Appendices to the Report of the Independent Review of the Response to Deaths in Prison Custody

November 2021

HMIPS
HM INSPECTORATE OF PRISONS FOR SCOTLAND

SHRC
Scottish Human Rights Commission

families outside
supporting families affected by imprisonment

APPENDICES

Independent Review of the Response to Deaths in Prison Custody

Appendix 1

Review Terms of Reference (from the Cabinet Secretary for Justice)

On 7 November 2019, the Cabinet Secretary for Justice requested HM Chief Inspector of Prisons, Wendy Sinclair-Gieben in accordance with section 7(2)(d) of the Prisons (Scotland) Act 1989 to undertake a review into the handling of deaths in prison custody.

The purpose of the review is to identify and make recommendations for areas for improvement to ensure appropriate and transparent arrangements are in place in the immediate aftermath of deaths in custody within Scottish prisons and YOIs, including deaths of prisoners whilst in NHS care. The review will include consideration of deaths of prisoners whether on remand or following conviction. All stages of the review will be grounded in relevant human rights standards.

The review will:

- conduct a comprehensive analysis of the relevant human rights legal standards, at both the European and international levels;
- examine the policies, training and operational procedures in place within the Scottish Prison Service (SPS) and NHS relevant to deaths in custody. This will include arrangements in the immediate aftermath of a death in custody, including the identification and preservation of relevant evidence and the roles and responsibilities of management and individual staff involved in such incidents;
- examine the arrangements in the aftermath of a death in custody, including current processes within the SPS and NHS for the immediate Critical Incident Response & Support (CIRS) process and the subsequent joint Deaths in Prisons Learning, Audit & Review (DIPLAR) process as well as the previous Self-Inflicted Death in Custody: Audit, Analysis & Review (SIDCAAR) Guidance. The DIPLAR process is intended to enable areas for improvement and potential learning to be identified following a death in prison custody (including where the death occurs in hospital) in advance of an FAI. The review should examine the consistency and differences between previous FAI determinations and recommendations and learning arising from the DIPLAR process;
- examine the openness and transparency of arrangements following a death in custody, including communication with family members. To make recommendations for future practice, based on all of the above;
- examine the support arrangements in place for families, SPS and NHS staff and others affected by deaths in custody; and
- examine the views of families impacted by a death in prison custody including preventative approaches which can enable families to raise concerns regarding family members in prison;
- The CiCSG recognises that the cost of this project will incur an estimated £60,000 additional costs out with the HMIPS budget

The review, including evidence gathering and engagement with all stakeholders, will be underpinned by human rights standards throughout, and will draw on evidence from other previous reports and reviews within and external to the SPS and NHS. This should include consideration of the development of the DIPLAR process and relevant findings and recommendations arising from the published reviews by Dr Briege Nugent and the Expert Review of the Provision of Mental Health Services for Young People at HMP YOI Polmont (May 2019).

The Lord Advocate is the independent head of the system for the investigation of sudden and suspicious deaths and COPFS carry out that work on his behalf. The process for any potential criminal investigation or the investigation of deaths by COPFS are out with the remit of the review. The independent Inspectorate of Prosecution in Scotland carried out a thematic review of COPFS arrangements for Fatal Accident Inquiries in 2016, and completed a follow up review, which included arrangements for FAIs arising from deaths of young people in custody, in 2019, both with relevant recommendations.

The review will not consider or comment on the circumstances of individual deaths in custody which are the subject of on-going investigation by COPFS or have not yet been the subject of an FAI or, where there has been an FAI, no determination has yet been issued. It will not consider the deaths of people in police custody or following formal release from prison.

Appendix 2

Letter from Cabinet Secretary for Justice Requesting the Review

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By Email: Wendy.Sinclair-gieben@gov.scot

Wendy Sinclair-Gieben
HM Chief Inspector of Prisons for Scotland
Y Spur
Saughton House
Edinburgh

7 November 2019

Dear Ms Sinclair-Gieben,

I am writing, in accordance with section 7(2)(d) of the Prisons (Scotland) Act 1989 to ask you to undertake a review into the handling of deaths in prison custody.

Deaths in prison custody needs to be seen in the wider context of the prison population. Evidence confirms that Scotland's prisons care for people with higher levels of risk and vulnerability than the population as a whole. People in prison have poorer physical and mental health. Previous tragic deaths, including those of Katie Allan and William Lindsay (Brown), in HMP & YOI Polmont, and Allan Marshall at HMP Edinburgh, and other previous and on-going Fatal Accident Inquiries (FAI), have increased the focus on deaths in prison custody. The FAI into the death of Allan Marshall raised specific questions about the handling of the immediate aftermath of a death in custody.

I wish you to draw on the expertise of Professor Nancy Loucks, Chief Executive of Families Outside to inform the review process. I also understand that you are undertaking preliminary discussions to ensure the review is informed by human rights expertise and external assurance. In particular, this will bring a I would expect the review to identify and make recommendations for areas for improvement to ensure appropriate and transparent arrangements are in place in the immediate aftermath of deaths in custody within Scottish prisons, including deaths of prisoners whilst in NHS care.

The review should also include consideration of deaths of prisoners whether on remand or following conviction. The review will need to be taken forward in close dialogue with the Scottish Prison Service, NHS, Police Scotland and the COPFS Scottish Fatalities Investigation Unit (SFIU). The review should also involve engagement with prison governors, prison officers and NHS staff and with families affected by deaths in prison custody. I have appended the terms of reference for the review to this letter.

As you will be aware, the Lord Advocate is the independent head of the system for the investigation of sudden and suspicious deaths and COPFS carry out that work on his behalf. The process for any potential criminal investigation or the investigation of deaths by COPFS are therefore out with the remit of the review. The independent Inspectorate of Prosecution in Scotland completed a thematic review and follow-up review of the COPFS arrangements for FAIs, including deaths in custody, in 2016 and 2019 respectively, with relevant recommendations.

The review should not consider or comment on the circumstances of individual deaths in custody which are the subject of on-going investigation by COPFS or have not yet been the subject of an FAI.

It would be helpful if the findings of this review could be published during the Summer of 2020. I will ask Neil Rennick, Director for Justice to contact you to discuss arrangements for initiation of the review.

Thank you in advance for your contribution to this important wok.

HUMZA YOUSAF

Appendix 3

Death in Custody Literature Review – May 2021

Dr Briege Nugent and Dr Gemma Flynn

CONTENTS

Acknowledgements

We would like to take this opportunity to thank the Independent Review Panel for commissioning this study and for the team all their support throughout, namely, Wendy Sinclair-Gieben, Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS), Professor Nancy Loucks, OBE, Chief Executive of Families Outside, Judith Robertson, Chair of the Scottish Human Rights Commission, Ewan Patterson and Eleanor Deeming.

EXECUTIVE SUMMARY

Introduction and Aims

The main aim of this Literature Review is the collation and analysis of relevant literature on deaths in custody, to inform the work and recommendations of the Independent Review of the Response to Deaths in Prison Custody. This work focuses on post-death review processes, rather than the conditions that lead to a death in custody.

Methods

A search of literature from over the past 10 years and analysis of particular organisations' publications pertinent to this review were carried out. To help fill gaps in information on the impact on bereaved families in Scotland, media sources were analysed. Interview data with representatives from the Scottish Prison Service (SPS) and responses to direct queries are included. Each source was analysed thematically.

Context: Deaths in Custody and International Standards

Between January 2019 and the end of 2020 there were 71 deaths in Scottish prisons. Scotland has the highest mortality rate in prisons in the UK and above the average when compared to other countries internationally (Aebi and Tiago, 2020). Scotland also has the highest rate of imprisonment of north European Countries (Scottish Centre for Crime and Justice Research (SCCJR), 2019). The key international standards and legal frameworks such as the European Convention on Human Rights (ECHR) Articles 2 and 3, and the Nelson Mandela Rules 71 and 72 emphasise the importance of investigations into deaths in custody being independent, prompt and for the Next of Kin to have an opportunity to participate. These have legal standing and are not just suggested as considerations but as legal rights. The process of responding to a death in custody is covered in legislation and by policy and operating procedures in the SPS and NHS.

Processes of Review and how this compares to England

The initial process of review in Scotland, the Death in Prison, Learning, Audit and Review (DIPLAR) is undertaken by the SPS internally in all cases, except for an expected death of natural causes. In this instance the SPS and NHS can complete the paperwork without a DIPLAR. This process brings staff together to establish learning and has limited 'outside' involvement, with an independent Chair in cases of all unexpected deaths added as a recent development. 'Independent' is defined as someone who is not employed by the SPS but chosen by the organisation and therefore the level of impartiality they have is uncertain. The Governor and NHS Prison Health Board Leads have responsibility to ensure an action plan is put in place with certain timescales, but it is not clear how this is monitored. DIPLAR Reports are not in the public domain but in the Guidance they are referred to as public documents. HMIPS (2019) observed the lack of training of those involved in DIPLARs to maximise learning outcomes from the process and the inconsistency in approaches.

The Scottish Fatalities Investigation Unit (SFIU) begins the process of preparation for the Fatal Accident Inquiry (FAI). In cases of suicide where the person has had prior contact with the NHS, the NHS carries out a separate review, but it is unclear if this is communicated back to the SPS. The FAI is the main independent process of review. From the point of death to the FAI beginning is currently around two years, and in some cases much longer because of delays, seriously undermining the value of the process as raised by a thematic Review of FAIs in 2016 and a follow-up report in 2019 carried out by the HM Inspectorate of Prosecution in Scotland. The Sheriff makes a determination and recommendations to prevent future deaths, but there is no statutory obligation for these to be addressed, and therefore there is an accountability gap identified in the literature with a lack of enforcement and follow-up.

In contrast to Scotland, in England and Wales the investigations are independent, carried out by the Coroner and Prisons and Probation Ombudsman (PPO). There are similarities in the delays experienced, and because of the number of agencies involved the responsibility recommendations and who is responsible is not clear, with limited follow-up to ensure implementation or progression.

Communication and treatment of bereaved families

In Scotland, the guidance indicates that the police break the news of death to families, and the Chaplain makes contact to offer support and act as a liaison to relay their concerns at the DIPLAR, because the families are not permitted to attend (SPS, 2020b). In 2020 the SPS issued a Governor's and Manager's Action stating that it is the responsibility of the Governor to identify a Senior Manager to provide any necessary feedback to the Next of Kin and not the responsibility of the Chaplain. The SFIU and the Procurator Fiscal (PF) are then supposed to make direct contact with the family, offering to meet with them face-to-face and informing them throughout of the process. In Scotland, a review by HM Inspectorate of Prosecution in Scotland noted that this contact with families is good practice, and the Crown Office Procurator Fiscal Service's Family Liaison Charter has been highlighted in this report as good practice. Unlike State bodies, families are not immediately entitled to legal representation, unless they can afford it or are aware of and qualify for Legal Aid. This is currently under review in Scotland, with broad support for this to change.

In England, based on the Prison Instructions, the communication with bereaved families in theory appears to be handled more directly. The Family Liaison Officer (FLO), who has a similar role to the Family Contact Officer in Scotland, should break the news to the family face-to-face and gives them an open, detailed account of the death. The Governor should write a letter of condolence, reporting the agreed action plan, arranging for property to be handed over and for a service to be carried out in remembrance, as well as offering to help with funeral costs. The Clinical Reviews commissioned by the NHS in England can include families but in practice do not. In the English system, the final stage of review is carried out by the PPO who make direct contact with families, however, 32% of families have reported wanting more communication (PPO, 2019). Families are not immediately entitled to legal representation unless they qualify for Legal Aid, and the evidence suggests that full participation of families at inquests improves accountability, and in effect, saves lives (Coles and Shaw, 2007).

Impact on Families

There is a dearth of research on the impact of death in custody investigation processes on families. This review has drawn from testimonies from families who participated in the Harris Review in England through Family Listening Days, research carried out by the organisation INQUEST in England, alongside an analysis of comments by families who have engaged with the tabloid press. These give voice to the deep dissatisfaction and sense of injustice felt by families affected. 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 Harris Review concluded that the neglect of families points towards 'institutional insensitivity' and the need to shift practice away from the dominance of security considerations, towards taking account of and accommodating a grieving family, as they would in a palliative care setting.

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 it is argued in this review that this should be enhanced in the Scottish setting. In communicating with families, information should be delivered as soon as possible, but bearing in mind the difficult process of grief, may mean that information is not always retained. It is worth noting that, legally, the body of a prisoner belongs to the state and not the family. Research indicated that particular sensitivity is needed around the issue of seeing the deceased's body and that this should be accommodated as a priority in the post-death process. Families involved in research in Listening Days (INQUEST, 2018) also expressed suspicion towards the investigations, which did not always include their perspectives. Families regularly viewed this as evidence of the Prison Service prioritising damage limitation over an objective search for truth *(ibid*). Most prominently, families across a range of research bodies found that a lack of individual and institutional compassion was an excessively harmful bi-product of the scant communications they received. The role of the FLO, 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.

Prison and NHS Staff Perspectives

In Scottish prisons, help for staff following a death is provided through the Critical Incident Response and Support (CIRS) policy, which is not mandatory and involves an assessment of support on a one-to-one basis or within a group. This can lead to support such as counselling being provided through the Employment Assistance Programme, which is delivered by an independent body. NHS staff can also self-refer to this and also have their own separate support structures in place. There is little research evidence available about the effectiveness of either of these processes, which should be a focus of concern (Nugent, 2018). High levels of trauma were reported by staff that had been in contact with self-inflicted deaths in

prison, and the limited research indicated the extensive emotional difficulties felt by staff in this context. In terms of post-death reviews, staff felt unfairly blamed and subject to 'institutional anxiety', where the perceived blame-attribution element of inquests meant that reflections on future good practice were practically non-existent. Where support can be provided for staff, it should aim to address their significant emotional needs at this difficult time and also provide staff with information to convey to the broader prison. The significant lapse in time between death and completion of an FAI has the effect of keeping prison staff in a position of having to justify their practices sometimes years after the event. This also has the effect of moving staff towards dependence on administrative process, again hindering their ability to employ significant accumulated experience in improving conditions. Therefore, broader reforms of the post-death process, which are expressed by families as necessary are also shared by prison and NHS staff.

Impact on Other Prisoners

People in prison often have backgrounds of trauma, loss and bereavement. Due to the significant and meaningful interpersonal relationships found within prisons, the emotional impact of the death of another prisoner can be extensive. Following a suicide, fellow prisoners are especially vulnerable to committing suicide themselves. The same frustrations with delays and the lack of transparency with the current investigation processes add stress to an already difficult situation. Compassion can be extended to people in prison by recognising these challenges, in particular through sanctioned acknowledgements of death and grief, as well as forms of support such as bereavement counselling where possible.

Recommendations

- In light of the international standards for review processes to be independent and transparent, the DIPLAR system should be reviewed, and this process shifted to being undertaken by an independent body.

- The contact with families post-death by the SPS is minimal and could be perceived as cold and unnecessarily defensive. The practices developed in theory in England and Wales, with the FLO and the Governor making contact and being open with families about the details of the death from the start, should be adopted in Scotland.

- The contact with families by the SFIU, as set out in the COPFS Family Liaison Charter, is good practice, and this proactive approach should be adopted by the SPS and any agencies developed in relation to review of deaths in custody in the future.

- At present, families have limited input into processes, and the connections to support in the community may not be happening. It has been observed that families of people in prison are often regarded as no one's responsibility (Loucks, 2019), and this needs to end. Policy and practice need to be informed by those with lived experience who are affected by it.

- FAIs are still taking around two years to happen from the point of death, and therefore the legal standard for reviews to be prompt is not being met. This research brings to light that this lack of timely justice affects families, staff and prisoners adversely. Sheriffs make recommendations, but these are not legally binding, and follow-up does not currently happen. It is recommended that Sherriff's recommendations are placed on a statutory footing.

- This report supports the recommendations made by HMIPS (2019) for the need for co-ordination of reviews, with further analysis of comparative data on suicides, and to consider international evidence. It is further recommended that consideration be given to having one independent body that takes account of all deaths in custody, including natural deaths, and that is able to understand trends and follow-up on recommendations with statutory powers to make decisions legally binding. This body should also ensure that, at every stage, families are informed and their views taken into account.

- There are a number of particular gaps in research identified, namely the impact on families, prison staff, NHS staff, and prisoners of the death of someone in prison. These warrant specific studies to help explore and understand more about current challenges and mechanisms of support.

- This research brings to the fore the need for compassion and a human rights-based approach to inform processes. In this context, compassion relates to no death being seen as the same, with an acknowledgement that no individual deals with grief in the same way, and a person-centred approach taken. It is important that families, staff and prisoners get access to the support they need and that institutional and structural barriers to asking for help are challenged.

1. Introduction, Aims and Overview

The main aim of this Literature Review is the collation and analysis of relevant literature on deaths in custody, to inform the work and recommendations of the independent review.

Methods

The review focuses on literature published between 2010 and 2020 and on the responses to deaths in prison custody, with a focus on examples from Scotland, but also from the UK as a whole and internationally, and including the legal standards that affect this area. A standard literature review approach was adopted initially using the main search engines provided through University of Edinburgh, ProQuest Platforms, as well as Google Scholar. Search terms related to: deaths, review, custody, prison, suicide, family, fatal accident inquiry, hospital, and palliative. The search was ordered in terms of relevance and the first 100 abstracts of each of the searches carried out.

