FAIR AND EFFECTIVE CRIMINAL JUSTICE

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Input to the Special Rapporteur on extrajudicial, summary or arbitrary executions on "Deaths in custody"

Penal Reform International (PRI) welcomes the opportunity to inform the Special Rapporteur's forthcoming thematic report to be presented at the 53rd session of the Human Rights Council on deaths in custody. This submission is based on research for PRI's recent briefing, Deaths in prison: Examining causes, responses, and prevention (2022), published with the University of Nottingham, and an upcoming guide on investigating deaths in prison in line with international human rights standards. The information relates to prisons as facilities holding sentenced persons and those in pre-trial detention, and does not include police custody.

Background

Mortality rates are up to 50% higher for people in prison than for people in the wider community.[1] People die in prison as a result of a wide range of causes and contributing factors that raise serious concerns for the protection of human rights, public health, and prison management. Yet, little is known about who is dying in prison and why. Public availability of accurate and reliable data on incidents of violence and deaths in police custody and prisons is key in the interest of transparency and facilitating effective investigations.[2] This briefing draws on research conducted by PRI and the *prison*DEATH team,[3] including information from survey responses from a variety of stakeholders (people working in prison administrations, prison inspectors and monitors,

[1] UN Human Rights Council, *Human rights in the administration of justice: Report of the United Nations High Commissioner for Human Rights*, A/HRC/42/20, 21 August 2019, para. 30.
[2] UN High Commissioner on Human Rights, *Human Rights in the Administration of Justice: Violence, Death and Serious Injury in situations of deprivation of liberty*, A/HRC/42/20, 30 July 2019.
[3] Dr Philippa Tomczak (University of Nottingham, UK), Dr Róisín Mulgrew (University of Galway, Ireland), and Dr Catherine Appleton (St Olavs University Hospital and the Norwegian University of Science and Technology, Norway).

academics and non-governmental organisations) in 25 countries covering all regions, as well as 19 European prison administrations, following a call for information by PRI.[4]

Deaths in prison: a data 'blind spot'

Data remains a key problem in understanding and addressing deaths in prisons.

Firstly, there is no internationally recognised definition of a 'death in custody'[10] and even within countries, what is included may be unclear. In at least nine out of the 25 countries surveyed, no information could be found on what is classified as a 'death in prison'.[5] Some countries only include deaths which occur in a detention facility, such as Italy. More often, countries also include deaths outside the facility while the person is under sentence or in pre-trial detention, such as those that occur during transportation or while receiving care at a hospital or hospice in the community (such as Argentina, Georgia, Pakistan, Scotland, Spain, and the US). Some limited countries also include deaths while on temporary leave: Ireland includes people on temporary release or unlawfully at large, and England and Wales include people on temporary leave for medical reasons. Some also include deaths shortly after the person has been released from prison (within one month of temporary release in Ireland and up to 10 days after release in Turkey).

Among the 25 countries included in PRI's survey, official information relating to deaths in prison was published in just 11 countries, either by the justice ministry (as in England and Wales, Italy, and the US); prison oversight bodies like Ombudspersons offices, National Preventive Mechanisms, or Inspectorates of Prisons (as in Argentina, Canada, Ireland, and Italy); national research or statistics agencies (Australia and Switzerland), or the prison service (Scotland).

In some countries, data on deaths in prison is totally absent or highly unreliable, either due to lack of transparency or poor or complex data management systems which lead to inaccuracies and undercounting. This is often the case where different authorities are responsible for different facilities or regions and may collect different information and/or may not be effectively centralised. For example, an academic review published in 2021 of deaths in custody that occurred between 2009-2018 in one Brazilian state, found that the actual number of deaths was 2.2 times higher than officially reported for the period.[6] In the same year, another academic review in India found that, despite a legal requirement to report every custodial death to the National Human Rights Commission, in 2015 'only 31 out of 97 custodial deaths were reported, and only 26 of them were submitted for autopsy'.[7]

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[4] Survey responses were collected from Argentina, Australia, Austria, Brazil (Mato Grosso do Sul), Bulgaria, Cameroon, Canada, Central African Republic, Chile, Ecuador, England & Wales, Finland, Georgia, Germany, India, Iran, Ireland, Italy, Kazakhstan, Pakistan (Sindh, Punjab), Scotland, South Africa, Switzerland, Turkey, and the US. Although for Brazil and Pakistan information is only available for individual states, for the purpose of analysis they are treated as representative for the country. The survey is available at www.penalreform.org/wp-content/uploads/2022/11/Survey_Deaths-in-Prison-Worldwide.pdf. Responses from the European prison administrations are available at www.europris.org/epis/kms/?detail=471.

