HMIPS

HM INSPECTORATE OF PRISONS FOR SCOTLAND

families outside

supporting families affected by imprisonment

DRAFT SUBMISSION TO THE SPECIAL RAPPORTEUR ON EXTRAJUDICIAL, SUMMARY, OR ARBITRARY EXECUTIONS: SCOTLAND'S INDEPENDENT REVIEW OF THE RESPONSE TO DEATHS IN PRISON CUSTODY

The Independent Review of the Response to Deaths in Prison Custody was commissioned in 2019 by Scotland's Cabinet Secretary for Justice. HM Chief Inspector of Prisons for Scotland, Wendy Sinclair-Gieben, was invited to undertake the review which was tasked with making recommendations to improve the response to deaths in prison, through a human rights-based approach and in consultation with families and those directly affected by deaths in custody. Co-Chairs of the Review were Professor Nancy Loucks (Chief Executive of Families Outside) and Judith Robertson (Chair of the Scottish Commission for Human Rights).

Over a two-year period, the review identified a number of key concerns. There was no national oversight mechanism to review data and report on recommendations, learning and good practice, and the existing inquiry processes needed greater independent scrutiny.

Improvements were also required to fulfil human rights standards in investigations into the right to life and the prohibition of torture and cruel, inhuman or degrading treatment (CIDT), specifically in regard to promptness but also to ensure perceptions of independence, adequacy, openness to public scrutiny and importantly enhance the input of next of kin. A lack of family engagement was identified at every step, with compromised humanity and compassion. Staff required more effective training and support, grounded in an appreciation of the impact of a death. A comprehensive review of the causes of deaths in custody was also identified as necessary.

The Review's key recommendation was that a separate independent investigation be undertaken into each death in prison custody, by a wholly independent body, as soon as possible after any death, and involving the families of those who had died. A further 19 recommendations and six advisory points were made under five thematic categories:

- Family contact with the prison and involvement in care
- Policies and processes after a death
- Family contact and support following a death
- Support for prison staff and for people held in prison after a death
- SPS and NHS documentation concerning deaths

Of note is the Scottish Government's response to the Review. Every recommendation was accepted in principle by the Scottish Government. One year after publication, deaths in prisons in Scotland had increased. A follow-up on progress by an external Chair found that, despite efforts to make progress on the key recommendation, only three recommendations had been completed, and one partially completed. The follow-up report details:

> *"From the updates it is clear that some of the issues are complex and will take longer than one year to resolve. Some will need investment of additional resources. However, others seem to be relatively straightforward and could be achieved at little or no additional cost"*

---

1. **Existing practices for data gathering, analysis and reporting of deaths in custody, including the use of statistics and the disaggregation of data (e.g., by different categories and causes of deaths in custody; place of occurrence – e.g., on remand, in prison, in hospital, etc – types and legal status of affected populations, etc) including figures of deaths in custody documented in recent years.**

The Review found a lack of national oversight mechanism to review data and report publicly on recommendations, learning, and positive practice following deaths in custody. There was no published systematic evaluation of data and trends and action to reduce the risk of further deaths. The subsequent progress report found that significant gaps still remain in publicly available data.

Since 2019, the Scottish Prison Service (SPS) publishes the following data on its website: date of admission; date of death; age; gender; ethnic group; legal status; and any medical cause of death. However, the Scottish Government's Justice Analytical Services does not appear to undertake any analysis of trends. As of November 2022, Justice Analytical Services agreed to assist the Understanding and Preventing Deaths in Prison Working Group.

A working group established to support the development of a new single framework on preventing deaths in custody works with publicly available data and has identified gaps in that data to gain a better understanding of causes of deaths in prisons, and is now working with SPS, Justice Analytical Services, and the National Prison Care Network to obtain further data for its analysis of trends. A working group established to support compliance with the State's obligation to protect the right to life via a comprehensive review into the main causes of all deaths in custody is taking similar action.

---

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

    a. **Which legal provisions and requirements exist for cases of deaths in custody? (e.g., is an investigation into a death in custody mandatory or discretionary? Who is responsible for the decision and for the investigation?**

Once death has been confirmed, the Police are immediately informed by the SPS, and the scene of the death is secured. All deaths in custody are subject to an investigation directed by the Crown Office and Procurator Fiscal Service (COPFS) followed by a fatal accident Inquiry (FAI). Other investigative processes outside the FAI include the SPS and National Health Service (NHS) Death in Prison Learning, Audit and Review (DIPLAR) organised within 12 weeks of the death. In the privately-run prisons, the company conducts its own inquiry under legal privilege for any deaths which occur.

