1.1. The Meru G.K prisons, located in Meru municipality was built in the 1940's by the colonial government to cater for the bigger Meru area, and currently serves the following four districts: Meru Central, Meru North, Meru South and Tharaka

1.2. Despite the population growth and the increased number of inmates, the original structures remain. There hasn't been any expansion to accommodate increasing number of inmates.

1.3. Most structures were designed by the colonialists and resemble torture chambers, the purpose for which they were constructed.

1.4. The entire prisons was severely congested, having been designed to accommodate a maximum of 500 inmates, but was holding 1600 inmates, 1405 men and 195 women as well as 43 children below 4 years.

1.5. The whole prisons occupies 10 acres of land of which only 4 acres is being gainfully utilized because of the very steep gradient of the remaining land.

2. Male Side

2.1. The male side has the offices, eight wards (numbered 2 to 8), and four segregation cells, all made of concrete. The eight wards are of various sizes.

2.2. Each ward has an internal toilet and shower while the whole male side has only one external toilet, one shower and two urinals. The toilets found to be grossly inadequate to serve all the inmates.

2.2.1. In total there are nine toilets for the entire population of 1405 inmates and a similar number of shower rooms. Eight of the toilets are within the wards while one is outside.

2.2.2. In most cases, the toilets within the ward are used as an extension of the ward in terms of sleeping /sitting /standing due to lack of space. Some inmates spend the day and night there in spite of the unhealthy conditions.

2.2.3. The segregation cells lack toilets. The inmates are forced to use buckets as toilets and these are the same buckets they bathe with.

2.2.4. The toilets were found to be filthy and unhygienic.

2.3. The cells lack a drainage system and the wastewater is scooped out manually where possible.

2.4. The floors are made of concrete, but with a number of potholes making efficient cleaning impossible.

2.4.1. The potholes trap water and make the place dirty and can breed various insects.

2.4.2. There were a lot of cases of lower limb fungal injections due to the dirty humid floors.

2.5. The general condition of most of the buildings is poor with peeling paint and multiple cracks on most of the walls.

2.6. The poor ventilation is a striking feature especially in the wards and segregation cells. The ventilation is so poor that the rooms are stuffy, hot and would be in total darkness if not for inadequate electricity bulbs that have to be on, both day and night.

2.6.1. Most rooms had between 2 to 4 small windows, which were high up and only served as lighting vents and not ventilation.

2.7. The roofs in most of the cells and wards were reported to leak during rainfall, aggravating the pathetic conditions for the inmates.

2.8. The level of congestion noticed generally in the wards and cells was quoted as 'beyond any possible imagination'.

2.8.1. The team noted that the number of inmates per square foot defied the rule of natural justice by any stretch of imagination.

2.8.2. The conditions in the wards and cells were such that the inmates have to sit or stand in a certain pattern so as to fit inside.

2.8.3. Because of congestion, the inmates lacked basic physiological needs like adequate and restful sleep, fresh air, or even comfortable sitting.

2.8.4. The congested environment apart from being unhealthy is likely to predispose the inmates to stress and provokes violence.

2.8.5. Indeed violence was found to be frequent among the inmates and incidences of inmates collapsing inside the cells are frequent as confessed by the warders and fellow inmates.

2.8.6. Evidence of circulatory failure due to prolonged standing was also witnessed among the inmates who had bilateral pedal oedema (swelling of the legs due to accumulation of fluids) and leg wounds due to stasis (decreased flow of body fluids).

2.9. The team noted that 150 inmates had already been transferred out by the time of the inspection, yet the wards were still very congested.

The table below shows the population per room on the male side. The dimensions of the rooms are approximations.