[5] Austria, Canada, Central African Republic, Chile, Ecuador, India, Kazakhstan, South Africa, and Switzerland.

[6] Liu, Y. et al., 'All-cause and cause-specific mortality during and following incarceration in Brazil: A retrospective cohort study', Plos Medicine, 17 September 2021.

[7] Ram, U. and Kumar, P., 'Incarcerated population in India', *International Journal of Prisoner Health*, Volume 17 Issue 2, 28 May 2021, pp. 171-186.

PRI's research also revealed a sizeable data gap in the availability of disaggregated figures on deaths among men and women (available in 15 out of 25 countries in our survey), foreign nationals (available in 8 of the countries[8]), and the mean age at death (available in 5 countries[9]).

In countries where data on deaths in prison is disaggregated by ethnicity, the causes and circumstances of death reveal systemic discrimination and racial disparities across many parts of the prison system, from access to healthcare to experiences of violence. An analysis by journalists in Australia of deaths in custody over 10 years found that Indigenous people were three times more likely to not have received all required medical care prior to death, according to coronial reports. Coroners were also twice as likely to find that police, prisons, or hospitals failed to follow all of their own procedures in cases involving an Indigenous death in custody.[10] In England and Wales, a report by the charity INQUEST on deaths of "racialised people" in prison from 2015 to 2022 highlighted inappropriate use of segregation, racial stereotyping, neglect of physical and mental health, failure to respond to warning signs, and bullying and victimisation of racialised people.[11] Some countries in Europe, however, prohibit the collection of data on race or ethnicity by criminal justice systems as to do so is perceived as discriminatory. Such prohibitions have been noted in, for example, Finland, France, Hungary, Portugal, and Slovakia.

Causes of deaths in prisons around the world

The way deaths are classified varies across jurisdictions and there are different ways of capturing legal determinations and medical causes. Similarly, varying medical and legal processes to certify, investigate and determine the cause of deaths are employed (including medical examiners, through autopsies or post-mortems, and inquests).

Death by so-called 'natural causes' officially account for many deaths in prison, yet the term is not clearly defined. It seems to be a catch-all term conflating different causes of death between old age, illness, and cardiovascular diseases, which is interpreted differently across jurisdictions and with regional variations.

'Non-natural' deaths may include more specific classifications including homicide, suicide or self-inflicted death, accidental causes, drug-related deaths and deaths arising from excessive use of restraint, or torture or other ill-treatment. Deaths may initially be classed as 'undetermined' or similar where the circumstances are unclear, pending an investigation.

Misclassification of causes of prison deaths remain a serious human rights concern. Deaths in prison may be inaccurately classified due to lack of or inadequate inquiry or investigation by authorities, or in an effort to avoid accountability. For example, in 2022, the UN Committee against Torture noted with concern that Cuba recorded an average of 100 deaths in custody per year without determining if the authorities were responsible for any of them.[12] Misclassification of the causes of deaths in prison not only calls into question the accuracy of data but may also affect

[8] Austria, Argentina, Cameroon, Iran, Ireland, Pakistan (Punjab), Scotland, and Turkey.
[9] Argentina, Bulgaria, Brazil (Mato Grosso do Sul), Ireland, and Scotland.
[10] 'The facts about Australia's rising toll of Indigenous deaths in custody', *The Guardian*, 8 April 2021, www.theguardian.com/australia-news/2021/apr/09/the-facts-about-australias-rising-toll-of-indigenous-deaths-in-custody.
[11] INQUEST, *Deaths of racialised people in prison 2015–2022: Challenging racism and discrimination*, October 2022.
[12] UN Committee against Torture, *Concluding observations on the third periodic report of Cuba*, CAT/C/CUB/CO/3, 9 June 2022, para. 30

whether or what type of investigation is carried out, and consequently the type of accountability and prevention measures adopted. It also impacts negatively on the grieving loved ones of the deceased.

In addition to specific causes of death, there are many other factors or circumstances that may contribute or be linked to how or why a person dies in prison. Structural factors that can contribute to unnecessary or premature deaths in prison include the prison environment, poor conditions of detention (which may be linked to severe overcrowding), disciplinary measures (including solitary confinement), neglect, inadequate access to healthcare (including long wait times and delayed transfers to hospital), and discrimination against individuals or groups. These factors may also be linked to broader societal problems. Corruption, for example, within a given society can permeate and influence the culture of its prison system and facilitate access to weapons, drugs and movement within and between prisons by gang leaders.[13] Environmental and transnational factors increasingly pose serious threats to life in prison, including extreme weather caused by climate change, global pandemics, and military conflict.