The SPS issued a Governors' and Managers' Actions notice (GMA) 071A-18 (SPS, 2018) detailing the information establishments are to send to SPS Headquarters Legal Services Branch. This is to assist with the preparation of a Death in Custody file used by the SPS Legal Representative to prepare for an FAI following a death in custody. The records to be sent are:

- Statements from the staff who found the deceased
- Incident reports following the death
- 'Talk to Me' (Suicide Prevention Strategy) documents if they exist
- Any paperwork/evidence where concerns were raised prior to the death
- CCTV
- Telephone recordings
- Relevant redacted intelligence in a format which can be disclosed to the court if required by the Procurator Fiscal
- Recording of the radio message requesting assistance

Evidence provided to the Review by families and prison staff highlighted concerns about the adequacy of the FAI process, in particular the length of time between a death in custody and the FAI (often several years); the limited opportunity for family participation in the FAI; the narrow focus of the FAI; and the lack of broader learning from FAI findings and recommendations.

Concerns were highlighted by families, SPS, and NHS staff which echoed the finding of separate reviews of the FAI process. NHS and prison staff responses around the awareness of Critical Incident Response and Support (CIRS), DIPLARs, and Fatal Accident Inquiries (FAIs) prior to experiencing a death in custody were broadly similar, expressing ambiguity surrounding their scope and function. For many staff, elements of uncertainty existed around all of these processes.

---

b. Investigation procedures and accountability mechanisms for deaths in custody (e.g., administrative, judicial or other investigatory body? External oversight?)

The COPFS is Scotland's prosecution service. The Procurator Fiscal (PF) investigates all sudden, suspicious, accidental, and unexplained deaths to establish the cause of death and the circumstances. In all cases, deaths in prison custody (whether the death occurs in prison or hospital) are immediately reported to the Police and are subject to an investigation directed by the Procurator Fiscal Service followed by an FAI, unless the Lord Advocate decides an FAI is not required as they are satisfied that the circumstances of the death have been sufficiently established during the course of proceedings.

Nowhere in this process is there an opportunity to identify emerging problems, including changes to the vulnerability of people held in prison, or to uncover systemic weaknesses in operational performance in prisons. Equally, the lengthy time between the death and the FAI undermines the public scrutiny of any issues that may been experienced at the time of the event.

The investigation is managed by the Scottish Fatalities Investigation Unit (SFIU) under the COPFS. The work of taking statements is done by Police officers working with the Procurator Fiscal Service, most of whom have no expertise in prison custody. An FAI involves a public examination of the circumstances of a death in the public interest. Like most civil and criminal cases in Scotland, an FAI takes place in the local Sheriff Court. FAIs in prison cases are heard by different Sheriffs depending on which area the death has occurred and the availability of Sheriffs. Only in a very small number of cases is an expert opinion sought on prison management issues.

The FAI is defined as a: "... fact-finding procedure rather than fault finding … not to establish civil or criminal liability. Witnesses cannot be compelled to answer any questions which may incriminate them, and the Sheriff's determination may not be founded upon in any other judicial proceedings … to encourage a full and open exploration of the circumstances of the death." The Scottish Government states that the purpose of the FAI is to expose systematic failing and is deemed critical for the maintenance of public confidence in the authorities. This does not appear to be the case in practice. The Sheriff in conclusion makes a determination as to the time, place, and cause of death and can make recommendations as to how deaths in similar circumstances may be avoided in the future. It is noticeable that very few FAI determinations include recommendations to improve practices or prevent future deaths. In over 90% of all FAIs, no finding of a reasonable precaution is made, no finding of defect is made, and no recommendations are made to improve practice or prevent death. However, significant findings and concerns following one FAI led in 2019 to the SPS undertaking a comprehensive review of one of their key operating protocols, some considerable period after the incident.

Following the consultation in 2014, the Scottish Courts and Tribunals Service (SCTS) now has responsibility to disseminate the determination and recommendations to all relevant parties. The relevant parties are then to respond in writing within eight weeks, and this is published. If no response is given, this is also published by the SCTS.

The DIPLAR process was piloted across prisons and NHS Boards for two years prior to being formally introduced in November 2018 and was intended as a joint process between the SPS and the NHS. The DIPLAR process was amended in February 2020 to introduce a level of external oversight into the process, whereby if a death appeared to be unexpected or self-inflicted, then the DIPLAR meeting must be chaired by a Non-Executive Member of the SPS Advisory Board. However, as the Chair is a member of the SPS board, the human rights requirement of independence in an Article 2 loss of life investigation requires that those carrying out the investigation are independent of the events, in terms of institutional connection and practically. As the Chair is a Non-Executive Member of the SPS Board, there is an institutional connection which undermines the independence of the process.