WARD/CELLS	AREA (square feet)	OCCUPANCY	COMMENTS
Segregation cell	18	16	No toilet , No shower, Poor ventilation, No Drainage
Ward 2	432	229	Poor light, Roof leaking, Hot, Stuffy, Flies
Ward 3	432	229	Poor lighting, Roof leaking, Stuffy, Hot, Flies
Ward 4	432	227	Poor ventilation, Hot, Stuffy, Flies
Ward 5	200	182	Poor ventilation, Hot, Stuffy, Flies
Ward 6	64	46	Poor ventilation, Many flies
Ward 7	64	57	Poor ventilation, Many flies
Ward 8	405	55	Leaking roof, Poor ventilation, Hot, Stuffy, Flies
Ward 9	405	109	Leaking roof, Poor ventilation, Hot, Stuffy, Flies

3. In terms of separation of the inmates, the team observed that the situation was 'totally chaotic'.

3.1. The convicts, the remanded inmates, the sick and the psychotics were all mixed up in the wards.

3.2. The team inferred that the lack of basic segregation was 'a perfect medium for breeding internal violence, crime and diseases'.

3.3. The team found out that of all the infections diseases requiring isolation of the sick, only cases of hepatitis were being isolated. Even then, the sick in isolation were locked in a store without any ventilation.

3.4. The healthy inmates was naturally documented as posing a big health risk, totally against the principles of public health that dictates 'people must be prevented as much as possible from getting communicable diseases'.

4. <u>Female Side</u>

4.1. The female side of the prisons has four wards and segregation cells.

4.2. It was generally is less congested than the male side, the buildings being of mixed type i.e. stone, mud and timber buildings.

4.3. The wards, roofed with mabati, were observed to lack ventilation. These wards were documented not to have any windows, with the portal for air circulation being the eaves.

4.4. The wards had about 30 inmates each, and a separate one for female inmates staying with their children.

4.5. The segregation cells held about 5-7 inmates each and were found to be relatively cleaner compared to the male side.

4.6. About 50% of the women who were present did not have clothes on, all they had was a blanket wrapped around their bodies.

4.7. The toilet and bathing facilities were found to be inadequate for the 195 women and the 43 children. There were no toilet facilities inside the wards and there were only 2 toilets and showers outside serving the entire female population. Nevertheless, these toilets were clean and had water, in contrast to the male side.

4.8. There were 43 children in total all under 4 years of age. Of these, 27 belonged to the convicts while 16 belonged to remandees. The general condition of the children looked better compared to the remainder of the population. Specific convicts are assigned to take care of the children during the day when their mothers go to court or to work.

4.8.1. Overall nutritional status was good of the children, and this was attributed to the separate kitchen that prepares their food, providing them with five meals in a day

4.8.2. However, some were found to have moderately severe fungal skin infections.

4.8.3. The children spend most of the day in the poorly ventilated rooms and have little time outside. The team commented that 'these children are not prisoners and hence should not be subjected to harsh conditions and efforts should be made to make their life more enjoyable'.

5. <u>Food and Water</u>

5.1. The main dishes eaten are Maize meal uji for breakfast, Ugali /rice with vegetable for lunch and Ugali /rice with beans for super. The diet is fixed with no variation and there is no animal protein provided.

5.2. The team was informed that medically certified convicts under the supervision of the warders do the cooking. They all looked clean and healthy, however no medical certificates were produced to prove their good health.

5.3. The vegetables were being cut on a dirty sack on the floor. The cabbage looked yellowish and dirty, which the convict-cooks erroneously thought were 'vitamins'

5.4. The potholed state of the kitchen floor makes it hard to clean. The team stated that pools of water present are perfect breeding sites for vectors and microorganisms.

5.5. The prisons facility was noted to be well supplied with water. It has two water lines, one from Meru Water Supply Agency, and another from a tapped spring. It also has a standby borehole.

6. Health Services

6.1. The prisons has a dispensary, which is manned by 3 nurses.

6.2. It is open from 8am to 5pm during weekdays and 8am to 1pm on weekends and they see quite a lot of patients daily.

6.3. At the dispensary they may see up to 50 – 70 patients per day. These nurses are overworked as they are too few to cater for the prisons population.

6.4. The team found that in the prisons, there may also be up to 500 sick inmates who need to be seen yet the staff is few.