It was apparent though that, because of the dearth in academic focus on this area, 'grey literature' or publications not peer reviewed are especially important and would not necessarily be found using this process. Therefore the team also focused on reviewing particular organisations' publications, namely the HM Inspectorate of Prisons for Scotland (HMIPS), Prison Reform Trust, INQUEST, the Independent Advisory Panel on Deaths in Custody in England and Wales, the Howard League for Penal Reform, Care Quality Commission, SCCJR, the Council of Europe, Equality and Human Rights Commission (EHRC), the Scottish Prison Service (SPS) and the Scottish Government. A gap specifically of the voices of families and research into their views about processes in Scotland was supplemented by a review of media reports. Interview data with SPS personnel or responses given to queries as part of this review are also included. The Independent Review Team also provided advice and support throughout.

Limitations

The main limitation for this review is the dearth of research on this subject, indicating that it is a neglected focus of enquiry in criminology. The views of bereaved families, prison and NHS staff and other prisoners, to understand about the impact of the existing process and current mechanisms of support following a death in custody, is limited. As will be discussed in the recommendations, these gaps in knowledge also point towards the need for these processes to be independently carried out, transparent and open so that there is public accountability, and to inform a human rights-based, compassionate and appropriate response.

Structure of this Literature Review

- Section 2 sets out background information on deaths in custody, drawing on statistics from both Scotland and England and Wales.

- Section 3 sets out the key international standards and bodies of review that influence investigation of deaths in custody.

- Section 4 sets out the different stages of the review process in Scotland for deaths in custody.

- Section 5 presents the review processes in England and Wales. The reason for this is that it is the only system found which has been clearly documented, and though not without fault, has areas of good practice the Scottish system would benefit from adopting.

- Section 6 focuses on the research of the impact on families who have experienced a death of a family member in custody, processes of review and current published support mechanisms.

- Section 7 focuses on the research on the impact on staff of experiencing a death in custody and processes of review, and the current published support mechanisms.

- Section 8 presents research on the impact of prisoners of experiencing a death in custody and processes of review, and current published support mechanisms.

- Section 9 presents the conclusion and recommendations.

2. Context: Deaths in Custody

Key Findings

- Any death in prison is a tragedy. Between January 2019 and the end of 2020, Scotland has recorded 71 deaths in prison.
- The number of natural deaths in particular is likely to rise with the ageing prison population.
- A high number of suicides happen within the first six months of custody, and past research highlights that those on remand are at high risk.
- Scotland has the highest rate of imprisonment and the highest mortality rate within prisons in the UK, based on 2018 figures.

A comparison of data provided by the World Prison Brief shows that Scotland has one of the highest imprisonment rate (143 prisoners per 100,000) of Northern European countries (SCCJR, 2019). Iceland for example in comparison, the figure per 100,000 is at 37, Northern Ireland is 76, and England and Wales 140. Any death in prison is a tragedy and over the past ten years the numbers have continued to rise. By the end of 2020, there were 34 deaths in custody in Scottish prisons, and 37 deaths the previous year. The following table provides a breakdown of the figures and these are based on an analysis of information provided from the Scottish Prison website. Five deaths in 2020 were COVID-19 related.

Categorisation of Deaths	2019	2020
Suicide	14	5
Natural Cause - Sudden	9	10
Natural Cause - Expected	10	7
Homicide	0	1
Undetermined or cases of overdose	4	11

Past research shows that those on remand are especially at risk (World Health Organisation, 2007; PPO 2014). Although not a new observation, it is worth noting that, with the ageing prison population, the number of natural sudden and expected cases is likely to increase. Following a similar trend both nationally and internationally, a high percentage (37% this year and 32% in 2019), of those who died did so as a result of suicide within the first six months of their time in prison. Suicide is the leading cause of death of young people (aged 24 or under) in prison in

Scotland as well as internationally, with Scotland having higher a rate than England and Wales, though comparisons are complicated (Armstrong and McGhee, 2019).

To give some comparison, the number of deaths in custody in England has been described by INQUEST and echoed in press reports in Scotland, as a 'national scandal' that requires immediate and urgent attention. Understaffing and underfunding, as well as successive governments refusing to grasp the true nature of the crisis, are identified as the core reasons (INQUEST, 2016). Since 2016, the number of deaths (*ibid*). In England, in the 12 months to June 2020, there were 294 deaths in prison custody - a decrease of five per cent from 309 deaths the previous 12 months, 25 of which COVID-19 was a contributory factor (Ministry of Justice, 2020).

The Council of Europe published figures on the mortality rate of the prison population in 2018 within each country (Aebi and Tiago, 2020).[1] Scotland's mortality rate is high (47.6 per 10,000), and above the average of 30.4 per 10,000), which is also higher than England and Wales (39.5) and Northern Ireland (33.2). The statistics also show that Turkey has one of the lowest rates of mortality (4) and gives rise to questions about how data is being recorded (İnsan Hakları Derneği (İHD), 2020). Norway and Sweden also have one of the lowest figures, at just over nine per 10,000 (Aebi and Tiago, 2020). While statistics provide quantitative information on trends, the human stories are hidden from view (INQUEST, 2016).

Cost of Suicide in Prisons

The average cost of a completed suicide in the general population has been estimated as £1.67m (Howard League, 2016). In 2015, the 95 suicides that took place in prison in England that year are estimated to have cost at least £160m and as high as £300m. These costs include police investigation, coroners' costs, PPO investigations, and the cost of legal representation (*ibid*).

Conclusion

Scotland has recorded 71 deaths in prison over 2019 and 2020. Over the past ten years the number of deaths has continued to rise. The number of suicides in 2019 were particularly high, and the number of natural sudden and unexpected deaths are likely to increase with the ageing prison population. Scotland is reported to have the highest mortality rate in the UK and the highest rate of imprisonment, and the processes post-death, although an area where little research has been carried out in the past, deserve attention and scrutiny.

[1] The mortality rate per 10,000 inmates is calculated by dividing the total number of inmates who died in 2018 by the total number of inmates on 31st January 2019 (used as a proxy for the prison population in 2018), and multiplying the result by 10,000. Therefore, it is not an exact science, and caution needs to be taken when drawing on these statistics, but they do give some sense of comparison.

3. Key International Standards and Review Processes

Key Findings

- The legislation, standards and relevant case law emphasise the importance of investigations being independent, prompt and for the Next of Kin to have an opportunity to participate.

The following legislation and standards were identified as being applicable to the investigation of deaths in custody in Scotland:

The European Convention on Human Rights (incorporated in Scotland in 1998) Article 2 protects the right to life, and **Article 3** prohibits torture or inhuman or degrading treatment or punishment. There is a positive duty on states to investigate following any death in state custody (*Edwards v UK*).

The Convention Against Torture and other Cruel, inhuman or degrading treatment of or punishment (CAT) Article 14 - competent authorities should proceed to a prompt and impartial investigation when there are grounds to believe torture has been committed.

The International Covenant on Civil and Political Rights Article 6 is the right to life, and **Article 7** prohibits torture. The Human Rights Committee interprets Article 6 to involve the need for investigations into allegations of breaches to be independent, impartial, prompt and to inform the Next of Kin and to give them legal standing into any investigations.

The Body of Principles for the Protection of all persons under any form of detention or imprisonment was adopted by the UN General Assembly in December 1988. **Principle 34** orders that where there has been a death in custody, an inquiry shall be held by a judicial or other authority and the report made available.

The Nelson Mandela Rules (2015) are the UN's Standard Minimum Rules for the Treatment of Prisoners. **Rule 71** refers to investigations of death needing to be independent from the prison administration, prompt, impartial and effective. **Rule 72** emphasises that the body is treated with respect and dignity and returned to the Next of Kin, and a culturally appropriate funeral facilitated.

Her Majesty's Inspectorate of Prisons for Scotland (HMIPS), the Prisons and Probation Ombudsman (PPO), the Harris Review, academics writing in this area and charitable organisations all reflect on the importance of prison overcrowding as a factor leading to deaths in custody (Tomczak, 2019; INQUEST, 2020; INQUEST, 2018). Rule 1 of the Nelson Mandela Rules states that:

> "All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoners shall be subjected to, and all prisoners shall be protected from, torture and (…) other ill-treatment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times."

There has been very little literature to date on the impact of COVID-19 on the prison system, but the Association for the Prevention of Torture (APT) has recently highlighted the importance of the Mandela Rules in strengthening the role of the National Preventive Mechanism (NPM) in monitoring the responses in prison to the pandemic and upholding Rule 1.[2]

United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules, 2010) address the specific needs of women in prison and calls for gender-sensitive non-custodial measures.

The **UN Pocketbook of International Human Rights Standards for Prison Officials** states with regards to complaints and inspection procedures:

> "There shall be thorough, prompt and impartial investigation of all suspected cases of extra-legal, arbitrary and summary execution, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances."

International Committee of the Red Cross (ICRC) Guidelines for Investigating Deaths in Custody emphasise the basic standards for investigations to clarify the circumstances of deaths and to reduce trauma prohibiting an effective remedy for the Next of Kin and prevent the recurrence of deaths (Gaggioli and Elder, 2017).

Further Relevant Domestic Legislation

The **Corporate Manslaughter and Corporate Homicide Act 2007** 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 (Doyle and Scott, 2016).

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.

[2] To view the article, please refer to: https://www.apt.ch/en/news_on_prevention/nelson-mandela-rules-5-years-prohibition-torture-more-relevant-ever

Relevant Case Law

The case of *Edwards v. United Kingdom* in 1992 in the European Court of Human Rights laid down the principles that must be followed when investigating a death in custody. An investigation must be:

(a) Instigated by the state (a negligence action taken by the deceased's family will not suffice);

(b) Independent of those implicated in the death, both institutionally and in practice;

(c) Prompt and open to public scrutiny (to maintain public confidence);

(d) Be capable to giving rise to a finding of responsibility and to enable the eventual prosecution of those responsible through the acquisition of relevant evidence;

(e) Give the Next of Kin of the deceased an opportunity to participate.

Current Review Processes the UK are Subject to:

The Council of Europe, Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) is a specialised independent monitoring body of the Council of Europe. It is not an investigative body but provides a non-judicial preventive mechanism to protect persons deprived of their liberty against torture and other forms of ill treatment, complementing the work of the European Court of Human Rights. The CPT visits places of detention in every member state once every four years to see how persons deprived of their liberty are treated. At the end of the visit, the CPT relays its preliminary findings to the Government, followed by a report with recommendations. The CPT requests a response and engages in confidential dialogue regarding the implementation of recommendations. In 2018, the CPT visit to the UK resulted in a critique of the excessive lengths of time that it takes Fatal Accident Inquiries (FAIs) to be opened and concluded (Council of Europe, 2019).

In 2019, the Prison Reform Trust submitted evidence to the CPT to raise concerns about the rise in number of deaths in custody in England and Wales. They also emphasised that the PPO (2018) has noted the drug related deaths, the level of mental health issues and need for suitably skilled healthcare professionals, and called for a strategy for older prisoners considering the rise in deaths of natural causes. The PPO had reported finding inhuman treatment of those in prison who were elderly, frail and/or very unwell with limited mobility and being escorted to hospital in handcuffs and restrained until shortly before they died.

The United National Human Rights Office of the High Commissioner and the Committee Against Torture (CAT). The Committee Against Torture (CAT) is a body of 10 independent experts that monitors implementation of the Convention against Torture and Other Cruel, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment by its State parties.

The Association for the Prevention of Torture (APT). The APT is an international non-governmental organisation based in Geneva, founded in 1977 with a focus on preventing torture. It supports governments, justice systems, National Preventive Mechanisms (NPMs), national human rights institutions (NHRIs) and society to take effective actions to prevent torture and other ill treatment. HM Inspectorate of Prisons for Scotland (HMIPS), Healthcare Improvement Scotland (HIS), the Care inspectorate and Scottish Human Rights Commission (SHRC) are four of the 21 bodies that comprise the UKs NPM, which has a duty regularly to monitor the treatment of detainees and the conditions in which they are held.

The High Commissioner for Human Rights and Office of the High Commissioner for Human Rights – OHCHR assists Governments to implement international human rights standards, including expertise and technical training in the areas of administration of justice, legislative reform, and electoral processes. In 2019, the EHRC submitted a report to the UN Committee Against Torture in response to the list of issues raised in the UK. This noted that the number of non-natural deaths in custody remains a serious concern and raises questions about the treatment of prisoners with mental health problems. They also recommended introducing a statutory obligation on prisons and youth custodial institutions to respond to recommendations from investigations into deaths in custody by publishing an action plan.

The Equality and Human Rights Commission (EHRC). The EHRC is Great Britain's national equality body established by the Equality Act 2006 to operate independently, and is responsible for enforcing the Equality Act 2010, and to be an authoritative organisation on equality and human rights law.[3] The EHRC has carried out a number of reviews over the years in relation to deaths in custody. In 2015, there was a specific focus on reviewing adults with mental health issues who had died in prison, police cells and hospitals in England (EHRC, 2015). One of the recommendations was that structured approaches for learning lessons should be established, and a statutory obligation on institutions to respond to recommendations from inspectorate bodies to be published.

National Preventive Mechanism (NPM). The United Kingdom is a signatory to the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The UK NPM was established in 2009 to strengthen the protection of people in detention through independent monitoring. HMIPS, the SHRC and Mental

[3]To see more please refer to: www.equalityhumanrights.com

Welfare Commission are three of the 21 bodies that comprise the UK's NPM, which has a duty regularly to monitor the treatment of detainees and the conditions in which they are held.

Other External Sources

It is important to recognise the influence of other organisations such as the Howard League Scotland that also play a role as an independent organisation for penal reform and in the review of deaths in custody.

Conclusion

This section outlined the international standards, domestic law and organisations that provide scrutiny in Scotland about deaths in custody and makes it clear that this is an area that warrants rigour and a focus on scrutiny. The emphasis on the standards is for reviews to be independent, transparent and prompt, with families able to participate in the process. These standards have legal standing and therefore are not something Scotland could consider applying but are legally obliged to do so.

This review also highlights the dialogue that exists between agencies with the SHRC raising issues with the Human Rights Commission and Treaty bodies on behalf of Scotland, for example, whereby concerns have been raised about the delays in the legal process around FAIs. These bodies also offer support to organisations such as the HM Inspectorate of Prisons for Scotland.

4. The Processes of Review in Scotland

Key Findings

- The support processes for staff by way of counselling offered following a death generally have a low uptake.

- There is no specific guidance about what support should be offered to other prisoners and no consistent approach across the estate or systematic follow-up.

- The first stage in the review process, the Death in Prison, Learning, Audit and Review (DIPLAR) process, is internal and carried out jointly by the SPS and NHS, bringing all relevant staff together to establish learning. Attendance is voluntary and has limited 'outside' involvement. An 'independent' Chair in cases of suicide or drug-related death is a recent development. Independence is defined as someone who is not employed by the SPS, but they are still chosen by the organisation, and therefore the level of impartiality they have is uncertain.

- The Governor and NHS Prison Health Board Leads have responsibility to ensure an action plan following a death is put in place with certain time scales, but it is not clear how this is monitored or followed up.

- The DIPLAR Reports are not in the public domain and are sent to the Scottish Fatalities Investigation Unit (SFIU), although delays have been an issue in the past, and their value questioned.

- The separate NHS review in cases of suicide sits apart from the DIPLAR, and it is not clear if this information is shared or how it is followed up.

- The first point of contact with families following a death is the police, and further contact from the prison is through the Chaplain, who theoretically acts as a liaison to relay the families' concerns at the DIPLAR. HMIPS suggests that the family liaison role should be for the prison to advise the family who the Independent Chair is and ask if they have any questions. Recently, the SPS has made it the responsibility of the Governor to identify a Senior Manager to provide feedback and respond to the Next of Kin.

- The independent Scottish Fatalities Investigation Unit (SFIU) gathers evidence for the Fatal Accident Inquiry (FAI).

- The FAI is the main independent process of review. The Procurator Fiscal (PF) calls witnesses. The PF makes contact with the family from the outset and communicates with them throughout, and the Family Liaison Charter is highlighted as good practice. Unlike the State bodies, families are not entitled to public funding for legal representation unless they are eligible for legal aid, although this is currently being reviewed.

- It can take years for an FAI to take place, and the evidence would suggest that there is minimal contact is made by the prison to the bereaved family throughout.

- At the conclusion of the FAI, the Sheriff makes a determination about the time, place and cause of death and recommendations as to how deaths in similar circumstances may be avoided in the future. However, the recommendations made are not on a statutory footing and there is a lack of enforcement and follow-up, and therefore an accountability gap with relevant agencies only obliged to respond about how they may or may not fulfill the recommendations.

Introduction and Overview

The process outlined below is the immediate response and what happens in Scottish prisons following a death, before discussing the review process carried out by the SFIU and through the FAI.

The Immediate Response

No SPS policies were identified that set out what happens to the body, but in response to queries raised in this review, SPS reports that, following a death in custody, Police Scotland takes control of the scene and possession of the body. Any request to view the body of someone who died in custody is the responsibility of Police Scotland and the PF. A more detailed discussion of the family's contact with the body is given in section 6. It is only in 2020 that there is some written guidance provided by SPS that makes reference to the ongoing practice now established, that it is the police who break the news of the death to the family (SPS, 2020b).

The focus in the written Guidance on the immediate response when a death in custody takes place is that the Critical Incident Response & Support (CIRS) policy is initiated. The Policy sets out that this involves a staff support meeting which takes place as soon as possible after the incident and is discussed in more detail in section 7 (SPS, undated). All staff involved in the incident are offered the opportunity to attend, including the NHS and external partners. The purpose of the meeting is to ascertain the wellbeing of staff and not to talk about the incident (SPS, 2020). The evaluation of 'Talk to Me' (TTM) (Nugent, 2018) noted that, in the privately-run prisons, the CIRS process is replaced by the Post-Incident Care Team (PICT). Following a death, staff are also brought together in the same way as with CIRS, checked by the nurses and offered support.