The DIPLAR process is currently being amended to incorporate input from families and responses to actions more explicitly.

---

c. What is the level of forensic medical involvement in the investigation of deaths in custody (e.g., is a full post-mortem investigation required in every death in custody?

The need for post-mortem investigations is determined by the SFIU, which deals with all deaths in custody. The decision is based on initial details and a pro forma report, a full sudden death report by police, including medical conditions, any visits to medical centres, and concerns, and CCTV within the establishment.

The cause of death is established by the pathologist, with an 'interim' cause given at this point, although the final determination can take weeks and, in some cases, even months. Most families consulted for the Review spoke of having to wait at least two weeks after a death until after the post-mortem. This too could vary, however. In one extreme case, the family did not get the body back for six months.

---

d. Availability and use of national or international protocols? (e.g., do investigations follow the United Nations Principles on the Effective Prevention and Investigation of Potentially Unlawful Death (2016))?

In addition to the European Convention on Human Rights (ECHR), the UK has ratified a number of international human rights treaties which are binding on the UK and Scottish Governments. These include, for example, the International Covenant on Civil and Political Rights, the Convention against Torture, and the Convention on the Rights of the Child. There is a significant body of international guidance which reflect and interpret these international obligations, providing a point of reference for good practice in the treatment of prisoners and prison management. When a life has been lost in circumstances that may engage State responsibility, there is a duty to undertake effective investigations. This is often referred to as the procedural aspect of the Article 2 right to life. The obligation to investigate extends to all cases of alleged breaches of the obligations. The purpose of an investigation under Article 2 is to secure the effective implementation of domestic laws safeguarding the right to life and to ensure accountability for deaths that have occurred under a State's responsibility. State authorities must act of their own motion once a matter has come to their attention. It must not be left to family members to lodge complaints before investigations are triggered.

The standards of investigation can be summarised as follows:

- **Independence**. Those carrying out the investigation must be independent from those implicated in the events. This requires "not only a lack of hierarchical or institutional connection but also a practical independence".

- **Adequacy**. An adequate investigation is one that is capable of gathering evidence sufficient to determine if the behaviour or inactivity was unlawful. Investigative authorities must take reasonable steps to secure evidence concerning an incident. Where there has been a use of force by State agents, the investigation must be adequate and effective in that it should be capable of leading to a determination of whether the force used was justified.

- **Promptness and reasonable expedition**. The European Court of Human Rights has stressed that a prompt investigatory response is generally regarded as essential in maintaining public confidence in a State's adherence to the rule of law and in preventing the appearance or perception of a State's collusion in or tolerance of unlawful acts. The Court has also found that the passage of time is liable to undermine an investigation and will compromise its chances of it being completed.

- **Public scrutiny and participation of next of kin.** In all cases, there must be involvement of a deceased's next of kin to the extent necessary to safeguard their legitimate interests. There will often be a lack of public scrutiny of Police investigations; however, this can be compensated for by providing access for the public or the victim's relatives during other stages of the available procedures.

There is a substantial body of international legal standards and guidance relevant to deaths in custody. In common with the rights protected under the ECHR, international human rights law protects the right to life and freedom from torture, inhuman, and degrading treatment, and stresses the heightened duty of States to take necessary measures to protect the lives of people deprived of their liberty, which includes providing necessary medical care, shielding from inter-prisoner violence, preventing suicide, and providing reasonable accommodation to disabled prisoners.

International human rights law also stresses the need for appropriate investigations into arguable breaches of the right to life. Investigations must be independent, impartial, prompt, thorough, effective, credible, and transparent. The involvement of a deceased person's next of kin in the investigation is also of paramount importance.

A number of resources have been developed on the response to deaths in custody, providing State authorities with detailed guidance on the requirements. Resources include the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules 2015), the UN Manual on the Effective Prevention of Extra-Legal, Arbitrary and Summary Executions (known as the Minnesota Protocol); the Council of Europe CPT Effective Investigation of ill-treatment: Guidelines on European Standards, and the Bangkok, Beijing, and European Prison Rules. These various resources consolidate international expertise and best practice and provide useful benchmarks for assessing domestic arrangements for the prevention and investigation of deaths in custody.

The UN Convention on the Rights of the Child contains a number of important provisions relevant to those aged under 18, with particular emphasis on the need to reduce detention to a minimum, particularly pre-trial detention; the application of child-friendly policies and practices, with appropriately trained personnel; and the need for the systematic collection and analysis of disaggregated data and regular evaluations of the effectiveness of measures taken.