6.5. The top 5 conditions seen at the dispensary, *obtained from the Monthly Activity Report to the Ministry of Health,* are:

6.5.1. Malaria
6.5.2. Respiratory infections
6.5.3. Diarrhoeal diseases
6.5.4. Skin diseases
6.5.5. Intestinal Worms

6.6. The nurse on duty at the dispensary told the team that on average, 10 inmates are referred each day to the Meru District Hospital. The letter of referral and that most of the patients are taken to the district hospital on the same day of referral.

6.7. The nurse on duty claimed that the dispensary receives adequate drug supplies, but another source informed our team that usually basic drugs lack, a consignment had only arrived the previous day.

6.8. The dispensary is a single small room with inadequate storage area.

6.9. The dispensary serves the inmates, staff and members of the general public.

6.10. The public health officer was reported to visit the dispensary every 3 to 4 months to receive the monthly reports.

6.11. The financial allocation from the Ministry of Health is a paltry 40,000/= for Drugs & Dressing, and 37,500/= for 'female inmates expenses'.

6.12. There is a high TB infectivity rate. In this year alone, about 12 warders out of a population of 167 had contracted TB, an infection rate of 7%.

7. The team went through the records of death at the facility, which recorded that there had been 47 deaths in the prisons, from the beginning of January 2004 till 1st of October 2004.

7.1. The leading causes of death are listed as:

7.1.1. Malaria
7.1.2. Tuberculosis
7.1.3. Pneumonia
7.1.4. Gastroenteritis

7.2. Some deaths were however not well explained in the death certificate book. Some causes of death were simply listed as trauma or head injury with no details of the manner of death.

V. Analysis and Comments on the Public Health Reports

The findings in the report summarized above, clearly confirm that conditions at the Meru Prisons are in contravention of principles 9-21 of the *'United Nations Standard Minimum Rules for the Treatment of Prisoners'*, which stipulate that a prisoner must have enough room to sleep, have adequate ventilation, adequate floor space, sufficient lighting, cleanliness and sanitary shower installations. These findings also demonstrate that the Prisons Department does not follow it's own rules as cited in the Subsidiary Legislation – the Prisons Rules in CAP.90 of the Laws of Kenya, particularly Part IV Rules 32-33, and Part V Rules 45-49.

The report reveals that the health status at the Meru G.K. Prisons on the day of inspection by our by the public health experts, which had actually been spruced up after all the publicity, fall far short of even the local standards stipulated in the Public Health Act CAP.242 of the Laws of Kenya. The mixing of ailing, infected and non-infected inmates is against the provisions of CAP.242 s.21-22.

Part IX of the Public Health Act makes provisions for healthy sanitation and housing. S.118(k) states that "any dwelling or premises which is so overcrowded as to be injurious or dangerous to the health of the inmates, or is dilapidated or defective in lighting or ventilation, or is not provided with or so situated that it cannot be provided with sanitary accommodation to the satisfaction of the medical officer of health;" shall be deemed to be a nuisance liable to be dealt with under the Public Health Act.

The lack of separation of prisoners contravenes principle 8 of the '*United Nations Standard Minimum Rules for the Treatment of Prisoners*', which requires that different categories of prisoners be kept in separate institutions or in separate parts of the same institution with respect to their age, gender, criminal record, reason for detention and necessities of their treatment. Yet these categories have been clearly laid out in Part II of the Prisons Rules under Cap.90 of the Laws of Kenya.

The conditions in Meru G.K. Prisons as documented in the Expert Report demonstrate that the prisoners' Human Rights were being absolutely violated. Of paramount concern is the violation of being held under cruel, inhuman and degrading conditions in contravention of Article 5 of the *Universal Declaration of Human Rights* and Article 1 of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.

VI. Analysis and Comments on the Forensic Investigations

Death-in-custody may constitute a Human Rights violation when it results from extrajudicial execution, from torture; or from ill treatment, including medical neglect and poor prisons conditions; or from excessive use of force[2]. Death in custody is not considered a Human Rights violation only if certified to have resulted from natural causes or fatal illness that are unavoidable and untreatable. There is a forever concern that many so-called natural causes, illnesses or accidents may be cover-ups to hide Human Rights violations.