Subsequent to the CIRS, a DIPLAR is held within 12 weeks of the death. The DIPLAR Guidance makes reference to the need to record how the incident has impacted upon other prisoners, but it doesn't give details about how staff should give or receive support. SPS representatives reported as part of this review that Chaplains and staff talk with known friends of the deceased or those who are in the same residential location, however a process for this is not documented. Following a death by suicide, event of undetermined intent or drug-related, NHS staff must report the incident through NHS clinical governance adverse event management processes

(e.g. Datix/incident reporting system). The NHS may complete an adverse event review either prior to or following the DIPLAR.

Police, who may have had no experience of the prison system, have first responsibility for notifying the family, after which the Chaplains make contact with the families on behalf of prisons (SPS, 2020b). According to the COPFS (2016) in the Family Liaison Charter, the police may appoint a FLO to keep the family informed about the progress of the police investigation. A FLO is an "experienced police officer who has been specially trained to provide information to bereaved family members. At an appropriate stage in the investigation, this role will be transferred to COPFS staff" (*ibid: 11*).

Support Process

The support processes for staff, and in particular the CIRS process, are described in more detail in section 7. The DIPLAR Guidance states that, if a staff member identifies that a crime may have been committed, or there has been a potential breach of policy during a CIRS meeting, the responder would inform a manager, and this would be investigated through normal processes (SPS, 2020).

The support processes for families and prisoners are discussed in section 6, but it is worth noting that there is no documentation about what further support should be offered. It ought also to be recognised that although the Chaplain may be perceived as 'neutral', for some people it could be argued that the religious affiliation may be a barrier to communication. In a review by HMIPS (2019) following two deaths in custody, it was recommended that there should be more opportunities to engage with families both in advance and subsequent to the DIPLAR**,** to ensure their views are heard and considered, and also that the Independent Chair makes contact.

The Death in Prison, Learning, Audit and Review (DIPLAR) Process

From 2018, the SPS and NHS have jointly implemented the DIPLAR process to learn from all deaths. The SPS consulted with legal counsel prior to setting this up. According to the Guidance (SPS, 2020b: 2), the aims of a DIPLAR are to:

> "learn from the incident, consider the circumstances and the immediate actions taken. It examines management processes and practice and how the person was being managed in prison, whether shared practice and service integration was apparent. The process also focuses on how the incident impacted on staff involved, other prisoners, the person's family and the establishment as a whole…The process should not focus negatively on the incident but adopt an objective, critical stance when appraising the information, seeking to identify not just areas in need of development or improvement but also highlighting the reason certain practices and processes were successful in supporting the person during previous difficulties."

The DIPLAR must convene no later than 12 weeks after the death. Following the meeting, the final DIPLAR meeting paperwork must be submitted in eight weeks. However, where there is an ongoing police investigation, the DIPLAR cannot take place until this has concluded.

Staff attendance is voluntary, and as part of this review, the SPS reported that as yet they have had no one opt out of participating.

According to the Guidance, there are three 'levels' of review, namely:

1. Self-Inflicted Death in Prison Review (Suicide or intentional self-inflicted death includes cases where it is clear that the person's intention was suicide);

2. Event of Undetermined Intent Review (cases where it is not clear whether the death was the result of intentional self-harm or accidental); and

3. Natural Causes Death Review (Deaths where there was a known health condition that may have contributed to the death or where it was an expected death due to terminal illness).

The DIPLAR consists of 3 sections:

1. Death in Prison Learning, Audit & Review Report;
2. A Timeline of significant events; and
3. A joint SPS/NHS Learning & Action Plan.

According to the DIPLAR Guidance, attendees at DIPLARs, following a death by suicide or event of undetermined intent or drug-related, should be the Governor-in-Charge or Deputy Governor, Suicide Prevention Co-ordinator, Lay Person and SPS Headquarters (HQ) Health, the NHS Co-chair, NHS Services Manager for Prison Healthcare, NHS Healthcare Manager, Local Suicide Prevention Co-ordinator, Head of Health Strategy, First Line Manager and Personal Officer.

The following people may attend if appropriate:

- HMIPS Lay Person
- Prison Based Mental Health/Primary Care Nurse
- NHS Primary Care/Acute/Community Mental Health Services where there was contact with services in the preceding 12 months
- Chaplain (where they had contact with the individual in custody or the family)
- Social Worker
- Escort Provider where the death occurred in their custody (i.e. in hospital) or where they have relevant information to share
- Any other relevant member of staff including workplace officer, healthcare professional or staff who attended the incident

Where it is a death by natural causes or where there was a known health condition or expected death, the paperwork can be completed jointly by SPS and NHS without the requirement to hold a DIPLAR meeting. This would suggest that the assumption therefore is that there are no lessons to be learned from how a natural or expected death are responded to, and this could be challenged, with DIPLARs instead held for all deaths in custody. Where a meeting is required, the Guidance advises that the Governor or Deputy Governor of the establishment and the NHS Prison Health

Board Lead or Healthcare Manager co-chair are in attendance. It is further advised that the First Line Manager, Personal Officer, Chaplain, Social Worker, NHS health professional involved, Escort Provider (if appropriate) and any other relevant member of staff attend.

The Guidance outlines that 'HQ Health' from SPS has several roles within the DIPLAR process. These are namely to attend all DIPLAR meetings for apparent deaths by suicide or apparent drug related deaths; liaison with the local Suicide Prevention Co-ordinator and the Independent Chair to agree the date of the DIPLAR meeting for apparent drug related deaths and apparent deaths; review the draft DIPLAR within two weeks of being uploaded onto Sharepoint; ensure the learning from DIPLARs is shared across all prisons where appropriate.

The Guidance also states that the Chaplain's role is two-fold:

- to offer support to the family; and
- to act as a Liaison between the family and prison, offering to make introductions and provide information.

In advance of the DIPLAR, the Guidance states that the Chaplain informs the family of the process, offering to bring to the DIPLAR any specific concerns or questions that the family would like to express as, due to the impending FAI, the SPS is not in a position to invite the family. As already stated, more recently, the SPS has established that it is the role of the Governor to appoint a senior manager to provide feedback to the Next of Kin following the DIPLAR (SPS, 2020).

The DIPLAR Guidance states that it is the responsibility of the establishment's Governor in Charge or Deputy Governor to ensure staff attending are aware of the process and supported. Separate to the DIPLAR they can implement an investigation under the Code of Conduct Policy 2018 where unacceptable practices or behaviours are identified during the DIPLAR. The Guidance also states that, where a Code of Conduct investigation is required or ongoing, the 'SPS Chair of the DIPLAR must seek advice from their local Human Resources team to determine what can be discussed as part of the DIPLAR meeting and if individuals under investigation can attend'.

In the evaluation of the 'Talk To Me' suicide prevention strategy (TTM), the limited review of DIPLARs consisted of interviews with staff from four establishments where there had been a death in the past two years, attendance at a DIPLAR and an analysis documentation (Nugent, 2018). This was reported to be an effective way of preserving evidence, communicating with appropriate parties and recording learning and identifying actions, but only if approached with openness and honesty and taken seriously. The evaluation also raised concerns about how potential power dynamics within DIPLARs between staff at different levels may inhibit communication (Nugent, 2018). In the review of mental health provision by HMIPS (2019), a number of observations are also made about the lack of training of those involved to maximise learning outcomes from the process, the inconsistency in approaches, and the need for greater independence in advance of the FAI, also recommending independent chairs.

According to the Guidance, any DIPLAR report is a public document and may be shared across SPS to help guide and develop practice. However, as stated earlier, these documents are not actually made available to the wider public. The DIPLAR Guidance states that the documentation will be requested as evidence at a subsequent FAI. Furthermore, a record of learning and actions to be undertaken and associated timescales should be documented in the Joint Learning & Action Plan and signed by the Governor/Deputy Governor and NHS Prison Health Board Lead. It further states that it is the role and responsibility of the Governor to ensure that any actions identified are completed within the agreed timescales.

The recorded instances of the use of the Code of Conduct are held in the case files that are kept in the SPS Healthcare branch of the Strategy and Stakeholder Engagement Directorate. It is unclear from the documentation if this particular information is analysed centrally. However, an analysis of deaths in custody is carried out annually for the SPS Executive Management Team by the SPS Healthcare team and is used internally to provide oversight.

In February 2020 the SPS issued a Governors and Managers Action, which is a formal instruction, requiring Governors to provide quarterly updates to HQ Health on progress against actions (SPS, 2020).

The Suicide Prevention Co-ordinators Forum meets quarterly and reviews all DIPLARs in full to discuss the learning further and implement actions. They also provide a report to the National Suicide Prevention Management Group (NSPMG), which has representation from relevant organisations outside the SPS who are experts in this field, such as the Samaritans, Breathing Space and Families Outside. The group meets quarterly and, up until 2018, had considered all DIPLARs in full. They now have a more strategic role, to consider any changes required to the TTM Strategy and remedial action before the eventual FAI hearing takes place. The NSPMG can raise concerns with Governmental Ministers.

The SPS (2018) issued a Governors and Managers Actions (GMAs) 071A-18 detailing the information establishments are to send to SPS HQ 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 a FAI following the death of a prisoner in custody. The records to be sent are statements from the staff who found the prisoner; incident reports following the death; Talk to Me papers; 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 PF; and Recording of the radio message requesting assistance. The GMA also emphasises the need for the documentation to be relevant and to bear in mind that the papers could be provided to the deceased prisoner's family if they are represented at the FAI (SPS, 2018). Establishments are advised to make a copy of all records and when a request has been made by the PF that the original documentation is sent (*ibid*).

NHS Processes for Possible Suicide

Where the person has had contact with mental health services, the NHS Board must complete a suicide review and produce an action and learning plan, which is submitted to Healthcare Improvement Scotland (HIS) (SPS, 2020b). Some Boards hold a review as a matter of course. Health Boards report to HIS on how suicide review actions have improved the quality of care and reduced suicide risk. There are mechanisms to identifying and sharing learning across Health Boards. Each NHS Health Board has a significant adverse event review process, which may be implemented following a suicide, drug-related or death by natural causes in prison. These may take place prior to the DIPLAR being completed. The time scales for completion of these reviews differ between Health Boards. Some NHS significant adverse events reviews may require the participation of the SPS and on occasions may include a joint learning and action plan that is countersigned by both SPS and NHS. However, it is not clear whether the learning from the NHS Boards is systematically shared with the SPS.

A review of the arrangements for investigating the deaths of patients being treated for mental disorder was carried out in 2018 (Scottish Government, 2018). This concluded that changes are needed so that investigations are more accessible to families and carers, and institutions need to be accountable and responsible for fulfilling human rights. In the cases of suicide, there was a call for a clearer link between scrutiny and improvement (*ibid*).

Second Stage of Review: The Scottish Fatalities Investigation Unit (SFIU)

The SFIU was set up to deal with sudden deaths reported to the PF, including deaths in custody. Based on an interview with a representative from the SFIU as part of the wider Deaths in Custody Review the different steps in the process of review that should be carried out was set out as follows:

SFIU deals with the death from the very outset, which are reported to them immediately by the prison establishment, the hospital or the police.

- They should take initial details and compile a pro-forma report for all deaths with basic information about the deceased.
- They are then to request a full sudden death report from the police, with medical conditions, visits to medical centres and any concerns that have been voiced.
- If the death was a suicide, SFIU should get details from the police and if it involved anyone else within the establishment, the means for how it was carried out and any concerns.
- CCTV within the establishment should be reviewed, to check whether there was any contact between the deceased and staff or other prisoners.
- The SFIU then consider whether there is the need for a post-mortem and any sign of criminality. If so, this should be organised through the mortuary and pathologist. 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.

In terms of contact with the Next of Kin, the representative from the SFIU reported the following stages of contact to be carried out, in keeping with the commitments set out in the Family Liaison Charter:

1. Contact the bereaved family by phone to inform them if a post-mortem examination is necessary.

2. Contact by phone the bereaved family on receiving confirmation of the initial cause of death and confirm they can proceed with funeral arrangements.

3. If unable to release a body for burial or cremation following a post-mortem, communicate to the family and give reasons for this as soon as possible by phone.

4. Contact the bereaved family to inform them if the Final Post-Mortem Report is not going to be available within twelve weeks, and provide an update on the expected timescales. Victim Information and Advice (VIA) to send out a letter explaining this.

5. Contact the bereaved family within 14 days of the receipt of the Final Post-Mortem Report if there is any change to the cause of death of the deceased, and answer any questions the family may have as a result of this change. VIA should do this by telephone.

6. Contact the family within twelve weeks of the death to inform them of the progress of the investigation, and offer a personal meeting to take place within 14 days or communicate in the way the family prefer.

7. Thereafter, contact with the family should be every six weeks to advise of progress and if they would like a personal meeting.

8. At any stage where there is a significant development in the investigation, contact with the family should be made unless it is likely to prejudice any potential prosecution and a personal meeting offered.

9. The family is informed within 14 days of Crown Counsel's decision on whether or not there should be criminal proceedings.

10. The SFIU informs the family that a FAI is to take place and a personal meeting offered within 14 days to explain the reasons, and this is also given in writing.

11. The PF then contacts the family to explain the process.

12. The SFIU offers to meet with the bereaved family at the conclusion of any criminal proceedings or an FAI to explain the outcome and discuss any issues arising.

All deaths in custody, even those that involve someone who has been identified with long-term palliative care needs, are investigated under the FAI process. The review

by HMIPS (2019) recommended that the SFIU reviews the DIPLAR process to ensure that the information collated and shared does not impinge and contributes to the FAI process. The review of FAIs carried out in 2019 advised that the SFIU prioritises the FAI of any young person in legal custody (Scottish Government, 2019).

The Final Stage of Review: The Fatal Accident Inquiry (FAI)

The COPFS is Scotland's prosecution service. The PFs investigate all sudden, suspicious, accidental and unexplained deaths to establish the cause of death and the circumstances. In all cases, deaths in custody (whether the death occurs in prison or hospital) proceed to an FAI. FAIs are usually held in a Sheriff Court, though they can be held in alternative accommodation (Scottish Government, 2014). Previous recommendations to hold FAIs in less formal and intimidating settings by for example Lord Cullen in 2014 on the Consultation on Proposals to Reform Fatal Accident Inquiries Legislation have never been implemented (Scottish Government, 2014).

The FAI is 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." (Scottish Government, 2019: 3).

The purpose of the FAI is to expose systematic failing and is deemed critical for the maintenance of public confidence in the authorities (Scottish Government, 2019). The evaluation of TTM (Nugent, 2018) reported that, of the 56 FAIs that had taken place in that past two years, only four recommendations were made towards SPS, however it was also determined that no reasonable precautions could have prevented the death. In two cases, a lack of information-sharing was identified: in one case from the Health Care staff and another from the PF. 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.

Contact with Families

Although the impact and support for families is focused on more in section 6, this section outlines some of the published processes of engagement. According to the Guidance set out in the Family Liaison Charter (hereafter 'the Charter') and in line with what was reported by the SFIU above, the PF should contact the bereaved family no later than 12 weeks after the date the death has been reported to inform them of the progress of the investigation. A personal meeting should be offered at this time to take place within 14 days unless the family indicates they do not wish to do so, and in which case the PF communicates according to the needs and wishes of the family (COPFS, 2016). The Guidance sets out that contact thereafter should be every six weeks and also if there is a significant development, unless communication of this would prejudice any potential prosecution. According to the

Charter, COPFS should contact the family within fourteen days of the Crown Counsel's decision on whether there should be criminal proceedings in relation to the death. Relatives should also be offered support through the COPFS Victim Information and Advice (VIA) service. The Charter states a commitment that the PF offer to meet with the bereaved family at the conclusion of any criminal proceedings or FAI to explain the outcome and to discuss any issues arising.

The review carried out in 2019 by the Inspectorate of Prosecution in Scotland noted that COPFS had good contact with families and offered to meet with them face-to-face, except where there were criminal cases (HM Inspectorate of Prosecution in Scotland, 2019). They recommended that COPFS should provide a single point of contact for families throughout the process. The continued delays in FAIs are highlighted as causing distress to families and de-valuing the process (*ibid*). It is worth noting, though, that in the Charter, the only mention of families' right to legal representation is in the appendix and 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 a consultation (Scottish Government, 2014). In the consultation responses, the Sheriffs' Association commented on the need to guard against FAIs being treated as 'dry runs' for any civil proceedings (Scottish Government, 2014). Other issues raised by respondents 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 (INQUEST, 2019). Without specialist legal representation for families, INQUEST argues that the issues uncovered at many inquests would have remained unchallenged and hidden from public view (*ibid*). 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 (INQUEST, 2014). Therefore, the evidence suggests that the full participation of families improves accountability, and in effect, saves lives (Coles and Shaw, 2007). 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 in the event of an FAI (Scottish Government, 2020). The effect of the current limited participation of families is reflected on more in section 6.

Good Practice: The Crown Office and Procurator Fiscal Family Liaison Charter

The Family Liaison Charter (the Charter) applies to any death reported in Scotland and sets out:

- how and when initial contact will be made with the nearest relatives;
- what information the nearest relatives can expect to receive;
- the key stages where updates on progress will be given throughout the investigation; and
- what contact and information will be given during any criminal proceedings and at the FAI.

Crucially, information is to be provided in a manner agreed by the nearest relatives and COPFS at the outset. Where a personal meeting takes place or there has been telephone contact (if that is the preferred method of contact), this will be followed up with a letter containing a summary of those discussions.