For more information on specific causes of deaths in prisons and some of these relevant factors, see Deaths in prison: Examining causes, responses, and prevention (2022).

Investigation of deaths in prison

Obligation to investigate

The obligation to investigate all deaths in custody is in some countries explicit in national laws, while in others is stated in action protocols. In Kenya, the 2017 Coroners Act states that all deaths under state custody will be subject to a full investigation.[14] In Chile, the "Intersectoral Protocol for Early Warning of Deaths under State Control, Custody or Care" involves the Ministry of Justice and Human Rights, the Ministry of Health, the Investigative Police, the Carabineros of Chile, the Public Ministry, the Chilean Gendarmerie, the National Service for Minors, the National Service for the Elderly, the Legal Medical Service, and the National Institute of Human Rights sets obligations and standards with the aim of promoting effective and timely investigations in case of death. Particularly, it states that prosecution authorities must carry out a series of diligences in all cases of deaths under State custody to determine if it was caused by negligence or deliberate actions.[15]

Other countries with national laws and protocols to investigate all deaths in prison include England and Wales, Argentina, and Australia, regardless of the causes and circumstances. In such systems, outcomes of investigations may include recommendations to take measures to prevent future loss of life or harm and result in prosecution charges to those responsible. Yet, implementation of

[13] Róisín Mulgrew, 'Prisoner Lives Cut Short: The Need to Address Structural, Societal and Environmental Factors to Reduce Preventable Prisoner Deaths', Working paper on file with PRI.
[14] The National Coroners Service Act 2017, Kenya Gazette Supplement No. 18 of 2017, Republic of Kenya.
[15] Ministerio Público de la República de Chile, *Instrucción general que imparte criterios de actuación en delitos de violencia institucional*, Oficio FN Nº618/2021, p. 15. www.camara.cl/verDoc.aspx?prmID=185862&prmTIPO=DOCUMENTOCOMISION.

preventive measures faces multiple challenges, with authorities often failing to tackle systemic issues and to deliver redress to the family of the deceased.[16]

Investigation procedures and oversight mechanisms

Coronial investigations – or inquests as they are often referred to – are legal inquiries into the cause and circumstances of a death. Coroners may rely on information obtained from pathologists, police officers, prison personnel, medical practitioners, and specialist physicians. The scope of Coronial inquests depends on each jurisdiction's legal framework but, usually, these are limited to fact-finding and do not determine any liability or criminal responsibility.[17] If, during or after the investigation there are elements of a possible crime, they may inform law enforcement authorities to conduct a criminal investigation. Countries with coronial systems for investigating all deaths in prison, regardless of the cause, include England and Wales, Australia and Kenya.

In Australia, recent amendments to Coronial inquest protocols have adopted the recommendations made by the Royal Commission into Aboriginal Deaths in Custody since 1998 to expand the scope from only determining the cause of death to also identifying and addressing underlying factors that contribute to avoidable deaths and formulate recommendations. [18]

In England and Wales, Coroners may conduct an Inquest under Article 2 of the ECHR (right to life), which will include looking at factors that contributed to the death.[19] Coroners also issue reports called Prevention of Future Deaths Report (PFD Report), which are addressed to those institutions or individuals that can and should take actions to prevent further deaths; these actors must provide a response within 56 days. PFD Reports and responses are also made available to interested third parties, such as relatives or legal representatives of the deceased person. [20] Also, the Prison and Police Ombudsman (PPO) conducts an investigation separate from the coronial inquest, with the objective of identifying any shortcomings in the treatment received by the deceased person and to highlight any lessons that can be learned. The PPO produces a report that is shared with relevant authorities, including the coroner. [21]

In Kenya, the Government enacted the National Coroners Service Act in 2017, creating a mechanism for mandatory reporting of deaths and complements police investigation with forensic medical science. It assists courts to reach a reliable finding in such matters and aids the government to formulate policy based on forensic studies to prevent similar deaths from