The '*Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment*' adopted by General Assembly resolution 43/173 of 9 December 1988, states that:

- *Officials* who have reason to believe that a violation of this Body of Principles has occurred or is about to occur, shall report the matter to their superior authorities and, where necessary, to other appropriate authorities or organs vested with reviewing or remedial powers (Principle 7 –2).
- *Any other person* who has ground to believe that a violation of this Body of Principles has occurred or is about to occur shall have the right to report the matter to the superiors of the officials involved as well as to other appropriate authorities or organs vested with reviewing or remedial powers (Principle 7 –3).
- A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary (Principle 24).
- The fact that a detained or imprisoned person underwent a medical examination, the name of the physician and the results of such an examination shall be duly recorded. Access to such records shall be ensured (Principle 26).
- Whenever the death or disappearance of a detained or imprisoned person occurs during his detention or imprisonment, an inquiry into the cause of death or disappearance shall be held by a judicial or other authority, either on its own motion or at the insistence of a member of the family of such a person or any person who has knowledge of the case. When circumstances so warrant, such an inquiry shall be held on the same procedural basis whenever the death or disappearance occurs shortly after the termination of the detention or imprisonment. The findings of such inquiry or a report thereon shall be made available upon request, unless doing so would jeopardise an ongoing criminal investigation (Principle 34).
- Damage incurred because of acts or omissions by a public official contrary to the rights contained in these principles shall be compensated according to the applicable rules or liability provided by domestic law (Principle 35).

Our investigations strongly suggest that the prisoners who died in their cells, died because of injuries that were sustained under circumstances implying homicide. The question that remains is whether they suffered those injuries in the hands of the prisons warders, their fellow inmates or both. Whatever the case, the prisons officials must explain the circumstances that led to the deaths of these inmates including refuting the allegations that the victims were beaten by warders, why no prompt action was taken prevent the deaths in the cell, why cries from the cellmates were ignored, why it took a whole night till the morning for the bodies to be discovered, why there were attempts at cleaning off evidence in the cell, and why proper procedures were not followed upon discovery of the deaths.

[2] Amnesty International and Council for the Development of Social Science Research in Africa, (CODESRIA). *Monitoring and Investigating Death in Custody.* Amsterdam & Senegal, 2000.

VII. Overall Remarks

Prisons administrations and managers face many challenges in addressing the many problems in our prisons. We laud the open-door policy introduced by the current Commissioner of Prisons. We also appreciate the various ongoing reforms instituted by the Minister of Home Affairs. However we must point out that Prisoners Rights, especially those that are entrenched as their Basic Human Rights under the Bill of Rights MUST be respected without any limitations. The Government is forever always responsible and accountable for those under its custody. There cannot be any excuse or apologies by the Government for the violation of a prisoner's Right to Life and other basic Human Rights, by any error of commission or omission.

All required resources, especially those under the Prisons Department, must be marshalled to safeguard the lives and basic Human Rights of prisoners. These include Prisons land; income generated from the land such as through farming and skilled labour.

The deaths in Meru clearly demonstrate that prisons in Kenya are nothing short of smoldering disaster zones, likely to explode in a bigger scale any time. There has been a lack of definite or consistent prisons upgrading systems. Simple evidence is the fact that only one prisons has ever been built in post-independence Kenya, yet the population has grown five-fold from 6 million 30 years ago to 30 million at present. During this period, the prisons population has also grown tremendously, yet there hasn't been any significant increase in prisons capacity to match the growth in the number of inmates.

Prisons overcrowding has been cited as one of the main contributors to the high levels of prisons violence[3]. Other explanations include changing composition of the prisons population, large numbers of violent offenders, increasing numbers of persons with mental illness (or intoxicated inmates), escalating problem of ethnic conflicts, and conflicts relating to gangs. Improvements in technological and architectural advancements have been proven to bear a positive effect on the security and management of prisons. The availability of education, training, work and behavioral programs (for example, anti-violence programs) would contribute positively towards the rehabilitation of many inmates.