Delays between the death and FAI taking place

The main concern with the post-death process is the delay between the death and FAIs taking place, with the lack of progress in this described as 'disappointing' (HM Inspectorate of Prosecution in Scotland, 2019). On average, it takes 23 months for a mandatory FAI to take place, with only 37% having a first notice lodged within 12 months (*ibid*). Of the outstanding FAIs on 71 deaths in custody, 65 (92%) deaths occurred in prison and six (8%) in police custody (*ibid*). At the time of the review in 2019, there were 68 (48%) of all outstanding FAIs older than 12 months; 30 (21%) older than a year; 25 (17%) older than two years; eight (6%) older than three years; and 12 (8%) still ongoing after four years. Delays are down to a range of reasons such as allocation of cases, getting witness statements and inactivity with staff shortages and long-term absences cited (*ibid*).

The Outcome of an FAI: The Accountability Gap

The Sheriff 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. However, there is an accountability gap identified in the literature as will be outlined, with a lack of enforcement and follow-up (HMIPS, 2019; Scottish Government, 2019; 2014). As stated in the consultation carried out in 2014:

> "Under the existing legislation Scottish Ministers have no powers to enforce recommendations made at FAIs, which are not in any case legally binding on the parties to whom they are addressed. This is the responsibility of the bodies and agencies to which the Sheriff addresses his recommendations, and that the Government expects them to accept that responsibility and take appropriate

> action … The Government has serious reservations as to the practicality of the Government actively monitoring the implementation of recommendations. As the recommendations are not legally binding, the Government does not have, and should not have, a role in monitoring or enforcement." (Scottish Government, 2014: 26)

In the consultation responses, some reported being disappointed that the Scottish Government was not taking a stronger position on the enforcement of recommendations (Robertson, 2014). The organisation *Unite* specifically called for Sheriffs to be given additional powers to make their recommendations legally enforceable (*ibid*). It was further suggested that the Scottish Government could disqualify those who do not respond to Sheriffs' recommendations from being awarded public sector contracts (*ibid*). However, the consultation stated that the Sheriffs Principal related that enforcing recommendations was an issue of both principle and practicality, and they do not have the resources to follow up on what should be done, feeling that the responsibility should fall to the Scottish Government (*ibid*). The Scottish Legal Action Group suggested that the Government could establish a small department whose duty it was to monitor these issues (*ibid*). Following the consultation in 2014, the Fatal Accidents and Sudden Deaths, etc, (Scotland) Act 2016 has now given the Scottish Courts and Tribunals Service (SCTS) responsibility to disseminate the determination and recommendations to all relevant parties. The relevant parties are to respond in writing within eight weeks, and this is published. If no response is given, this is also published by the SCTS. Many full reports of FAIs are accessible on SCTS's website but a more public friendly version with follow-up publications related to deaths in custody would be helpful. This is further supported in a review by HMIPS (2019) that recommended that further work to analyse the FAI determinations and recommendations against the DIPLAR learning to enhance learning is required. Furthermore, HMIPS (2019) recommended that a Memorandum of Understanding be developed between relevant agencies on the appropriate methodology for enquiry and reporting, the sharing of lessons learned and the management information systems needed to support effective information capture and analysis.

The Process of Judicial Review

The process of judicial review is only available where all other effective remedies have been exhausted and there is a recognised ground of challenge, at which point the court reviews a decision, act or failure to act by a public body or other official decision maker (Harvie-Clark, 2016). A petitioner in a judicial review action can be exposed to considerable financial risk, and as well as having to pay their own fees in a civil case, they would also have to pay the fees of those they lost against. However, some may be entitled to legal aid, and the court may grant a 'protective expenses order' where they are acting in the public interest (*ibid*). Technically, a family could take an action should they feel that the prison system has breached its duty in relation to Article 2 and/or 3 of the ECHR, though to date, there have been no judicial reviews taken by families in relation to the SPS and deaths in custody.

Other Related Process: HM Inspectorate of Prisons for Scotland (HMIPS)

As described in section 3, HMIPS is a member of the NPM. Their role is to inspect and monitor the treatment and conditions for prisoners in Scotland, and this is against predefined Standards for Inspecting and Monitoring Prisons in Scotland, developed in conjunction with the SHRC, first published in 2015. The level of inspection is two-fold, that is Independent Prison Monitors (IPMs), with every prison across Scotland monitored once a week, and professional inspections made of prisons by inspectors. Where there are concerns raised, return visits are made to follow-up, and these can be formally escalated to the Governor and Healthcare Manager for action. HMIPS has an important role in carrying out thematic reports on areas requiring specific attention. Following a number of deaths of young people, HMIPS carried out an important review of the provision of mental health services for young people entering and in custody at HMP YOI Polmont. Two of the recommendations particularly relevant to this review were to enhance and have more consistent DIPLARs, maximising learning from previous incidents, and for the Scottish Government to provide a central co-ordination point for Government reviews (HMIPS, 2019b). At present, HMIPS, other than being represented at the DIPLAR where it is deemed appropriate, does not have direct responsibility for reviews of deaths in custody. In its annual report, one of the recommendations made by HMIPS (2019) is the need for co-ordination of reviews, with further analysis of comparative data on suicides, and to consider international evidence.

Conclusion

The SPS carries out the initial process of review internally following a death in custody by way of the DIPLAR. This process is focused on establishing learning and has limited involvement from the 'outside', and having an 'independent' Chair is a fairly recent development in cases of suicide or drug-related deaths. Independence is defined as someone who is not employed by the SPS but they are still chosen by the organisation, and therefore the level of impartiality they have is uncertain. The Governor and NHS Prison Health Board Lead have responsibility for the action plan, which is not in the public domain, and it is not clear how this is monitored. In cases of suicide where the person has been in contact with the NHS, they may also conduct their own review, but it is not clear if this information is shared with the SPS. In a review carried out of the investigations of the deaths of patients being treated for a mental disorder, it was raised that there is a need for a clearer link also between NHS' Boards scrutiny and improvement. The Scottish Fatalities Investigation Unit, which is independent from the Prison Service and begins the process of preparation for the FAI, carries out the next stage of review following the DIPLAR. Past research has raised concerns about the consistency of DIPLARs and their effectiveness as a way of maximising learning. The FAI is wholly independent and aims to establish facts, with the PF calling witnesses. The Sheriff makes a determination and recommendations to prevent future deaths, but there is a lack of enforcement and follow-up, with the literature identifying a consequent accountability gap.

In 2020 SPS developed some written policies that clarify that it is the police who break the news to families, and the prison Chaplain contacts the family to offer support and acts as a liaison for the DIPLAR. More recently, the SPS has now made it the role of the Governor to identify a Senior Manager to communicate with the

Next of Kin any necessary information following the DIPLAR. The SFIU, which is an independent body, carries out the next stage of review, compiling information about the death and deciding if a post-mortem is required. Their role is also to communicate with the family in accordance with the Crown Office and Procurator Fiscal's Family Liaison Charter ('The Charter'). The PF should also follow what is set out in the Charter, offering to meet with bereaved families face-to-face and keeping them informed of the process throughout. At the FAI, families do not have direct access to legal representation unless they are aware and entitled to legal aid or can afford it. Delays between the time of death and an FAI taking place are generally around two years, if not longer, which mean they are often a source of great distress.

5. Comparable Processes of Review

Key Findings

- In contrast to the Scottish System, in England and Wales investigations carried out by the Coroner, The Prisons and Probations Ombudsman **(**PPO) and clinical reviews are independent of the Prison Service. The recommendations that follow are obfuscated by the many agencies involved, with similar delays experienced as in Scotland and limited follow-up to ensure implementation. Just as in Scotland, a more considered approach points towards the need instead for one independent agency to carry out this work so that they can also bring together all data, ensuring that deaths are not considered in isolation.

- The treatment of families by the prison system in England and Wales, as set out in the Guidance, is much more direct than it is in Scotland. In Scotland, the police break the news to the family, then the prison Chaplain contacts the family, offering support and acting as a liaison in advance of the DIPLAR. The SPS has recently introduced that it is for the Governor to identify a Senior Manager to contact the Next of Kin following the DIPLAR to communicate any necessary information. In England and Wales instead the guidance is that the Family Liaison Officer breaks the news to families face-to-face, the Governor writes a letter of condolence, reports to them the agreed action plan, arranges for property to be handed over respectfully and for a service to be carried out in remembrance, and offers to help with funeral costs. The PPO also makes contact with the family in the same way as the PF in Scotland.

- There is even less documentation about how staff are supported in England and Wales than in Scotland, and a similar gap in detail about how prisoners are supported following a death.

- There is limited research on international processes and the information on reviews of deaths in custody difficult to source. Insights gained though show that the accountability gap exists throughout with limited 'good practice' identified in terms of reviews leading to systematic change.

Introduction and Overview

There is a dearth of research about the response to deaths in custody in other countries. As a closely-related jurisdiction with similar but separate processes, the review process in England and Wales in this section will be outlined following the same structure as above, outlining the processes chronologically, with comparisons drawn with the Scottish system and areas of good practice from other organisations or countries outlined.

The Immediate Response

According to the Prison Instructions for England and Wales, once a death has been verified by a qualified person, prison staff should follow their local contingency plans on deaths in custody (Ministry of Justice, 2020). The police treat all deaths in custody as suspicious. This is particularly important when a death has occurred in a shared cell, and care should be taken when relocating cell-mates, as there may be vital forensic evidence that must be preserved. Staff are to complete Incident Report Forms. As soon as possible after the death, all documentation is to be gathered together and securely stored in a locked cabinet with signed access only until after the inquest and retained for 20 years. A 'Hot Debrief' should take place immediately and staff supported by the Samaritans.

Family Contact 'in theory'

The Governor/Directors should:

- write a personal letter of condolence to the family, which must include an invitation to the family to visit the prison;
- offer to contribute to reasonable funeral expenses of up to £3,000;
- take forward any disciplinary investigation arising from a death;
- write to the family once the final response and action plan to the draft PPO report has been agreed, and again following the conclusion of the inquest;
- following police authorisation, make arrangements to hand over the prisoner's property to the appropriate person. Items should be listed and appropriately packaged, i.e. not in an HMPS plastic bag. It is advised that the person signs a receipt of the possessions. The person should be told if any items are being retained as evidence at the inquest and therefore cannot be released immediately; and
- arrange for the Chaplain or other religious leader to offer to hold a memorial service for the family, other prisoners and staff.

The Prison Instructions published by the Ministry of Justice (2020) further outline the importance of family contact; that following a death or for terminally ill prisoners, initial and on-going liaison take place between the prisoner's nominated Next of Kin and the prison. Prisons must have a nominated FLO who is the named point of contact for the family, ideally meeting them face-to-face or, if distance is a problem, have another FLO at a local prison do this. Their role is to break the news of the death, giving an accurate account of what has happened so as to avoid unnecessary distress and suspicion, and inform the family of what will happen next, as well as offer to contribute to funeral expenses up to £3,000. The FLO should also leave information about the Coroner's office, should the family ask about the inquest. If there is information that cannot be released (for example because the police have asked for some information not to be divulged), explain why this is necessary, and if the answer is unknown, give a commitment to provide the information at a later date.

When a prisoner has no recorded Next of Kin, reasonable steps must be taken to trace any family. Subject to the wishes of the family, it is appropriate for the FLO and other members of staff to attend the funeral. The FLO or staff may lay a wreath on behalf of the prison after seeking the wishes of the family. The FLO should not attend if there is a risk of upsetting the family or to their personal safety. If the family does not want contact with the prison, their wishes must be respected. The FLO should also maintain a logbook. Contact with families should end appropriately.

Where a young person under the age of 18 has died, the establishment must inform the Local Safeguarding Children Board (LSCB) who will undertake a serious case review. This process involves the setting up of a LSCB sub-committee including a consultant paediatrician from the local NHS Primary Care Trust (PCT) and other relevant agencies such as the Crown Prosecution Service and the coroner where appropriate. This process works in parallel with other investigative processes, with the emphasis on learning lessons. (Prison Reform Trust, 2012). English and Welsh authorities publish anonymised overview reports and there has also been a triennial review of Serious Case Reviews carried out from 2014-2017 (Brandon et al, 2020).

Family contact 'in practice'

A review of 62 young people's deaths as part of the Harris Review carried out by INQUEST and Transition to Adulthood (2015) found poor implementation of family liaison common standards and principles. Families also reported no or very little access to information about their entitlements to financial compensation for funeral costs and independent advice about a death in custody. This patchy practice is in spite of clearly set-out guidelines by the Independent Advisory Panel, which were accepted by a range of custodial organisations, investigatory bodies and the Department of Health. The Family Listening Days carried out in October and November 2014 as part of the Harris Review also gave families the opportunity to voice their experiences, with a lack of information, and in some cases 'insensitivity and callousness' shown, for example, with restraints used when the person was dying or families receiving pro-forma bereavement letters (The Harris Review, 2015: 164). Deborah Coles from INQUEST points out that families also do not get a response from prison governors about the actions that will be taken following inquests (Prison Reform Trust, 2018).

Support for Staff and Prisoners

The Prison Instructions state that there should be local procedures in place to support staff and other prisoners, and for those who are working with those who are terminally ill (Ministry of Justice, 2020). It is not clear how these arrangements are monitored. A more specific review of the impact on staff and prisoners is presented in the latter sections.

The Second Stage of the Review Process: The Coroner Clinical Reviews

In the same way as in the Scottish system, an inquest is defined in statute as an inquisitorial fact-finding exercise directed towards addressing four key questions: who the deceased was, and where, when, and how the deceased came by their

death (Prison Reform Trust, 2012). Unlike the Scottish system, however, there are a couple of additional stages of review, namely the Coroner and Clinical Reviews.

The Coroner must investigate all deaths and contact the family. Coroners have statutory powers through the Coroners and Justice Act 2009 to compel document production and witnesses to give evidence. This 'inquest verdict' returned by a jury of ordinary men and women has powerful public significance and can feel like a more meaningful and fulfilling process for bereaved families (INQUEST, 2012). A coroner can also return a 'narrative verdict', which is a factual statement of the circumstances surrounding someone's death. Narrative verdicts can also allow coroners' courts to record comments on failings that have not directly contributed to a death but caused unnecessary distress both to the individual as they died and to the deceased's family (*ibid*). However, there is often a lack of understanding about narrative verdicts, and they are underused as a valuable source of learning (*ibid*).

Where there has been a suicide in prison, a Middleton Inquest is carried out to establish by what means and in what circumstances. The Coroner creates what is referred to as a 'Prevention of Future Deaths' (PFD) or 'Rule 43' report to whoever has the power to take preventive actions. Tomczak (2019) observes that this does not always happen, and not all Coroners copy their reports to the Inspectorates or send them to the right people. Recipients from the organisations have 56 days to respond. These reports are also sent to the Chief Coroner, who publishes the majority online in categories (Tomczak, 2019). The Ministry of Justice publishes a Summary of Reports and Responses under Rule 43 of the Coroners' Rules containing short summaries of Rule 43 reports. However, these are filtered, scant in detail, with no comprehensive overview, nor a publicly accessible database or website which allows access for prisons, healthcare bodies, local authorities or central government (Prison Reform Trust, 2012).

At present, the Coroner's role as a critic is unrealised (Tomczak, 2019; INQUEST, 2012). It is noted that responses given to the Coroner are generally to reference national policy and are not legally enforceable (Tomczak, 2019). Whilst Coroners' reports are now published on the judiciary website, there is no audit of progress or follow-up to ascertain the impact of these reports at a local and national level. As it stands, one death is considered in isolation from all others (INQUEST and Transition to Adulthood, 2015), whereas the value of these reports would only be made clear if there were comprehensive and systematic research and analysis of this data by a permanent institution and follow-up of recommendations (INQUEST, 2012). In the absence of any framework for the overview and scrutiny of findings and compliance, the impact of both narrative verdicts and Rule 43 reports by coroners is limited, and the current system is failing (*ibid*).

Clinical reviews are commissioned by NHS England/Healthcare Inspectorate Wales to review clinical care according to agreed protocols, including whether referrals to secondary healthcare were made appropriately. Families should be invited to participate in this process, but they routinely are not (Maganty et al, 2015). The Harris Review recommends that families are part of this process, but Tomczak (2019) does not, arguing that it is likely they would have little to contribute and would only add to the family's stress. If a prisoner dies in hospital with a recognised illness or medical history, the death is treated no differently than the death of a member of

the general public in hospital. Where a prisoner dies in a cell, and their death is 'believed to be due to natural causes i.e. heart attack', the police involvement is minimal 'other than securing evidence pending a post-mortem result' (NPCC/PPO, 2015: 1).

Final Stage of Review: The Prisons and Probations Ombudsman (PPO)

The PPO is wholly independent and reports directly to the Secretary of State. It is also operationally independent but sponsored by the Ministry of Justice (PPO, 2019). In England and Wales since 2004, the PPO undertakes Fatal Accident Investigations but has no powers to compel anyone to co-operate with these. The Prisons and Courts Bill 2017 proposed a statutory footing for the Ombudsman, but this Bill fell with the 2017 general election. The aim is to open the investigation within five working days and to make contact with the family within 15 days. The timelines for reporting are stated as being 26 weeks for self-inflicted deaths and 20 weeks for natural causes, but there are delays particularly when waiting on police investigations that diminish the impact on learning (Prison Reform Trust, 2018). The Ombudsman may make recommendations to bodies or individuals such as the prison authority or the Secretary of State for Justice. These authorities accept or reject recommendations within four weeks, detailing steps to be taken and time frames (Tomczak, 2019).

