UN Special Rapporteur on extrajudicial, summary or arbitrary executions

**Call for input: Deaths in custody**

**Response from Scotland**

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**Overview**

We are a team of researchers affiliated with the University of Glasgow (some with personal experience of bereavement due to death in custody) analysing deaths in custody in Scotland covering an 18-year timeline. Scotland has more deaths in its prison system each year than Rikers Island in New York, which serves a larger population. There is a higher suicide rate in Scottish prisons than in those of England, and higher even than those in Louisiana, one of the highest incarceration rate systems in the world. It has more drug deaths per capita in prison than outside of it, in a country that is already near the top in the world for drug deaths. We also argue, based on extensive research, that Scotland has no effective system for investigating deaths in custody.

Links to reports we have completed on deaths in custody are here:

* [Nothing to see here? Statistical analysis of 15 years of FAIs into deaths in custody in Scotland](https://www.sccjr.ac.uk/publication/nothing-to-see-here-statistical-briefing/) (2021)
* [A Defective System: Case Analysis of 15 years of FAI’s After Deaths in Prison](https://www.sccjr.ac.uk/publication/a-defective-system-case-analysis-of-15-years-of-fais-after-deaths-in-prison/) (2021)
* [Still nothing to see here? One year update on FAIs and prison deaths in Scotland](https://www.sccjr.ac.uk/publication/still-nothing-to-see-here-one-year-update/) (2022)

Scotland has a unique system of Fatal Accident Inquiries (FAIs), where the Prosecutor’s office leads an investigation overseeing police and an inquiry into death is overseen by a judge (called Sheriff). Hence, the bodies responsible for arresting, prosecuting and trying people also leads investigations into and determines liability for their deaths in custody.

The independence, effectiveness, accountability and rights compliance of this process has been criticised mainly by families of those who have died. **Over 75% of deaths take longer than a year to investigate; 40% of deaths in prison custody take three years or more to complete. Over 90% of these FAIs conclude that prison and police staff acted professionally, and each death was unavoidable or unpredictable and an isolated incident.**

Following several high-profile deaths in custody where the Crown Office Procurator Fiscal granted blanket immunity to officers or declined to initiate criminal proceedings, families have led efforts to challenge lack of accountability and effectiveness, and the Scottish Government convened an independent review of responses to death in custody. This has recommended significant change to Scotland’s current processes of death investigation, and a new Lord Advocate (highest law officer in the land) has announced significant changes to how these deaths in custody will be investigated. While these developments are promising, there have been promises in the past, while the rate of deaths in custody has been rising steadily over the past decade.

**1. Existing Data Collection Practices**

* Prison deaths are recorded and reported by the Scottish Prison Service on its website. **Currently no government agency analyses or audits information on deaths in prison and reports this publicly.**
* Our research is the most exhaustive analysis of this information to date and shows a rising number and rate of deaths in prison custody including for suicides, drug deaths and deaths from health conditions.
* Police deaths in custody are not centrally reported and media is the main but unreliable source of information about these. **This is a significant lapse of accountability.**

**2. Measures in place, including policies and good practices for investigating, documenting and preventing deaths in custody**