[16] See, for instance, Deborah Coles and Helen Shaw, *Learning from Death in Custody Inquests a New Framework for Action and Accountability*, INQUEST, static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5fc4784abc819f1cf467fc62/1606711371492/Learning-from-Death-in-Custody-Inquests-A-New-Framework-for-Action-and-Accountability.pdf.
[17] See, for instance, The Crown Prosecution Services in England and Wales.
[18] See, for instance, The Coroners Court of Victoria, Practice Direction 6 of 2020 Indigenous Deaths in Custody.
[19] 'Deaths in custody', *The Crown Prosecution Services in England and Wales*, www.cps.gov.uk/legal-guidance/deaths-custody, [accessed on 05 March 2023].
[20] Coroners and Justice Act 2009, Paragraph 7 of Schedule 5; Regulations 28 and 29, Coroners (Investigations) Regulations 2013.
[21] 'Why does the Ombudsman investigate deaths?', *Prison and Probation Ombudsman*, www.ppo.gov.uk/investigations/investigating-fatal-incidents/why-investigate-deaths/, [accessed on 05 March 2023].

happening. However, non-governmental organisations have reported that the act has not been fully implemented since their enactment, partly due to lack of appropriate funding.[22]

In Argentina, in addition to the intervention of judicial authorities, the Prison Ombudsman's National Office, an independent institution, carries out administrative investigations into each death that occurs in federal prisons. The objective is to formulate separate conclusions on the cause and circumstances of death, and to assess the effectiveness of the judicial investigation.

In Ontario, Canada, the coroner's expert panel on deaths in custody examined the cases of non-homicide deaths of inmates from 2014 to 2021, finding that -with very few exceptions- almost every life lost could be deemed a preventable death.[23] The panel issued a report with 18 recommendations on how to improve inmate well-being and reduce the number of deaths inside correctional facilities, including the establishment of new quality standards for correctional health-care services in alignment with best practices from relevant professional colleges and organisations.[24]

Forensic and medico-legal aspects and national protocols

The National Prosecutor Office in Chile issued general guidelines for handling cases of deaths in prison, which outline the minimum steps that must be taken, including the possibility of receiving technical assistance from the Specialised Unit on Human Rights, Gender Violence and Sexual Crimes to conduct investigations with a broader scope that consider risk factors and negligence, according to standards set in the Minnesota Protocol.[25]

In Peru, national guidelines require that Regional Offices of the National Penitentiary Institute send the registry of deaths to the "Multidisciplinary Commission to Diagnose, Evaluate and Control Deaths of persons deprived of liberty", including deaths certificates and autopsy reports. In its 2021 Report, the Commission stressed that information send by penitentiary authorities was incomplete and inconsistent, which minimum requirements missing, such as information on who reported the death to which relative, among other.[26]

In Mexico, laws and guidelines in place require that every death of a woman is investigated as potential femicide, according to the protocol for ministerial, police and expert investigation with a gender perspective for the crime of femicide.[27]

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[22] Independent Medico-Legal Unit, *Joint Civil Society Organisations Shadow Report in Response to the Third Periodic Report*, www.omct.org/site-resources/legacy/Joint-Kenya-Civil-Society-Shadow-Report-on-CAT.pdf.
[23] Ontario Chief Coroner's Expert Panel on Deaths in Provincial Custody December 2022, *An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody,* January 2023, p. 1.
[24] Ontario Chief Coroner's Expert Panel on Deaths in Provincial Custody December 2022, *An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody*, January 2023.
[25] Ministerio Público de la República de Chile, *Instrucción general que imparte criterios de actuación en delitos de violencia institucional*, Oficio FN Nº618/2021, p. 14, www.camara.cl/verDoc.aspx?prmID=185862&prmTIPO=DOCUMENTOCOMISION.
[26] Instituto Nacional Penitenciario, *Resolución Presidencial No. 158-2022-INPE/P*, 25 Julio, 2022.
[27] Procuraduría General de la República, *Protocolo de Investigación Ministerial, Policial y Pericial con Perspectiva de Género para el Delito de Feminicidio*, https://www.gob.mx/cms/uploads/attachment/file/253267/Protocolo_Feminicidio.pdf.

In Panama, the Ministry of Government has put in place a Protocol regarding deaths in custody. This Protocol outlines processes for notifying penitentiary and judicial authorities as well as family members. The Protocol also defines the procedures for initiating administrative and criminal investigations into any death in custody.[28]

Penal Reform International briefing note

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[28] Ministerio de Gobierno, Dirección General del Sistema Penitenciario, *Protocolo de Actuación en Caso de Muerte de Personas Privadas de Libertad*, https://www.sistemapenitenciario.gob.pa/wp-content/uploads/2019/07/Protocolo-en-caso-de-muerte-ppl.pdf.