For recommendations that fall to the Prison Service to consider, co-ordination of responses is undertaken by the Briefing and Casework Unit, who commission contributions from the appropriate Director of Offender Management or Headquarters group (National Offender Management Service (NOMS), 2016), which is now called Her Majesty's Prison and Probation Service (HMPPS). The PPO must be notified of action taken as a result of any recommendations. The Prison Service has a target of four weeks to reply to recommendations; if this cannot be met, they must inform the PPO. If the draft PPO report criticises an identified member of prison staff, they will normally disclose an advance draft of the report, in whole or part, to the relevant authority so they have the opportunity to make representations. The PPO takes the feedback to the draft report into account and issues a final report for the bereaved family, the relevant authority, the Coroner and the Primary Care Trust or Healthcare Inspectorate Wales and the National Patient Safety Agency (NPSA) (NOMS, 2016).

According to the Prison Service Instructions (Ministry of Justice, 2020), at a local level, prisons must undertake an analysis of evidence from investigations by the Police, the PPO and any others that might be locally commissioned to contribute to the continuous improvements in the prevention and reduction of deaths in custody. The National Safer Custody Managers (NSCMs) are part of Offender Safety, Rights and Responsibilities Group in HMPPS HQ. The NSCM team hold responsibility for analysing and coordinating responses to the PPO investigation reports. The team publishes Quick Time Learning Bulletins on national learning. These can be found using the search engine on the HMPPS intranet. For example, a bulletin published in 2011 highlights the need for the Prison Service to provide documentation to the police, PPO and coroner and also to retain documents and send a copy to the Treasury Solicitor (NSCMs, 2011). The team also leads on Learning Days that are

held throughout the year which focus on specific policy areas such as violence reduction and learning from deaths in custody.

In 2018/19, the PPO carried out 334 fatal incident investigations - an increase of six per cent over the previous year and a 23% increase in self-inflicted deaths, with worryingly high numbers in some prisons, and one per cent homicides (PPO, 2019). In the minutes of the meeting of the All-Party Group on Penal Affairs published by the Prison Reform Trust (2018), the PPO states that Action Plans are drawn up by establishments and reviewed, but they also state that there are not enough resources to follow up on this *(ibid*). The PPO annual report (2019: 10) noted that they:

> "continue to make the same recommendations repeatedly, sometimes in the same establishments and, often, after those recommendations have previously been accepted and action plans agreed to implement them."

This sentiment is also repeated in the previous annual report and a thematic report on self-inflicted deaths among women (PPO, 2018).

In the annual report in 2019, the PPO also highlights the inappropriate use of restraints on people who are very unwell, often immobile and present a low risk of escape or offending while being escorted to, or in hospital. The PPO argues that these practices continue because of structural and cultural barriers to prisons complying with policy and legal requirements (PPO, 2019: 11).

In order to promote more reflective learning, the PPO has introduced a publication called *The Investigator* to engage with stakeholders, and over the past nine years published over 40 bulletins and thematic reviews.

Delays

In the Scottish system, as reported above, 31% of cases take two or more years after the time of death to be completed. Similar delays are experienced in England, whereby between August 2010 and January 2011, approximately 25% of deaths in custody inquests were taking more than two years to complete (INQUEST and Transition to Adulthood, 2015). The reasons for delays included outstanding investigations by other bodies such as the PPO and a lack of available resources. Whilst there has been an improvement in the timeliness of PPO investigations, delays frustrate the learning process and can be distressing and confusing for families.

<u>Contact with Family</u>

The Harris Review recommended that families are given entitlement to legal representation at the inquest, but this was rejected by the Government (Ministry of Justice, 2015). The Bereaved Families Survey, an appendix to the PPO (2019) Annual Report, reported that 32% of families did not think they had had enough communication from the PPO.

The Accountability Gap and Lack of Monitoring Recommendations

The lack of oversight and the failure to act on recommendations made by the Coroner or PPO is observed time and time again (Bereton, 2015; Harris Review, 2015; McFeeley, 2012; INQUEST, 2018 and 2020). It is not always clear who is responsible for change, and no effective mechanism to monitor, audit and follow-up recommendations from the investigation process results in a lack of effective cross-sector learning and implementation of reform (INQUEST and Transition to Adulthood, 2015; National Council for Independent Monitoring Board, 2013). Tomczak (2019) argues that the PPO could be more direct about where change is needed. As well as calling for criminal justice resources to be reallocated away from prisons to community sentences, improved training for staff and access to justice for families, there is also a call for a 'National Oversight Mechanism' and accountability for institutional failings that lead to deaths in prison (INQUEST, 2018 and 2020; Prison Reform Trust, 2018; INQUEST and Transition to Adulthood, 2015). Describing the current process, INQUEST and Transition to Adulthood state that (2015: 34):

> "Lessons are far too frequently lost, they are analysed poorly or ignored; misunderstood or misconstrued; dissipated or dismissed."

The Harris Review called for the PPO to be given statutory powers to follow-up actions following a PPO report and inquest findings enhanced, to require the production of documents and compel witnesses to participate with PPO investigations. They called for the PPO to be made independent from the Ministry of Justice (MoJ). The Government response was that such extra powers would be considered, should Parliament have time, but that this separation from the MoJ was unnecessary.

Related Processes: Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England and has undertaken regular inspections of health provision in prisons and YOIs, in partnership with Her Majesty's Inspectorate of Prisons (HMIP), for some years. Previously, each inspectorate used their own separate inspection framework, however after the Harris Review, the CQC and HMIP piloted using a single framework for inspection, which leads to a joint report.

HM Inspectorate of Prisons for England and Wales

Her Majesty's Inspectorate of Prisons for England and Wales (HM Inspectorate of Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions, secure training centres, immigration detention facilities, police and court custody suites, customs custody facilities and military detention. If the Inspectorate identifies significant concerns, they can write directly to the Secretary of State to raise an Urgent Notification, with a response required within 28 days. These notifications are published.

The Victims' Right to Review (VRR)

A submission by the Crown Prosecution Service to the Harris Review sets out the Victims' Right to Review (VRR). If the CPS decides not to charge, then the family can seek a review of the decision. This involves a further review of the case by a different prosecutor. There is no right to a further review of the VRR. Families also have the right to bring a private prosecution, and their legal advisors will be able to provide them with the necessary information.

Looking to other processes

Review of Police Custody Deaths

As part of the Harris Review, a submission from Hickman Rose solicitors pointed out the need for the PPO to have the ability to make recommendations about internal disciplinary proceedings that should be brought, in the same way that the Independent Police Complaints Commission does in the context of police custody death investigations.

Inspection of Schools

The Harris Review (2015) makes reference to the system operated by Ofsted for inspecting schools, and in particular the placement of a school into 'special measures'; similar arrangements also apply to NHS Trusts (usually triggered by a CQC inquiry). In the same way that the CQC routinely consults patients on their experience, the Review believes that HMIP should ensure that it takes account of the views of prisoners' families, as well as prisoners, on the prison regime.

Youth Justice Board (YJB)

The YJB's monitoring role in the secure estate has a Performance Monitoring Framework which provides clearer information about establishments' performance and any areas of risk. They report focusing on the areas of greatest risk, as identified through performance reporting and from the reports of regulators and inspectors. This approach has led to a range of focused reviews across the estate on subjects including restraint minimisation strategies, the transfer of health information and adjudication. While investigations of deaths are ongoing, the YJB uses draft reports to act (Youth Justice Board, 2014).

Looking to Other Jurisdictions

There is a gap in the literature about comparative international practice on deaths in custody and the review processes. The following section presents information from Canada, Australia, New Zealand, USA and South Africa, and generally this is not readily available, and in particular information regarding practices after someone has died in prison was sourced through newspaper articles published. Other information was also attempted from Scandinavian countries but no accessible sources were found.

Ontario and Canada

Tomczak reports that a specialist designated department is noted by Coles and Shaw (2012) in Ontario to monitor the implementation of the recommendations made by coroners (ibid). Further investigation into the review of deaths in custody in Ontario does not seem to show any evidence of this department and instead a lack of data collection was highlighted, and since 2010 natural deaths are no longer formally evaluated (Antonowicz and Winterdyk, 2014). In 2017 an independent review of Ontario Corrections found that despite 150 deaths in custody over the preceding decade, the majority had not been subject to an independent review and systematic reflection or change limited, with families also reported as not having access to adequate or clear information (Independent Review of Ontario Corrections Team, 2017). A recent article published by the CBC News focusing on the jail Thunder Bay in Ontario spotlights the systematic failures that have been happening, with only eight of the 13 deaths recorded reportedly leading to inquests (Turner, 2020). The report claims that recommendations have gone 'unheeded for 18 years.' For example, the need to improve communication and have an electronic medical record system was suggested in seven of the eight inquests reviewed but has not since been developed. Overall then the claims of good practice in Ontario are not substantiated.

In terms of Canada more widely, on the Correctional Service Canada (CSC) website there is Guidance published directed towards families and this outlines the role of the Family Liaison Officer, which is similar to the role of the FLO in England and Wales to inform and assist families throughout the process (Correctional Service Canada, 2017). It also states that the CSC can cremate the body should the family be unable to arrange the funeral arrangements and there is also a mention of returning property and support for families to access a one off payment in some cases (ibid). The National Board of Investigation is described in this Guidance also, and sounds similar to the PPO, with a report published within a year that can be accessed by the family. However, in the same way as the system in England and Wales, there does not appear to be any analysis of broader trends and no clear accountability for the implementation of recommendations. Antonowicz and Winterdyk (2014) review of three provinces deaths in custody data in Canada, including Ontario, lead them to conclude that Canada should look to the process in England and Wales to garner lessons to improve their system.

Australia

Tomczak (2019) reports that in Australia government agencies have funded an online, publicly accessible database to assist with investigations and prevention strategies. Further searches found that this agency is called the Australian Institute of Criminology (AIC) and they have co-ordinated the National Deaths in Custody Programme (NDICP) since 1992 (Antonowicz and Winterdyk, 2014).[4] Sixty different pieces of information related to the death are collected, providing a breakdown of indigenous and non-indigenous deaths, and it is reported that no other country has

[4] Information for this section was also sourced from: https://www.aic.gov.au/about-us

consistently collected this level of detail over an extended period of time (Antonowicz and Winterdyk, 2014).

In terms of details about what happens when someone dies in prison there was no central information able to be sourced about the steps taken. However, it would appear that this is dependent on the state, whereby for example information found and not readily accessible on Queensland from an online legal handbook notes that if the person who died was an Aboriginal or Torres Strait Islander prisoner, the Aboriginal and Torres Strait Islander Legal Service in the area must be notified[5]. There are two investigation processes, which take place following a death in custody, that is the police service investigation who report to the coroner and, if relevant, the Director of Public Prosecution. This is followed by the Queensland Corrective Service (QCS) investigation conducted by inspectors appointed by QCS, who report to QCS. A Corronial Inquest will be based on the decision made through these processes and it is at this point that recommendations may be made. A written copy of this report must be given to the family.

A recent report reviewing deaths over the past 25 years states that the number of indigenous people dying in prison across Australia has decreased since 1999 (Ginnoni and Bricknell, 2019). However, Evershed et al (2020) review of 589 coronial reports shows the accountability gap that still exists in Australia between the making of recommendations and changes being implemented. The evidence also shows indigenous people not getting access to appropriate healthcare, being excluded as witnesses, and generally families experiencing poor treatment with for example coroners criticising unnecessary delays in notifying the Next of Kin. The research also found that the indigenous population are still more likely to be sentenced to prison than the non-indigenous population (*ibid)*.

USA

Antonowicz and Winterdyk (2014) describe the USA as taking similar but less comprehensive efforts as Australia in their review of deaths in custody, passing the Deaths in Custody Reporting Act (DICRA) in 2000. The Mortality In Correctional Institutions (MCI) (Formerly Deaths In Custody Reporting Program (DCRP) collects data on deaths that occur while inmates are in the custody of local jails, state prisons, or the Federal Bureau of Prisons (BOP). Since 2015 as well as aggregating the data, the BOP submits detailed data about each prisoner's death. The MCI provides individual-level data on the number of deaths by year, cause of death, age, race and sex. These data are also used to produce facility and population mortality rates. The collection of individual-level data allows BJS to perform detailed analyses of comparative death rates across demographic categories and offense types and facility and agency characteristics.

The Bureau of Justice Statistics began the MCI in 2000 in response to the passage of the Death in Custody Reporting Act (DCRA), however it is worth noting that this

[5] The following information was sourced from: https://queenslandlawhandbook.org.au/the-queensland-law-handbook/offenders-and-victims/prisons-and-prisoners/deaths-in-custody/

data is reported on the website to be collected for 'statistical purposes only', and cannot be used for DCRA enforcement.[6]

There is no information found on official sources about the practices or processes in the USA when someone dies. A report by Flanagan (2020) for the *Washington Post* flags the rise in the numbers of people who are now dying in prison in the USA and the different practices that exist from State to State. Flanagan describes the process for early release if someone has been diagnosed as being terminally ill as complex and often dependent on what is referred to as a 'death clock'. Whereby in some states like Kansas and Louisiana, death must be within 30 to 60 days. In others like Massachusetts and Rhode Island, prisoners with as long as 18 months to live may be released. The quality of care in prisons is described as often inadequate for those near the end of life in their sentence. She cites a report in the American Society of Clinical Oncology which described the injustice of how in some prisons staff are reluctant to give medication for individuals to deal with pain. Access to faith leaders is not always available so even reading last rites can fall to fellow prisoners. It is up to the prisoner to identify a person from the outset who will take control of their body and even then there are no guarantees about what will then happen. Flanagan reports that in Ohio for example, if the prisoner's loved one is unable to accept the body within two days after notification, the relative may be disqualified. If no one comes forward, then the prisoner will be buried in an 'indigent' grave and prison officials will dispose of the prisoner's belongings and monies remaining on prisoner accounts.

New Zealand

The Department of Corrections in New Zealand has very clear guidance on their website that sets out what happens when a death happens in custody and the review process.[7]

It is emphasised that the Department of Corrections make arrangements taking into account the cultural, religious and spiritual beliefs of the deceased. The main points worth noting is that it is clarified that corrections staff secure the scene for investigation, the police notify the Next of Kin, the body is taken for an autopsy and released to the family thereafter. A review is firstly carried out by the Coroner, who is described as an independent judicial officer whose role is to enquire into the cause of death. After this the Ombudsman examines the Inspector of Corrections report. They either confirm that the inspector's investigation was carried out thoroughly and fairly, or make any additional recommendations they consider are necessary, and may conduct their own independent investigation. The website states that "Corrections is committed to ensuring all investigations are thorough and carried out with integrity and respect to everyone involved."

The deceased's Next of Kin will be contacted by corrections to collect the property. In some cases a memorial service for the deceased is held at the prison, which is organised by the prison Chaplain and the Area Adviser Maori. If asked, they can

[6] Information for this section was taken from https://www.bjs.gov/index.cfm?ty=tp&tid=19

[7] Information for this sourced from https://www.corrections.govt.nz/working_with_offenders/prison_sentences/managing_offenders/deaths_in_custody

arrange to have the deceased's cell blessed by the appropriate people. The website describes how family or friends may wish to see the place of death and where possible the prison director will allow such a visit. It is noted that "The family of the deceased will generally be contacted by an investigation team to make enquiries about any issues they have." Overall, the indications are that what is possible in terms of family engagement is dependent on the prison and may vary.

An article published by Sumner and Reid (2020) spotlights the high number of suicides of those on remand and that this disproportionally affects those who are Maori at a prison in Christchurch. This report also points out that there had been concerns raised by the Ombudsman report in 2017 with regard to for example a lack of culturally appropriate support, and that despite these concerns little had been done. In short, this shows evidence that as has been found in the other countries, at present there is a lack of follow up in terms of recommendations made to ensure implementation.

South Africa

The Judicial Inspectorate for Correctional Services (JICS) is part of the South African Government, whose mandate is to uphold and protect the rights of all inmates who are incarcerated. JICS is responsible for the independent oversight of the Department of Correctional Services (DCS) and must therefore report to the Ministry of Justice, Correctional Services and the portfolio committee.[8] At the head of JICS is the Inspecting Judge. They collate data on deaths and Section 15 of the Correctional Services Act 111 of 1998 provides that any death in prison must be reported to the Inspecting Judge by the DCS 'who may carry out or instruct the Commissioner to conduct any enquiry.' The Inspecting Judge may also conduct an enquiry into any death in prison and this particular role appears to be much more direct than the other systems, whereby for example, in Scotland, an enquiry can be prompted by the HM Inspectorate for Prisons, but the decision to take this forward ultimately lies with the Government. In the most recent annual report the Inspecting Judge notes that mandatory reporting has been in 'disarray' and calls for institutions to be regarded as being part of communities and even to imagine a world without correctional facilities (Cameron, 2020). In the Annual Report the Inspecting Judge in South Africa describes their role as 'fiduciary', and promoting the wellbeing of all those in prison, that is both staff and prisoners (*ibid*). Overall, the Annual Report highlights the challenges and again what has been referred to in this report as the accountability gap (*ibid*).

Discussion

The procedures and practices in Canada, Australia, the USA and South Africa to review deaths in custody differs and also appear to differ between states within these areas, making comparability even more challenging. Where information was sourced from Canada and New Zealand on the process immediately after someone dies, it is described as being similar to the initial stages in England and Wales, with contact made to the family by the prison directly. The investigative processes in South Africa, Canada and Australia are alike to what happens across the UK with

[8] Information for this section was sourced from: http://jics.dcs.gov.za/jics/

reviews proceeding to a national level of scrutiny. In South Africa, the Inspecting Judge who sits at the top of the Correctional Services can also instruct an independent inquiry into a death and this is a particularly special role, not found elsewhere. In Australia and New Zealand it would appear that the review process are not always taken to a national level of review. Collation of data happens in all of the countries included in this analysis, however, there is an accountability gap noted in terms of the changes to be implemented.