* Legal reform to the [*Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016*](https://www.legislation.gov.uk/asp/2016/2/contents/enacted), mandates a public inquiry into all deaths in custody. This is a change from the prior legislation (1976) where such inquiries discretionary prior to 2017.
* Investigation is overseen by the Scottish prosecuting body, the Crown Office, which has a specific unit, the Sudden Fatality Investigation Unit (SFIU) for investigating FAIs, a change recommended by an independent review that also resulted in the law reform of 2016. The creation of this unit has not, according to our research, made any difference to the low rate of ever identifying an issue of breach of the state’s duty of care.
* In theory, police investigation of deaths must first determine no crime has been committed before an FAI is initiated. However, except in the case of prisoner on prisoner homicides, there have been almost no instances of a criminal investigation taking place and so deaths in custody are generally sent directly for FAIs via a ‘Sudden Death Report’. The recently appointed Lord Advocate has reviewed and is making changes to this approach.
* The inquiry itself, the FAI, is judicially managed, overseen by a Sheriff (lower court judge). Sheriffs typically receive no training in conducting an FAI. Lawyers, outside of prosecutors, receive no training in participating in an FAI (e.g. on behalf of the bereaved family).
* The FAI is inquisitorial, not adversarial, seeking to establish the truth of what happened. It is not a forum for establishing liability. It must establish the cause of death, and **must make findings where evidence supports this of (i) any reasonable precaution that might have prevented the death, (ii) any defect in the systems of operation that contributed to death, (iii) any recommendations that would assist preventing another death**, (iv) any other findings of fact relevant to explaining the death. **In practice, FAIs almost never make any finding beyond the time, place and medical cause of death**.
* It is notable that any **recommendations** the Sheriff makes in the few FAIs where this has been done, **are not legally enforceable**. While the bodies which are subject of recommendations must make a response to these, there is no penalty for not doing this and there is no mechanism to enforce a response nor any mechanism to audit whether recommendation have been implemented.
* The main accountability of the effectiveness of this system has been via the Inspectorate of Prosecution in Scotland, which conducted thematic reviews in 2016 and [2019](https://www.gov.scot/news/inspectorate-of-prosecution-publishes-followup-report-on-fatal-accident-inquiries/) on FAIs, though there was no focus on deaths in custody (e.g. also covering deaths where FAIs can occur such as workplace accidents or disasters). These reports as well as an earlier inquiry identified **the time that FAIs take as a significant issue**. These time frames have increased after each review/inspection.
* **There is a real concern about independence and accountability of this process** given the Prosecutor is charged with independently investigating the bodies it normally collaborates closely with, namely the police and prison service, to investigate deaths in their care. The vanishingly low rate of FAIs ever identifying areas of concern, is one source of evidence for this concern. High profile cases including the death of [Allan Marshall](https://justiceforallanmarshall.com/) in prison while being restrained by up to 17 officers, where these officers were granted comprehensive immunity and the death of [Sheku Bayoh](https://www.theguardian.com/uk-news/2023/feb/09/sheku-bayoh-senior-officer-shrugged-shoulders-when-confronted-over-death-inquiry-told) during police restraint, where a decision not to prosecute was challenged by the family have led to public and family campaigns for justice resulting in a public inquiry in the case of Sheku Bayoh, and a recent and unprecedented decision in the case of Allan Marshall to investigate corporate responsibility of the prison service for his death, including corporate homicide (aka manslaughter) charges.
* **Support for families to be included and have their rights protected in FAIs is weak.** Our research showed that families rarely participate in FAIs, and even more rarely have legal representation when they do so. While legal aid provision is possible for FAIs, the bar is high to access this and many families do not qualify. The inquiry is held in an intimidating court setting, where families treatment by judge, prosecutor and others has been reported as rude, dismissive, lacking in compassion, arrogant. Legal reform in 2016 also led to creation of family liaison officers, but we are aware of few families who have been supported at all by them. **A key issue is the delay to conducting an inquiry, as noted above it often takes several years for it to commence, and the stop-start and elongated nature of some proceedings** where families have to come and go and be available over long and unpredictable periods of time.
* Although some responses from Scotland to this questionnaire are likely to claim human rights are a pillar of practice, this is not observed in any of the research we have conducted. **Families are not routinely aware of their rights of participation and effective investigation**; the high threshold to access legal aid effectively prevents many from having legal representation; there have been deaths where relatives of the deceased represent themselves in court, raising questions and challenging evidence. This has re-traumatised them. There has been almost no mention at all of the rights of those who have died in custody as part of the FAI. There is no formal consideration of rights violations in the FAI itself. Scotland has no awareness of the Minnesota Protocol, its first mention appearing only after our report came out, in the [report on the Independent Review on responses to deaths in custody.](https://www.prisonsinspectoratescotland.gov.uk/publications/independent-review-response-deaths-prison-custody) The [progress report on actioning recommendations](https://www.gov.scot/publications/independent-review-response-deaths-prison-custody-follow-up-progress-report/) of this review noted disappointment at how little progress had been made, and called for thorough consideration of the role of FAIs.
* **Suicide is the leading cause of death of women and young people in Scottish prisons, and these have increased following the introduction of a suicide prevention policy** (called Talk to Me). At FAIs, the main architect of this policy, an employee of the prison service with no mental health training qualification, testifies in cases of custodial suicide and has said, as an example, that the rate of suicide is normal and similar to that of deprived neighbourhoods outside of prison. In cases of drug deaths this person has testified that it would be impossible to provide the health care that is available in the community to those in prison. This violates a key right to an equal standard of care in prison as in the community.

**Conclusion**

OPCAT has issued two reports following visits in [2018](https://rm.coe.int/1680982a3e) and [2019](https://rm.coe.int/16809fdebc) to the UK, singling out Scotland for poor treatment of prisoners, including extensive use of isolation and segregation and incarceration of women in need of intensive mental health services. These issues remain a concern and precipitate conditions that increase the risk of unwellness and death. **The statistical picture clearly shows increasing rates of death in Scottish prisons, and extremely low rates of investigations leading to corrective actions. These statistics belie the anticipated statements and contributions the Special Rapporteur is likely to receive from Scottish Government and statutory agencies about the quality of care and investigation that currently exists in this high imprisonment country.**