The FAI process is currently the principal way in which Scotland addresses the procedural requirement of the right to life in relation to deaths in custody. Assessment of compliance with the requirement for an effective investigation would involve consideration of the whole process. It was therefore not within the remit of

the Independent Review of the Response to Deaths in Prison Custody to consider whether Scotland is complying with the procedural aspect of the right to life by conducting an effective investigation, as consideration of the FAI process is out with that remit.

However, it is appropriate to apply the requirements for effective investigation in Article 2 to the whole process. Therefore, in taking a human rights-based approach, the Review had those requirements in mind in reviewing the steps taken immediately following a death, prior to the FAI. In the course of obtaining evidence, concerns were also highlighted by families and SPS and NHS staff which echoed the findings of separate reviews of the FAI process.

In addition to the strict requirements for an effective investigation, it is important that the overall substantive obligation to protect life, including by taking reasonable steps to prevent someone's life being avoidably put at risk, be taken fully into account in considering the approach taken to deaths in custody and the steps in place to ensure appropriate learning and action to prevent recurrence. This is similarly the case for the duty to prevent torture and inhuman or degrading treatment.

Further relevant domestic legislation includes The Corporate Manslaughter and Corporate Homicide Act 2007 which technically applies as a legal recourse to deaths in custody, but in reality (as is the case generally), it is very difficult to apply due to the diffusion of responsibility in organisations. The Mental Health (Scotland) Act 2015 Section 37 refers to the arrangements for investigating deaths of patients being treated for mental disorder who, at the time of death, were in hospital and stipulates that the review must be carried out within three years.

---

e. Are there procedures in place for facilitating the participation of victims' families and their access to effective remedies?

Families report feeling excluded and frustrated with the long delays experienced in the legal system. The imbalance in legal support, lack of timely justice, lack of clarity in the system, accountability, and most of all the perceived lack of compassion conveyed has an emotional toll. The Review published a separate report specifically detailing families' experiences of deaths in custody.

Where communication is evasive or lacking in detail, this also leaves families feeling distrustful, and in Scotland, as outlined, this has been especially stark. A fundamental right for families is proper legal advice and advocacy in the post-death process, and this should be enhanced in the Scottish setting. It is worth noting that, legally, the body of a prisoner belongs to the State and not the family.

Most prominently, families across a range of research bodies found that a lack of individual and institutional compassion was an excessively harmful biproduct of the scant communications they received. The role of the Family Liaison Officer, Narrative Verdicts, a factual statement by the coroner of the circumstances surrounding someone's death, and support agencies such as INQUEST were seen to have addressed a great many of these issues in other jurisdictions, and it is recommended here that these be considered or enhanced in the Scottish setting.

FAIs are usually held in a Sheriff Court, though they can be held in alternative venues. Previous recommendations to hold FAIs in less formal and intimidating settings by, for example, Lord Cullen in 2009 on the Consultation on Proposals to Reform Fatal Accident Inquiries Legislation, have never been implemented. Families and staff both reported that they found the FAI intimidating and adversarial and universally would prefer a less formal setting.

The continued delays in FAIs are highlighted as causing distress to families and de-valuing the process. The Family Liaison Charter only mentions families' right to legal representation in the appendix, and it is therefore a neglected area. In a review of FAIs carried out in 2009, Lord Cullen recommended that families be given access to legal aid so they have representation at an FAI, but this was rejected by the Scottish Government in 2014 following consultation. Other issues raised were that care would need to be taken to ensure that vulnerable families and those with poor English language skills have their voices heard. More recently, it has been raised again that families not being given access to funding for legal representation sits in direct opposition to State bodies and representatives who have unlimited access to public funding and there is a need to 'level the playing field' and for fundamental reform for representation.

In the past, a reduction in self-inflicted deaths of women in prison in England and Wales was reported to be the result of the scrutiny afforded to deficiencies in operational policies and practices at inquests where bereaved families were represented by specialist lawyers, suggesting that the full participation of families improves accountability, and in effect, saves lives.

At present, the Scottish Government is in the process of a consultation about reforming legal aid, and the analysis of responses shows that most are in favour so that families have access to financial support in the event of an FAI.

Wendy Sinclair-Gieben,
HM Chief Inspector of Prisons
for Scotland & UK NPM Chair

Spur Y1,
Saughton House,
Broomhouse Drive,
Edinburgh
EH11 3XD

6 March 2023

Professor Nancy Loucks OBE,
Chief Executive,
Families Outside

17 Gayfield Square,
Edinburgh
EH1 3NX

6 March 2023