Conclusion

The English processes of review of deaths in custody are entirely independent. The number of agencies submitting their recommendations for change obfuscates the message; the data are not brought together and analysed, so identifying or understanding trends is not possible. There are similar delays as experienced in Scotland, with limited follow-up on recommendations made and an accountability gap. The PPO reports that the same recommendations are being made time and time again with little change happening. There is a strong leaning towards having one single independent agency whose role is to monitor and follow up on recommendations, and to understand trends related to deaths in custody to help inform a preventative approach. Looking to other processes, and in particular the work of the CQC, who regularly ask patients about their experience, the same approach could be taken with families following an inquest. Gaining information on international processes of review is not readily accessible and there has been no substantive published research in this field. The search carried out shows that data is generally collated within countries, investigative processes are not always progressed to a national level, and the same accountability gap exists with limited ‘good practice’ identified in terms of systematic change.

6. Impact on Families of Deaths in Custody and the Review Process, and Current Support

Key Findings

- A number of recent high-profile cases, reported in Scotland's tabloid press, of families with a relative who has died in custody publicly express deep dissatisfaction and a sense of injustice due to a lack of direct communication from the SPS, long delays in the legal system and ineffective responses to the recommendations made.
- Although there is a dearth of literature in the Scotland-specific context providing direct accounts of the family experience, literature from families in England and Wales, particularly from the Harris Review and the organisation INQUEST in England, provide meaningful and transferable insight.
- Family feelings of being excluded from the process, the lack of timely justice, clarity in the system, lack of accountability and the need for greater compassion are emphasised in the accumulated literature.
- The Harris Review concluded that neglect of families is the result of 'institutional insensitivity', and there is a need to shift practices immediately from security considerations and towards accommodating a grieving family, as they would in a hospital or palliative care setting.

Introduction and Overview

This section employs existing literature to consider how families feel about their current experiences of Scotland's processes following deaths in custody. The discussion highlights the dissatisfaction expressed as a result of their limited participation and suggests steps which might be taken to provide families with greater involvement, transparency and most crucially, compassion. This section includes reference to research conducted in Scotland as well as in England and Wales to provide a comparison. The voice of families in this collective research body is not always present, so this section will begin with a discussion of recent media coverage.

A review of media coverage highlighting the voices of families following a death in custody

It is not uncommon for families who feel disconnected from review processes to reach out to media outlets to appeal publicly for reform. Indeed, extensive communication between families and the media should be viewed as indicative of a deep dissatisfaction with the process. This has been evident in the review of recent media coverage of Scotland's death in custody review processes.

It is worth also noting that the large majority of media coverage of this issue has come from tabloid rather than broadsheet publications, and further, that informal discussions of family involvement with the death in custody review processes have

taken place on new media platforms. Tabloid and informal media sources will more actively highlight individual accounts as opposed to broader social-structural analyses and include the personal views and experiences of families. In this sense, media accounts can provide a unique insight into the ongoing concerns of families engaged with the Scottish system of review and therefore have been considered as part of this appraisal.

High profile cases, such as the death of Katie Allan at HMP YOI Polmont, have prompted a range of public discussions around the failings of the post-death system in particular. Linda Allan, the mother of Katie Allan, expressed on a number of occasions that her decision to speak publicly following her daughter's death was motivated by her frustrations with the process, and the coverage of Katie Allan's death has highlighted perceived failings in the system. One of the particular issues covered has been the length of time taken for FAIs to take place, be concluded and their ineffectiveness to make change:

> "Perhaps it is my need to right injustice, to give a voice to others who have had none, that influenced our decision to 'go public'… Knowing what we do about Katie's treatment and death within the Scottish prison service, gave us no choice… To stay silent and wait for years for an FAI which would make no recommendations, exonerate those who played a part in Katie's death and risk others dying was not an option" (Linda Allan, 16th June 2019, "Grieving mum of Polmont prison suicide victim Katie Allan on family's fight"*, Scottish Daily Record*)

The Allan family's lawyer, Aamer Anwar, speaking on behalf of the family in the *Glasgow Herald*, also highlights the family's frustrations at the length of time taken:

> "They believe an FAI system - held on average now two years after a suicide is not fit for purpose, it is set up to fail families and hide what is truly happening" (Aamer Anwar, 2nd April 2019, "Parents of student Katie Allan who took life in Polmont say Scotland's 258 inmate deaths a 'massacre'," *The Herald*)

The length of time taken over the process persists as a continuous theme in media coverage of family experiences:

> "It began with the disdain from the Crown Office telling us that 'everything will take a very long time'… We now know that the 'very long time' represents a broken, under-resourced Crown Office who sit behind a 'family charter' full of empty words" (Linda Allan, 16th June 2019, "Grieving mum of Polmont prison suicide victim Katie Allan on family's fight"*, Daily Record*)

> "A system that accepts delays of more than four years for FAIs to be heard. A system that doesn't care. It has been seven months since we first met the Cabinet Secretary. What has happened since?" (*ibid)*

It is noted that a perceived lack of urgency over the review process is exacerbated by a lack of communication at all or clear communication with families from the Scottish Prison Service. This is worsened when families find that press communication is prioritised over direct communication with them.

Further, the family of Allan Marshall, who disputed the findings of the FAI into Allan's death at HMP Edinburgh also commented that this injustice had undermined the integrity of the prison service as a whole:

> "It makes you wonder about all the other deaths behind bars that are listed as having resulted from natural causes. It suggests that the prison authorities would rather cover things up than just be honest with people" (Alistair Marshall, 1st November 2020, "Family of tragic Allan Marshall 'disgusted' over natural causes claim", *Daily Record*)

The cumulative press coverage of the high-profile deaths of Katie Allan, Allan Marshall and William Lindsay have created an overarching narrative in tabloid coverage of feelings of injustice caused by delay and a lack of adequate accountability in the SPS more generally. Separately, the case of Sheku Bayoh (whose death followed contact with police) has found renewed prominence in public discourse following broader social debates around race and police injustice worldwide. Although this case concerns a death following police contact, coverage of this case has likely contributed to a broader sense of public dissatisfaction with delays in the Scottish justice system. Following the establishment of a public inquiry which is tasked with investigating the circumstances of the death and determining the role race played in this, Sheku Bayoh's family also expressed deep frustration at the perceived lack of swift justice.

Kadi Johnson, the sister of Sheku Bayoh, stated:

> "We have already waited five years and now it might be many more years. How long do we have to suffer? Why do we have to wait this long for answers? We have suffered enough. We are dismayed it might take three or four years. We have long given up hope that any of the police involved will be held accountable. We just want to know why Sheku ended up dying in such a brutal way." (Kadi Johnson, 6th July 2020, *Sheku Bayoh's family facing decade without answers as inquiry into his death in custody set to last four years,* Daily Record)

This is stressed again by the family's lawyer, Aamer Anwar, who notes:

> "Any delay in justice is a denial of justice." (*ibid*)

Returning once more to the experience of Linda Allan following the death of her daughter, an enduring theme in much of this coverage is the perception of a general lack of compassion for the family experience of the post-death review process. In describing the nature of her encounters with the Scottish Cabinet Secretary for Justice, Humza Yousaf, Allan notes:

> "Humza, flanked by officials, sat opposite us across a long boardroom table with briefing notes and I had to ask, is this how you meet bereaved parents?" (Linda Allan, 16th June 2019, "Grieving mum of Polmont prison suicide victim Katie Allan on family's fight", *Scottish Daily Record*)

As mirrored in the established academic and policy research in this area, evaluating the post-death review process and the experience of families shows that the systems in place have the potential to cause further harm and secondary victimisation for families enduring a deeply traumatic loss. The review of media accounts in Scotland provides a sense of the suffering of families who do not feel that they have other reliable actors within the system to provide timely justice, clarity or accountability. Family accounts such as that of Linda Allan do suggest that turning to media outlets or 'the public' is viewed as a regretful but necessary course of action directly prompted by the lack of compassion they perceived within the system:

> "Our wounds didn't have time to heal. As soon as they begin to scab over, they are ripped open by those who are part of the broken system responsible for Katie's death" (Linda Allan, 16th June 2019, "Grieving mum of Polmont prison suicide victim Katie Allan on family's fight"*, Scottish Daily Record*)

As such, this section of the review will consider the existing research on the themes of inclusion in relevant processes, timely justice, clarity in the system, accountability and compassion, while aiming to provide a fuller picture of the potential harms caused to those who experience the loss of a family member in custody. Following this, established models of better practice will be outlined in order to tackle these failings directly.

Family Experiences of the Responses to Deaths in Custody

As previously discussed, unlike State bodies, families are not entitled to legal representation unless they can access legal aid, although this is being reviewed, as noted in section 4 (Scottish Government, 2020). There is a dearth of research in Scotland hearing directly from bereaved families about their experiences of the legal system after a death in custody. In light of this gap, the following draws on research conducted in England and Wales, and those who participated in the Harris Review, to bring the voices of families to the fore.

Exclusion from the process

Imbalance in Legal Support for Families

INQUEST's 'Deaths in prison: a national scandal' (2020: 15) states strongly that "Bereaved families have a vital role to play in ensuring inquests do not merely sanction the official version of events". Indeed, this work makes a compelling case that excluding families from post-death reviews not only has a profoundly negative impact on families but undermines the validity of the process as a whole. "Skilled advocacy for the family aids the inquisitorial process and has helped to uncover systemic and practice problems" (*ibid*). Further, they note that the increased privatisation of services within the prison system generally (in England and Wales, at least), such as NHS commissioning of private healthcare, means that, at times, families asking questions about wrongdoing or advocating for policy change can face challenges from robust and extremely well-funded private legal defence teams. "This undermines the preventative potential of the inquest" (*ibid*), when the onus is on legal teams to defend strongly against acceptance of wrongdoing, rather than working with families to review circumstances of deaths and make subsequent

alterations to practice. We might consider that investment in the inclusion of family perspectives can also function as an investment in better justice outcomes and that this can be achieved by providing families with comprehensive access to legal aid.

As previously mentioned in this report, families in Scotland are currently not entitled to public funding for legal representation unless they are suitable for legal aid, although this is currently being reviewed. Lord Cullen's recommendation that families be given access to legal aid so they have representation at an FAI was rejected by the Scottish Government in 2014, although the current Scottish Government consultation on reforming legal aid suggests that there is broad support for reform so that families can have access in the event of an FAI (Scottish Government, 2020). The accumulated research from INQUEST on the use of legal aid in England and Wales suggests that this would mark a significant improvement for families in representing their views fully in the post-death process.

INQUEST (2020: 15) notes that, presently, this advocacy comes at a significant personal cost to families, and means that "at a time when they are grieving, bereaved families are forced to engage in intrusive means testing processes for legal representation". In England and Wales, families and family advocacy groups are significantly outspent on legal representation, for instance:

> "In 2017, the MoJ spent £4.2 million on Prison and Probation Service legal representation at prison inquests, while granting just £92k in legal aid to bereaved families through the Exceptional Case Funding scheme. The £4.2m from the MoJ is only a partial figure of the total spent on representing state and corporate bodies at inquests, as private prison and healthcare providers, NHS and other agencies are often separately represented" (*ibid*).

Tomczak's research describes the serious "inequality of arms and resources" (2019: 99), with one participant stressing that "It's just not acceptable that the Prison Service can have access to lawyers that we as taxpayers pay for, when the family have to battle… they have to go through a very intrusive funding application process, that causes a lot of distress within the family dynamic" (*ibid).*

We have already noted the emotional toll on families who, when placed in an adversarial role against the Prison Service, feel the need to turn to public statements of dissatisfaction via media sources. Tomczak's work suggests that "family members may feel a responsibility or a desire to participate in every stage of the investigation process, but this may disrupt their life significantly" (2019: 92). In particular, while families follow investigations in detail, Tomczak reports that they regularly find errors and inaccuracies, which often creates a sense of suspicion and a need to invest themselves fully in order to obtain justice for their family member. As family members become dedicated to attending every part of the inquest, Tomczak's research (2019: 100) also finds that this adds hours of expensive travel and childcare arrangements, along with the mental and physical strain of observing a courtroom for days and weeks at a time. Further, Harris (2015) argues that while families do gain something from the experience, just as many may find "their ability to cope may be lessened by detrimental experiences" (Harris 2015: 167, Tomczak 2019: 105). Coles and Shaw (2012) add that years of research on inquests indicate that post-death reforms are rarely guaranteed, or even evident. This complex

terrain, combined with the lack of affordable access to any effective advocacy, only increases the strain on families.

INQUEST's recent work on this matter makes a strong case that, if families do have to be in an adversarial rather than inclusive role with the Prison Service post-bereavement, then for better justice, we must advocate for their legal support to be sufficiently funded. They suggest that there is a need for a "radical transformation in the nature and culture of prisons… (where there are) profound levels of unnecessary trauma and distress for many thousands of families and friends" (INQUEST, 2020: 17). Their specific recommendation is for comprehensive "provision of automatic non-means tested legal aid funding for specialist legal representation to cover preparation and representation at the inquest and other legal processes (and that) funding should be equivalent to that enjoyed by State bodies/public authorities and corporate bodies represented" (*ibid*: 18).

'Now or Never! Legal Aid for Inquests' (INQUEST, 2019) stressed that automatic non-means tested funding would alleviate not only the financial burden but would also avoid the current excessive strain placed on families "at a time when they are grieving and at their most vulnerable, (facing) complex and demanding funding application processes" (*ibid*: 2). This call has received vocal support from Dame Elish Angiolini, who stresses this need as a foundation for better justice overall:

> "For the state to fulfil its legal obligations of allowing effective participation of families in the process that is meaningful and not 'empty and rhetorical' there should be access for the immediate family to free, non means tested legal advice, assistance and representation immediately following the death and throughout the Inquest hearing" (Angiolini 2017: 13)

Executive Director of INQUEST Deborah Coles, in giving oral evidence to the 2018 Joint Committee on Human Rights, stressed that we might in fact view this imbalance as a significant injustice, given the relative lack of power families have in even initiating their involvement in inquest processes. She states:

> "The inquest process is what families have been given to find out what happened to their loved one. They do not choose to initiate it; the state initiates it for them to find out. That is the process that they have to go to. The inequality of arms is the single greatest obstacle to families trying to get those answers" (Coles 2018, in INQUEST, 2019: 3)

Furthermore, evidence reported by INQUEST from the 'Angiolini Family Listening Day 2016' found that some families faced highly combative legal teams engaged in a "damage limitation exercise" (INQUEST, 2019: 6) and, due to a lack of funding, were forced to represent themselves in an adversarial and intricate legal process. As one family member states:

> "We had to do everything ourselves. We had no lawyer at the inquest. Those three weeks were the most terrifying thing I've ever done in my life. I had to cross-examine witnesses, it was absolutely terrifying, and they had lawyers.

> There needs to be a level playing field; a family member should never be put through that." (Angiolini Family Listening Day 2016, in INQUEST, 2019: 6)

The significant body of advocacy from INQUEST around the role of families in the post-death process makes the case that a compassionate approach should not place extra administrative and legal burdens on families at this difficult time. Louise and Simon Rowland, family of Joseph Phuong state:

> "Families are often left in the dark, trying to sort out numerous matters associated with a loved one dying whilst under the protection of the state, while trying to make sense of what has happened both emotionally and legally. Having access to funded legal representation is paramount for justice" (INQUEST, 2019: 12).

In aiming to address this potentially excessive strain for families, the Scottish approach should either advocate for comprehensive access to legal aid which can allow family representation to match that of the state, or design the process in an inclusive manner so that legal advocacy is not the only way for families to have a meaningful voice in the post-death process.

Lack of timely justice

INQUEST's 2018 research, which also employed 'Family Listening Days', gained further detail on family feelings of a lack of timely justice, along with a range of anecdotal accounts which provide a fuller picture of these frustrations. Where families pushed for clear timetables to be set, officials were often reluctant to do so, perhaps understanding in advance that organisational delays would be inevitable (INQUEST, 2018: 8). Families described understanding very quickly that the administration within the organisation was overwhelmed due to lack of resources and increasing caseloads (INQUEST, 2018: 8).

Echoing concerns expressed in Scottish media statements, the English and Welsh-focussed research also stressed the emotional toll that delays can take on families, in particular putting necessary processes of grief on hold (INQUEST, 2018: 17). This work highlights that delays cause distress for the close family members in the first instance, while they also face the additional strain of providing continuous updates to friends of the deceased, other family members, and the broader community (*ibid*). Recent academic work by Christian (2019: 84) argues that we must embrace "expanded conceptions of family members of the incarcerated", taking seriously the emotional impact that a custodial sentence can have on an extended group of invested parties. In this case, delays in justice can place a burden not only on the core family group but can also create strain in the broader community.

Where delays happen, families are rarely given adequate information as to why and for how long this will continue. They "want more information and greater insight into what may be causing log jams in the investigation and a failure to do so was deemed discourteous at best and unprofessional at worst" (INQUEST, 2018: 17). This is supported by Tomczak's (2019) work with families, who expressed that when reports arrive after a lengthy wait, where they fail to answer the questions of the family this

can exacerbate anger over the time spent waiting. Families stress that "the delay between the death and the inquest can… place a real toll on the family's ability to begin the grieving process and … they can't begin to grieve until they know the truth" (Tomczak 2019: 98).

Crucially, both Tomczak (2019) and Harris (2015) reflect that although it is not guaranteed in all cases, where there is a policy change enacted which is perceived as potentially saving future lives, this can ameliorate some of the pain experienced while waiting for the process to be completed.