There is no evidence from the authorities to show that they had taken steps to decongest the Meru Prisons, nor was there any evidence to show that the officer-in-charge made any attempts to avert the situation that culminated in the tragedy of five deaths on that single night.

We are of the opinion that there has been a failure to conduct effective investigations into the circumstances of the deaths that have occurred in Meru G.K. Prisons since the beginning of the year, in contravention of CAP.75 s.386-7, as well as numerous International Standards such as Article 3 of the *Universal Declaration of Human Rights* (right to life), Article 8 (right to effective remedy) in respect of lack of access to an appropriate means of obtaining a determination as to whether the authorities failed to protect the inmates lives, and Principle 34 of the *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment.*

[3] Australian Institute of Criminology. *Trends & Issues in Crime and Criminal Justice: Prisons Homicide in Australia: 1980 To 1998.* Canberra, 1999.

Recommendations

Our recommendations are very simple and straightforward. That the Government must abide by domestic laws governing penal institutions, investigation of deaths in custody and observance of Human Rights for all. *How can the Government claim to reform (or even punish) those who break the law by breaking the law, and still wear the title of the custodian of the law?*

At a minimum, we recommend a full and thorough investigation into the deaths in Meru Prisons as stipulated in CAP 75 sec. 386-387 of the Laws of Kenya, as well as various International Laws and Standards, such as the '*Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment'* and the '*United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions'*. We also demand that the Prisons rules, as laid down in the Prisons Act CAP 90, be observed in our prisons.

IMLU wants to see that victims of torture and those who have suffered related Human Rights violations receive justice and are compensated. We also want to see that perpetrators are apprehended and brought to book. We are ready to provide evidence in any legal proceedings, the least of which should be an inquest, so as to contribute to the administration of justice.

The Government must rekindle the mechanisms that have been laid down to handle such deaths. These include the Prisons Department, the Office of the Attorney General through the Police Department and Magistrate Courts, and the Ministry of Health.

Regarding the horrible state of our prisons that contributed to the tragedy at hand, we petition the Government and challenge the Prisons Department to turn things round. Mere rhetoric about lack of finance or budgetary allocation cannot be an excuse to break the law or destroy human beings. There are many things that can be done to decongest the prisons and improve conditions in prisons, and the Government merely needs to act prudently in order to reverse the situation. The first step is for the authorities to observe the law and cooperation with well-wishers willing to assist.

Immediate measures to decongest the prisons should include co-operation between the Police, the Judiciary and the Prisons Departments to speed up the legal processing of remand cases so that the numbers of remandees can be reduced. As noted earlier, the number of remandees in most of the overcrowded prisons far exceeds those of the convicts. Reasons for this scenario include poor police investigations, delays in court hearings owing to inefficient judicial procedures, postponement of cases owing to failure in court appearances as a consequence of lack of prisons transport for remandees to courts and a general apathy in the system.

We therefore encourage the Judiciary to maximize the utilization of mobile courts and call upon the Chief Justice, the Attorney General and the Police Commissioner to improve service delivery in their respective areas as a matter of urgency, so as to alleviate the situation.

We also call upon the Minister of Home Affairs and the Commissioner of Prisons to make use of s.25 of the Prisons Act CAP.90, which states that "Whenever it appears to the Commissioner that the number of prisoners in any prisons is any greater than can be conveniently kept therein and that it is not convenient to transfer the excess number to some other prisons;…such provision shall be made by the Commissioner, with approval of the Minister, may direct for the shelter and safe custody in temporary prisons…".

Though we laud the Governments effort to release massive numbers of prisoners by utilizing the Community Service Order (CSO), we urge that this is done with extreme caution. No more important than the fact that with the prevailing conditions in Prisons, none of these inmates, including remandees, could be said to have been exposed to some positive rehabilitation that would allow them to reintegrate easily into society. In any case, it is probable that many of them have been hardened even further. As aptly put by one author, "..The use of non-custodial community-based sanctions to replace the latter part of a sentence of imprisonment will require not simply the preparation of public acceptance, but also the active involvement of community agencies. It will require effective liaison between them and the prisons authorities".[4]

The Government needs therefore to properly vet all the inmates before release, and wherever possible, such inmates should be placed in Half-Houses[5] before release into society. We believe that effectively employed, the CSO will lead to a reduction in overcrowding, free resources for better enhancement of prisons services as well as promoting the rehabilitation and reintegration of offenders into society.

On the pathetic health conditions in the prisons, we urge the Ministry of Home Affairs to effectively collaborate with the Ministry of Health so as to ensure a proper system for the provision of medicals services within the prisons, at least to the level prescribed in the Prisons Act CAP.90, including the provision in s.29(1), which states that "There shall be a medical officer stationed in or responsible for every prisons".

It could be argued that under the Public Health Act CAP.242 s.125, it is the duty of the Ministry of Health to collect, investigate and consider and publish the facts as to the overcrowding situation in the Kenyan prisons, such as the Meru G.K. Prisons. It could further be argued that the Ministry of Health has failed inquire into the best methods of dealing with any overcrowding or bad housing that fails to secure or maintain health in our prisons. We therefore call upon the Director of Medical Service to ensure that his public health officers discharge their responsibilities accordingly as appertaining to prisons.

We further recommend the creation of a post of Director of Prisons Medical Services under the Ministry of Health who with a specially established Board of Prisons Health Services. The Board should be chaired by the Director of Medical Services (DMS), or a Deputy Director of Medical Services appointed by the Ministry of Health. It should also consist of at least a medical practitioner with specialization and experience in prisons health care, a clinical officer and a nurse with relevant specialization and experience, the Commissioner of Prisons or a nominee from the Ministry of Home Affairs, a Commissioner from the Kenya National Commission for Human Rights (KNHRC), a representative from the Civil Society and representatives from each of the various Prisons Units in the country. Such a Board should have statutory approval and be put in-charge of supervising health care delivery in prisons including the provision of clinical services, inspection of prisons conditions and facilitation of forensic services in Prisons.

[4] Andrew Coyle. *A Human Rights Approach to Prisons management: Handbook for Prisons Staff.* International Centre for Prisons Studies, London, 2002.

[5] The Half-House concept was used during the early days of post-independent Kenya, whereby inmates upon release from prisons were briefly accommodated in houses under prisons rehabilitation services before being finally reintegrated into society.

A proactive way of curtailing tragedies such as the one in this report would be the implementation of s.72 of the Prisons Act that provides for Visiting Justices. We call upon the Minister of Home Affairs to establish an extensive and elaborate network of Visiting Justices round the country, who should visit each prisons assigned to them regularly as provided in the Act. By inspecting the wards, cells, yards, food and hearing complaints from prisoners as well as questioning prisoners and prisons officers, these Visiting Justices would be a good position to act as surveillance of prisons conditions and report regularly to the Minister. Ex-officio Visiting Justices , especially the District Administrative Officers led by the District Commissioners, as well as the District Magistrates within whose jurisdictions the prisons are situated, should be compelled by the Minister to also serve as Visiting Justices and report to him regularly.

The problems in our prisons are but a reflection of the decadence in our society – problems that cannot be tackled through a department like the prisons, but requiring radical changes in the governance, criminal, justice, law, order, and social sectors. Paramount is the uplifting of living standards through poverty eradication in the country.

The Prisons Department through the Minister of Home Affairs and the Commissioner of Prisons, have the responsibility of drawing the attention of the Government: Legislature, Executive and Judiciary, as well as the Public and Donor Community, to the consequences of overcrowding in prisons and the lack of resources to manage prisons. This can be done through official bureaucratic means as well as appeals through effective outreach strategies and campaigns taking advantage of the public interest in prisons conditions.