> "One family described how they found comfort in knowing that ligature points have been removed. One family member described the value of knowing that 'two suicides had been prevented in the prison where my son died because of changes made after his death'. Another took similar comfort, saying 'I waited three years for someone to tell me he didn't die for nothing" (Harris 2015: 170)

Lack of clarity in the system

INQUEST's (2018) detailed analysis of the role of the Independent Police Complaints Commission (IPCC) (which later became the Independent Office for Police Conduct), provides further valuable data on family perspectives through their work on 'Family Listening Days'. In particular, this research was aimed at better understanding the experiences of families in post-death investigations and provided a range of valuable first-hand accounts highlighting the feelings of families. Many families in this group made comments that pointed to a lack of clarity in the system, with several respondents citing that, while they were well-treated by some actors, they weren't prepared for "just how evasive and dysfunctional state agencies are when they come to be investigated" (INQUEST, 2018: 4). This supports a recurring theme in the review of this literature more broadly, that often a defensive approach is taken with families viewed primarily as potential litigants, thus exacerbating a feeling among families of being on the outside of the process.

Crucially, this data suggested that, even where FLOs or members of the IPCC had provided a great deal of detail on the process to the families directly and quickly, the vulnerability of the moment and the experience of profound grief meant that this was difficult to take in. As the report states, drawing on the testimonies of families:

> "We felt confident in the process. But you are in a state of shock so you can't take all the information in. What would have helped us would be a leaflet or booklet on what we can expect about the process." (Family Listening Day evidence, INQUEST, 2018: 5)

> "At the time everything is going at 200mph so you can't think" (*ibid*).

INQUEST's 2018 research suggests that a fine balance needs to be struck with families, who very keenly want to see swift justice for their loved ones and compassion. Whereby, a compassionate approach would also take seriously that it is extremely difficult to absorb a range of information about a complex process in the aftermath of a loved one's death.

In this aftermath, it is important for families to understand their rights, what the processes for review are and when they might be happening. As the report states "for some families the early stages of their investigation were characterised by a lack of coherent information which left them unsure as to how the process would work, a situation compounded by the absence of available independent advice" (INQUEST, 2018: 5).

From within the system in England and Wales, despite the availability of FLOs, respondents in this research described an 'information vacuum' and 'bewilderment' at the initial stages (*ibid*: 6), with many turning to internet resources. Again, much of this confusion comes from a lack of clarity over the role of families, as either working with the prison in looking for objective truths around the death, or working against them as litigants and in need of independent advice:

> "Families want prompt contact with professional investigators who clearly explain how the investigation will work. They also want this initial contact to be timely for the families and appropriate in the context of their bereavement and grief. All the families agreed that independent advice and guidance was vital, not least around legal matters" (*ibid*).

These important findings demonstrate that there are significant subtleties required in the information provided to families - that they be delivered as soon as possible, but with the grief of families in mind and perhaps supported with some literature reiterating their rights. Further, families should be given an accurate sense of the context surrounding their role and its place in legal reviews of deaths in custody.

In the review of arrangements for investigating deaths of patients being treated for mental disorder, 42 families took part in a survey and follow up interviews. Their responses showed families are unaware of process and frustrated at the lack of openness in respect of information (Scottish Government, 2018: 26). It was concluded that there is a need to develop a process of investigation that is informed by the views of carers, families and staff and improve the co-ordination of support (*ibid*).

Families Seeing the Body After Death and engagement with the Prison

As already described above following a death in custody, Police Scotland takes control of the scene and possession of the body. Any request to view the body of someone who died in custody is the responsibility of Police Scotland and the Procurator Fiscal. The Procurator Fiscal instructs the release of the deceased person's body for burial or cremation and should contact the nearest relatives at the earliest opportunity to discuss matters (Scottish Association for Mental Health (SAMH), undated). A 'Family Support' booklet produced in 2020 by the Prison Chaplaincy and Families Outside outlines help and support following a death in custody (Orr and Stalker, 2020). This also describes the support that can be given through the Chaplain, which can include arranging for the loved one's possessions to be returned, for a visit to the prison and help with funeral arrangements. Both organisations can offer emotional support, practical advice and information about the DIPLAR and FAI processes. There are also contact details provided for other

organisations specifically for supporting someone who has suffered a bereavement, as well as the contact details for the specific Chaplains within each establishment.

INQUEST's 2018 work highlighted the particularly sensitive issue of families in England and Wales and their right to have access to the body and post-mortems. The research found that if there is poor transmission of information at this part of the process, not only does this exacerbate the grief of the families a great deal, but it can stoke the "(unintentional but strongly held) belief that the process lacks independence or is being used to hide evidence of wrong doing" (INQUEST, 2018: 7). Therefore, when making plans to ensure communication with families is timely and appropriate, it is important that this situation in particular is dealt with sensitively. This paper has previously noted that the public appeals and media accounts in Scotland have included expressions of suspicion towards the SPS. As such, ensuring that families are present at the post-mortem appears to be a crucial step in avoiding this outcome. Family accounts in this research indicated that, where there are delays or a lack of clarity, this can indicate to families a stronger desire on the part of authorities to attribute wrongdoing to the deceased, rather than prioritise family grieving. It is suggested that authorities "must be sensitive and empathetic regarding family wishes to see and touch the body of their loved ones" (INQUEST 2018: 7) and that neglect of this issue can breed suspicion on the part of families.

INQUEST's research (2018) strongly suggests that significant trauma is caused where families learn after the fact that they have missed the opportunity to see the body before the post-mortem. There are several unfortunate anecdotal examples in this data, for example a "family experienced further trauma when their relative's body was left out at the mortuary on the hottest days of the year and decomposition started. They did not see his body again before the funeral" (INQUEST, 2018: 7). While these instances may be attributed to individual malpractice, they highlight the strong desire of families to have detailed knowledge of what is happening with the deceased's body, above perhaps all other post-death considerations.

The 'Role of the Chaplain Following a Death in Custody' in Scotland (SPS, 2020b) sets out that one of the Chaplain's roles is to help organise a visit to the prison for the family, so they may (if they wish) visit the cell or the place where their family member died. The Chaplain can also help arrange the sensitive return of the prisoner's property, support with funeral arrangements or even conduct the funeral. It may be that prayers or a short service would be desired within the establishment and families can also attend these. The prison Chaplain can also direct families to other sources of support (*ibid*).

Lack of accountability

A key element of the process that can make families feel disappointed by the Prison Service's level of accountability is the lack of family inclusion in investigations. Families often report that either their views are not considered in the investigation of death or that they are treated with suspicion when they attempt to make those views known. INQUEST's 'Family Listening Day' research on experiences in England and Wales revealed perceptions that investigations were highly intrusive and improperly targeted. The report states it was "as though the families were being investigated to

identify ways this information might be used to support the police version of events or to create a narrative of familial dysfunction" (INQUEST, 2018: 9).

Put simply, to include families meaningfully within the processes of investigation both helps them to feel that the process is legitimate and helps avoid the inference that officials are prioritising the denial of blame. Families in these circumstances are generally well-intentioned, and one account makes the case that in fact they may provide a useful perspective in investigations. Specifically, it states:

> "The family should be treated as an ally to get to the truth. Family liaison has to be in the DNA of the organization as we normally understand what went wrong really well and none of us want someone who was not responsible for our loved one's death to be blamed for it" (INQUEST, 2018: 9)

Dixey and Woodall (2012) and Holligan (2016) find that many prisoners actively maintain bonds with their parents through their prison sentence. As such, parents should be considered uniquely placed to provide a crucial perspective on their child's death. For this reason, where parents are not sufficiently included in the post-death investigations, this may also breed suspicion of damage limitation over the search for objective truth.

INQUEST's research also highlighted an extreme distaste on the part of families for official interactions with the media. Drawing on experiences of death post police custody families expressed feeling that "the police use press releases to create a narrative of events that helps exonerate or explain their actions" (INQUEST, 2018: 10). Some respondents reported that facts were not checked with families before release, often including inaccurate and negative information. This was cited as a key instance in the process that appeared to prove to families that damage limitation on the part of officials was a stronger priority than taking accountability. One family example described:

> "The police press officer put out that he was a burglar. We told the IPCC to take it out of the paper, but the IPCC would not back us up and they would not remove this from the public domain and set the record straight. If they were meant to be for both sides and be fair they should have stood up for us as straight away they knew that he was not a burglar. At the beginning when I met them I thought these guys are going to help us. Me and my partner looked at all the records and burglary was never mentioned so why was it out there"? (INQUEST, 2018: 10)

Several other respondents confirmed this kind of treatment from official statements to the press, with families expressing distress at having read incorrect details such as gang membership, previous convictions, character aspersions, all of which "presented a narrative that blamed the victim, rather than waiting until a verified account of events was available" (*ibid*). This form of media communication created an adversarial atmosphere with officials and seemed to suggest that they were more so engaged in damage limitation than an objective pursuit of accountability wherever that may lie.

Accountability was a key theme of interest on the Family Listening Day, with many families keen to communicate that the lack of justice that they believed they have eventually received by this system left a "resulting sense of hopelessness and resignation, (leaving) families in turmoil" (INQUEST, 2018: 23). They cited a lack of action following clear misconduct as dismaying, often expressing confusion at the lack of suspensions for individual officers, for instance. Further, where transparency is weak, with families feeling that decisions are being "made behind closed doors" (*ibid*) and with an inability to access information on how decisions were made, this exacerbated the feeling of a lack of accountability.

Lack of compassion

The Harris Review, in its comprehensive assessment of the circumstances around self-inflicted deaths, argued that "the heart-breaking experiences of the families and friends of those who have died… need to be at the forefront of any discussion about what should happen after there has been a death in prison" (Harris 2015: 162). Through the family listening events associated with the Harris Review, a picture emerged of a system which had prioritised formal processes of review over compassion for families. An extract from evidence given by a family member to the panel states:

> "When they first told us about the death it was on a Friday, we were in shock. They told us that our son was found hanging and left us a number for us to ring for more information. We tried ringing this number all weekend but we couldn't get through to anyone" (Report of the Family Listening Events, Harris Review 2015: 163)

The review of arrangements for investigating deaths of patients being treated for mental disorder also emphasises the need for families to be dealt with compassionately (Scottish Government, 2018). In considering how best to infuse compassion and a human rights approach into a bureaucratic system with many players, accounts like these remind us that, where gaps in communication exist, these can inadvertently cause a great deal of harm to families in vulnerable situations. The Harris Review termed this 'institutional insensitivity' (2015: 164), a term which communicates not an intentional callousness on the part of individuals but a broader picture of neglect which can leave families with a feeling of having been forgotten.

Institutional insensitivity can occur both through poor design and despite the best efforts of well-meaning staff. The Harris Review for instance found that, "while the policies are intended to ensure families are more supported, the evidence we have considered suggests that families have found liaison with the prison following death to be unnecessarily distressing" (2015: 164). As such, when considering reform in this area, if compassion is to be a priority there must be a focus not only on obvious design elements of the process where families may be subject to active insensitivity, but also on potential gaps in communication that can lead to a feeling of neglect.

For instance, the account of Bindmans solicitors in the Harris Review stated that "some families we have represented have had no contact whatsoever from the prison after the death and some have found the contact to be unsympathetic and

insensitive" (2015: 164), suggesting both systemic neglect and a problematic approach to sensitive matters by staff. Providing further detail on the specific complaints of families, many at the Family Listening Days in 2014 stated that not enough attention was paid to ensuring that families could have spent the last moments with a terminally ill relative in prison.

Methods of communication and tone were highlighted in particular as having been unnecessarily callous:

> "When we attended the hospital the governor was there and the prison FLO. It was so disgusting, so degrading, they had him chained to the bed as if he was going to spring up and run away. He was cuffed to the bed first time round but then they removed them. The officers however remained. One officer was sitting at the bottom of the bed and another was waiting outside. Governor spoke to us in a very matter of fact way. He didn't offer his condolences or said he was sorry or anything" (Family Listening Event Report in Harris 2015: 164).

What comes across very powerfully from the work conducted with families through the Harris Review is that, when a person who has been in custody dies, seemingly small security practices that are standard when the person is alive, like restraints and the presence of officers, ought to be removed immediately. It is clear from the family accounts that they viewed these measures as a denigration of the person's memory and callous in their presence where no longer required. Guidance on how the end of life is dealt with by staff and prisoners in England such as the 'Dying Well in Custody Charter' (2018) suggest that a "safe and decent approach" (2018: 14) be used. Further, Turner and Peacock (2017) note the concern of the Prisons and Probation Ombudsman that there has been inappropriate use of restraints (2017: 60), however it is not clear that Scotland has these same concerns. A thematic report by HMIPS (2017) on the lived experience of older people in prison reports one case where there has been inappropriate use of handcuffing when someone has been in hospital. It further raises concerns about the standard of care provided and calls for a strategy to be developed specifically for older prisoners.

What is clear is that, in dealing with families in a post-death situation, prison officials should aim to shift their practices immediately from security considerations and towards accommodating a grieving family, as they would in a hospital or palliative care setting.

As already discussed in the earlier sections, in Scotland, families receive limited communication from the Prison Service. The theory of support outlined in the prison instructions in England and Wales is that, as well as the FLO breaking the news, the Governor should write a letter of condolence and offer financial support. In the Harris Review, several family members commented on the tone taken in these condolence letters, suggesting that they felt hurt by the lack of detail and the appearance of it having been a pro forma letter (Harris 2015: 165). In the Harris Review, families often cited the lack of specific detail given as evidence of a lack of compassion and one measure which can be easily improved in the content of any future communications made with families. As one family member states:

> "When we were told they gave us very little information and the officers also withheld information about how he was found. They had no need to do this as the information didn't impact on the cause of death but it did make me feel like I couldn't trust the prison about everything they were telling us about his death." (Harris Review, 2015: 165)

Crucially, as this account demonstrates, where the communication is evasive, lacks detail or contradicts itself, this leaves families with the impression that the Prison Service is working more actively to avoid blame than to express sorrow for the family loss or regret at their role in this loss. In light of these findings from England, it is hardly surprising that families in Scotland, as reported in the media, treat the silence from the Scottish Prison system with mistrust and as an indication of a lack of care.

Perhaps the most challenging element to tackle in improving conditions of institutional insensitivity is the admitting of wrongdoing and provision of explicit and full apologies to families. The EHRC (2015) highlights the need for a 'duty of candour' to be incorporated into the post-death processes. Candour is defined in the Francis Report (2013) as "the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint about the provision has been made" (2013: para 221). This idea of full candour as necessary would require a significant institutional shift away from an approach which defends or protects prison practices. This is made particularly difficult where there is a culture of an adversarial process in place. One family member noted:

> "I realise a litigation culture puts organisations in a position where apologies are seen as admitting wrong but sometimes they need to recognise both publicly and privately that they wished none of it had happened" (INQUEST Family Listening Events in Harris 2015: 166).

Therefore, where communication is made, and it is suggested that this should undoubtedly be a change made in the current process in Scotland, particular attention needs to be paid to the content and tone. In order to ensure that compassion is meaningfully expressed, a broader institutional shift away from viewing families as potential litigants is necessary.

Following the Harris Review, INQUEST's 2018 Family Listening Day built on this work by focussing on family accounts of forms of communication throughout this process, again stressing that this work requires the balancing of many factors by skilled communicators. As stated:

> "Families want personal, family centred contact; investigators who are able to respond in a manner that best suit the needs of each individual case. Regular contact works well for families and skilled communicators were identified as having made a significant difference." (INQUEST, 2018: 7)

Usefully, families in INQUEST's research provided further detail of what exactly they were looking for and what the traits of a 'skilled communicator' were in this setting, including reliability and openness:

> "She would always follow up our meetings with an email, with a structure, information from the meeting and what she hoped to do with the next meeting. She communicated. She was totally open. She would come with diagrams and everything." (INQUEST, 2018: 8)

There is also an emphasis in INQUEST's research away from pro forma letters and towards a flexible, personal approach. Families far preferred to feel part of a meaningful dialogue.

The need for compassion is illustrated powerfully in the Family Listening Day accounts, where "families spoke bravely and honestly about their grief, the shock and helplessness they have endured" (INQUEST, 2018: 25). Some gave accounts of chronic depression and subsequent work troubles:

> "Neither I nor my husband can work anymore. We can't because of the grief. So we have no money coming in. We've had to sell out house, there are days when I can't get off the sofa … It's not just that I have lost my son. My whole life has fallen apart." (INQUEST, 2018: 25)

Comfort (2008) explores the experiences and trauma of families in her influential work on 'Secondary Prisonization'. Drawing on Hasenfield (1972), she argues that "having contact with a correctional facility will in and of itself affect people's behaviours and outlooks, highlighting the role of the penitentiary as not only a people-processing but a people-changing institution" (Comfort, 2019: 66). This concept aims to highlight the range of powerful socio-structural influences that a carceral institution can hold over families of the incarcerated, from "agency and ambivalence alongside powerlessness and despondence" (Comfort, 2019: 67). Small (2015) argues that we should view those with family in prison "not (as) victims; they are multidimensional people with complicated views about imprisonment" (2015: 354). In employing this influential academic work in aiming to support families better, we might base models of compassion on this understanding, wherein the prison dominates as an unignorable force, often imposing powerlessness and despondence. Families, however, should be viewed as individuals with varied and unique support needs. Responding to a dearth of compassion in the post-death system must balance these ideas of structure and agency at once.

Established models of better practice

Family Contact Officers (FCOs) and Family Liaison Officers (FLOs)

In Scotland, the role of the FCO is key to liaise and communicate with families, helping to arrange visits, providing advice and support. However, as already explained, it is the police who break the news of a death to the family, which may be in spite of the connections they have established with an FCO. As already outlined in the previous discussion of processes in England, it is the FLOs that deal with practical issues of informing family members and Next of Kin of the passing of their relative, with the Ministry of Justice National Offender Management Service (NOMS, and now HMPPS) emphasising 'early engagement with families' (NOMS 2012). In describing the role of the FLO, "every family will react differently to the news of a death in custody … family relationships can be complex and (they) may need to

provide information to several different members of the same family" (NOMS 2012: 2). Previously noted analysis of the Scottish system finds that families feel disconnected from the process and so to have a point of contact who is tasked with reacting to their specific circumstances embeds a useful level of flexibility and creates a 'catch-all' position that will help to avoid making families feel removed from the outset. Comprehensive early engagement is also useful in having an official representative of the prison system create and maintain contact at a time of high vulnerability for families. Prison officials are "responsible for the day-to-day relationship between a prison and a family" (NOMS 2012: 2), to ensure that families are not left for long periods without information on the process and that, crucially, they have a representative to contact with questions as and when they arise.

Further, "a prompt and sensitive condolence letter from the prison can have a beneficial impact on the nature of the relationship that the FLO/prison has with the family" (NOMS 2012: 2). This is a supplement to the mandatory personal condolence letter that must be sent by the Governor/Director of the prison. To have a liaison with the capacity to act quickly and to prioritise the emotions of the family helps to build a sense of compassion as well as timely justice. The letter of condolence constitutes a small step but does a great deal to provide families with an official acknowledgement of their loss. Where this is coming from the FLO, this also gives a sense that the Prison Service is not simply expressing sympathy but actively looking to keep the family informed of the next steps in the process.

FLOs are encouraged to employ resources within the prison for support, such as the "psychology team, occupational health or members of the chaplaincy team" (NOMS 2012: 2). This helps to underline that the role of the FLO is pastoral to offer a level of emotional support and that staff in the FLO role should avail themselves of these resources. At the same time, a key aim is that the FLO be sufficiently well-informed of the circumstances of the death, which is achieved by including them in the "hot and critical incident debrief" (NOMS 2012: 2). As previously noted, a crucial element of the FLO role is to give comprehensive but appropriate information to families, explaining why certain information sensitive to the investigation must be held back, if applicable, and maintaining a log book.

Through these measures, the FLO can provide a sympathetic but informed contact point for families, negotiating a very difficult time and crucially working with the specific needs of the family to try to avoid the harmful dearth of contact and transparency that currently exacerbates this experience.

Finally, in attending the funeral if appropriate and laying a wreath on behalf of the prison, the FLO can come to represent a symbol of the expression of grief and mourning on behalf of the Prison Service, helping to express compassion from within a relatively bureaucratic process.

The Harris Review, as already discussed, notes that not all of the work that happens with families in practice is consistent, but at the very least, this template of working stands in stark contrast to the current Scottish system, whereby the prison often remains silent and, as such, appears lacking in compassion and is viewed with suspicion.

Narrative Verdicts

As previously discussed, 'Narrative verdicts' allow coroners' courts in England and Wales to record failings that may not have contributed directly to the death being examined, but which may have caused additional distress to the deceased. In particular, narrative verdicts have the ability to provide a potentially extensive level of detail to families, helping to address feelings of a lack of knowledge surrounding their loved one's passing. The Prison Reform Trust and INQUEST define narrative verdicts as:

> "a detailed form of inquest verdict in which a jury can establish any disputed facts and give an explanation of what they think are the most important issues contributing to the death, including identifying individual or systemic failings." (2012: 8)

The use of juries provides a sense of fairness and "a crucial expression of democratic accountability" (INQUEST, 2012: 4) while directing the lens of analysis beyond individual failings. INQUEST also noted that including juries in this work "has powerful public significance" (*ibid*), providing a sense that independent arbiters are taking stock of institutional failings.

However, the use of narrative verdicts in England and Wales is not without its limitations. Research on their impact finds that they are often underused and rendered ineffective when employed without a framework for compliance (Tomczak, 2019; INQUEST, 2012). Conversely, work conducted by the Prison Reform Trust and INQUEST (2012) on deaths of children and young people in prison stresses that narrative verdicts have the potential to address some key concerns of families of the deceased and, as such, might be considered as a solution to some of Scotland's failings in this area.

Key critiques of the narrative verdict and jury system suggest that, while broader structural failings are identified, they are rarely pursued, and there are no mechanisms in place to enforce subsequent reforms. It is crucial, then, if Scotland takes on a narrative verdict approach that, where broader patterns of harm are identified within the prison system, a person or body is tasked with ensuring that these recommendations are acted upon in a sufficient and timely manner.

Beyond their role as "a valuable learning tool for state agencies" (INQUEST 2012: 9), evidence on narrative verdicts suggests that they are in fact highly effective in addressing family feelings of neglect. They are reported as making "the inquest process more meaningful and fulfilling for bereaved families because they often reflect the full range of evidence heard at the inquest" (*ibid*). Going further, the 'Learning from Death in Custody Inquests' review (2012) finds that the thorough nature of narrative verdicts helps to provide a sense to families that "the court has done all that is possible to establish the important facts about how and why the deceased died and assist them in coming to terms with their traumatic bereavement" (2012: 6). The appearance of the jury providing independence and democratic accountability is paired with a thorough process, hopefully providing far greater satisfaction for families. McIntosh (2016) argues that embedding the principle of 'open justice' in inquests not only provides recognition but a sense of transparency

and procedural fairness. This approach could, if implemented, very directly address the current feeling of Scottish families of being under-informed and dissatisfied with the level of scrutiny in place.

Families Outside

Families Outside is the only national Scottish charity that works solely on behalf of children and families affected by imprisonment. They offer a national helpline, regionally based face-to-face family support, in-depth support, training for key professionals, influencing policy and practice to raise awareness of the barriers families face when someone goes to prison. Their database helps them to identify trends and key issues. For example, Families Outside contributes to the Scottish Prison Service's Suicide Risk Strategy Group and is able to provide 'live' feedback from families concerned about someone in prison who may be suicidal (Loucks, 2019: 124).

As described by Loucks (2019: 119):

> "Unlike other interest groups, families of people in prison deliberately do not draw attention to themselves, hesitate to reach out for support, and shy away from speaking out about their cause. These families are no one's specific responsibility in terms of funding or policy, which presents the challenge of getting potential funders, strategists, and practitioners to recognise the relevance of this issue and to take ownership of it."

Ultimately, this assertion is well-supported by the evidence gathered here. It is striking that the 'Family Listening Days' carried out in England provides a great deal of insight into much of this collected work. The content of these days showed families themselves to be a valuable source of knowledge who are not currently finding sufficient opportunities to share this. Similarly, where there is no obvious outlet or practice of advocacy for families, we miss the opportunity to collect this insight. Family concerns around the death in custody process are multi-faceted, touching on fundamental legal rights, issues of injustice in our system and the institutional practice of compassion. Research in England and Wales provides a blueprint for change, and Scotland's next steps can be informed by these accounts.

International Accounts

Tomczak's (2019) expansive work on Prison Suicide notes that "globally, the post-death vantage point has not received adequate attention in scholarship or practice" (2019: 4). Instead, it is observed that there is a tendency for deaths to be considered a normal occurrence in the management and operation of prisons (*ibid)*. Wangmo et al (2014) also stressed the "urgent need to systematically collect standardized data in many countries" (2014: 31).

As outlined in section 5 it would seem that Canada is the only country where there is specific guidance directed towards families published and available on their website. In this the role of the FLO is outlined and that the Corrections Service can cremate the body if the family are unable to arrange the funeral. There is also mention of returning property and support for families to access a one off payment in some

cases. The only other country to make reference to the family found in their publicly available guidance was New Zealand. Sumner and Reid (2020) highlight the lack of culturally specific support available for Maori prisoners and their families, however the New Zealand corrections website suggests that there has been an attempt to include Whānau, or extended family in Maori society, in considerations of death in custody processes.

Conclusion

In expanding the scope of analysis to experiences in England and Wales, and to research focussed around 'Family Listening Days', a broader picture emerges of the voices of families who continue to feel relatively unheard in the review process. This problem persists despite some existing policy and procedure that has aimed to make space for family perspectives (for instance, the COFPS Family Liaison Charter 2016). Some of these accounts suggest that fundamental issues of justice can be better addressed in the post-death system by more fully incorporating family perspectives. The evidence also suggests that denying families legal status and advocacy within this system causes active harm and injustice. At the procedural level, families should be ensured full legal rights through affordable and accessible representation. The issue of 'timely justice' is a strong theme in this work, and it is clear that elements of delay in the system can cause frustration and extended grief for those who have experienced the death of a loved one in prison. Families report a lack of faith in the system that is perpetuated by the Prison Services' approaches to reviews. Families express scepticism and suspicion around the aims of post-death investigations, viewing them as a process of damage limitation, rather than an earnest inquiry into objective truth around the circumstances of the death. Most prominently, families have communicated the potential for distress caused by 'institutional insensitivity' and a lack of compassion displayed at the personal and structural levels of this process. While certain solutions are proposed here, such as the use of FLOs, Narrative Verdicts and an increased role for voluntary support organisations, it is perhaps compassion around the grieving process, the delivery of information, the expressions of regret on the part of the prison that are most desired by families. This accumulated body of research suggests that to infuse compassion and a human rights approach into the system through reform of the process ought to be a priority.

7. Impact on Staff of Deaths in Custody and Review Processes, and Current Support

Key Findings

- Drawing on research from England, a death in custody affects staff emotionally, and delays in inquests create much unnecessary stress.
- There is broad consensus in research carried out in England that, at present, inquests have limited impact on change in prisons.
- Staff resent being made to feel responsible for complex cases where prison was being used as a last resort.
- Interactions with the bereaved family are shown to be challenging for staff in England.
- Medical staff report experiencing conflict with deaths and how the public perceive those they care for, and not feeling they have permission to grieve or to talk about their work outside of the prison system. This also suggests that NHS staff working in prisons may not see themselves as being part of a wider NHS team and could be indicative of them not accessing the NHS support structures that are available in the community, though this would need to be explored further.
- The scant research in Scotland of the support structures for prison staff such as counselling show that they generally have a low uptake, and a specific study into their value should be carried out. The uptake of NHS support structures for NHS staff that work in prisons is also not known and is worth exploring.

Introduction and Overview

Beyond the family unit, those who perform caring roles for people in prison either nearing death or post-death also have an investment in improvements in review processes. This group can include prison staff, NHS staff (including those involved in palliative care) and prisoners themselves. Existing international research on the role of caregiving in the prison setting (Linder and Meyers 2009; Maschi et al 2014; Burles et al 2016) points to the ethical complexities involved in balancing caring roles with the duties of the custodial setting. As will be discussed in this section, due to these wide-ranging roles assumed by prison staff, end of life care can fall to other prisoners. This section will consider supplementary academic and policy research on the perspectives of this range of caregivers to gain a fuller insight into the sometimes hidden impact of reviewing deaths in custody in the broader prison community. While a great deal of research in this area centres around self-inflicted deaths (SIDs), some focus is also given to deaths by illness and natural causes, which affect the ageing prison community and others who sometimes depend heavily on support from within the prison system.

Emotional Impact of Death on Prison and Medical Staff

The established research in this field strongly suggests that the spectre of self-inflicted death (SIDs) looms large in prison management. Liebling (1995) argued that not only are SIDs in custody common, but that "there is more SID risk in the prison system than can be accounted for by imported vulnerabilities alone" (Liebling 1995 in Ludlow et al 2015: vii). This creates a substantial burden for prison staff, who not only have to guard against SIDs in prison policy and practice, but also play an integral role in post-death investigations.

Ludlow et al (2015) explored views of prison staff on deaths in prison among 18 to 24-year olds. Within this research, prison staff expressed views around the effectiveness of post-death processes, including the lasting impact these have had on many working in this role.

Ludlow et al (2015: xi) found that many staff across prisons "described their involvement with a death in custody as having a significant impact upon their emotions and practices". This was expressed as a personal impact but also as a broader shift in the emotional tone in the prison community. Firstly, any SID is described as having a profound effect on the prison atmosphere on the whole, as one Non-Operational Staff member stated "any death affects the tone of the prison … It becomes quiet and flat" (*ibid*: 58). The study provides a vivid overview of the all too regular occurrence of staff witnessing tragic deaths in custody, taking a high emotional toll on their working lives. As a Safer Custody staff member reflected:

> "Repeated exposure to death doesn't make you used to it – staff are traumatised every time" (Ludlow *et al*. 2015: 61)

In considering the emotional impact of deaths in custody on correctional staff, Cassidy and Bruce's work conducted detailed research employing trauma and psychosocial indicators to explore the exact extent of this impact. Their findings suggest that "32% of participants were exhibiting symptoms at a clinical level" (Cassidy and Bruce 2019: 304). They note that the working conditions of the prison create a background of high levels of strain and that the impact of self-inflicted deaths on prison staff remains relatively unexplored in research (Snow and McHugh, 2002). They also found that clinical post-traumatic stress disorder and indicators of this condition were present, with symptoms of "intrusive thoughts, dysfunction, impairment, and tension" (Cassidy and Bruce 2019: 309).

Crucially, in the groups who did not develop these symptoms, participants still displayed struggles with "a profile of lower perceived control, less optimism and more pessimism, and a less positive problem-solving style" (Cassidy and Bruce, 2019: 209).

Sweeney et al (2018) explored 'prison officer culture', finding that the maintenance of machismo involved in the day-to-day work of the prison often prevents staff from expressing emotional strain or seeking help, with a specific concern that this could undermine their projected professionalism (2018: 472). Participant prison officers describe limited coping mechanisms, such as 'dark humour' (*ibid:* 473), becoming

desensitised over time (*ibid:* 475) and 'alcohol consumption' (*ibid:* 475). The conclusion of this work was that significant mental health damage is possible for staff in the wake of self-inflicted deaths in prison. Further research is required for certainty around the exact nature of these developments, however, Cassidy and Bruce suggested that "the level of involvement in an incident of death in custody needs to be monitored and those most closely involved offered intensive support" (*ibid*). Furthermore, assessment tools should be used to determine how serious these mental health strains have become (*ibid*). Their research demonstrates the difficult context and emotional struggles endured by staff that should be borne in mind when considering their capacity for involvement in post-death processes.

This is exacerbated where staff feel some culpability with the benefit of hindsight, and Liebling (1998: 81) found that this, combined with the perceived injustice of being critiqued by post-death investigations, "may reduce their behaviour to an obsession with procedures." This ultimately points towards staff being constrained in their ability to conduct their work intuitively and with the benefit of accumulated experience.

Further research found that the nature of the work in fact meant that "prison staff generally reported high levels of personal resilience following deaths in custody, 'near misses' or incidents of self-harm" (Ludlow et al 2015: 61). However, the involvement in investigations and inquests were reported as "particularly difficult periods" (*ibid*.), exacerbated by delays of several years to complete these processes. The lack of timely justice, as previously discussed, appears to cause not only emotional strain for families, but also for the prison staff hoping to move on in their professional lives. Staff reported to researchers that, as inquest dates were announced, they were forced to grapple with supressed memories (*ibid*). Tomczak's research (2019: 96) found that through the difficult process of cross-examination they are forced to relive events and struggle with the increased scrutiny coming from legal officials who may not be familiar with the subtleties of prison culture. Ludlow et al (2015: 59) add that not all prison staff receive support or training in preparation for these inquests.

Notably, staff reported feeling frustration at having been painted as responsible through investigation processes for deaths of "complex individual cases for whom prison is the 'end of the line'" (Ludlow et al 2015: 61). They also reported that interacting with the family of the deceased was both emotionally difficult and created unexpected safety challenges, particularly when combined with social media:

> "I've had a member of staff and their partner contact me and say that they were concerned for their safety […] I've never known it before. I've always known we've been to court and we've shown our faces, names, and all the rest of it, but obviously if there's a lot out there on Facebook and in the media and that this person is particularly at risk because they live [near] the family" (Safer Custody staff in Ludlow *et al*. 2015: 60).

Recent work by Tomczak (2019) also describes the long-term accumulation of 'institutional apathy', wherein "individual suicides can trigger vicious cycles of suicidogenic discourses and practices amongst prison staff" (2019: 17), often

normalising deaths and preventing broader lessons from being learned. Tomczak's work contains several accounts expressing the sentiment that "it's always like this, it is kind of what happens" (Prison Officer Account, Tomczak 2019: 18), a position which is regularly taken by prison staff who must balance "chaotic conditions and multiple prisoner risks … against the fact that sometimes, even given the best prison conditions and care, prisoners will take their own lives" (Tomczak 2019: 20).

Beyond normalisation and apathy as an institutional coping mechanism, Tomczak's interviews also revealed that in some prison staff, a culture of stigmatization of prisoners can emerge through the day-to-day work of prison management:

> "Whilst staff suspicion of prisoners is understandable to some extent, this suspicion may also lead staff to treat prisoners unfairly, dismiss potentially lethal behaviour as 'manipulative' and limit staff appreciation of prisoners' dynamic suicide risk factors" (Tomczak 2019: 23).

This work details the complexity of prison staff responses to suicide, highlighting that the culturally-specific coping mechanisms regularly employed may at times inhibit future prevention of SIDs. As such, recognising the complexities of the emotional impact on staff may be crucial in future preventative work.

Similarly, Sweeney et al (2018) find that the lack of resources and training available for prison officers not only undermines preventing SIDs in prison, but that the confusion and uncertainty caused by these conditions can further exacerbate guilt and rumination among staff (2018: 474). This creates a cycle of institutional apathy and strain among staff, while impeding prevention efforts.

In the Scottish context, this perspective is somewhat endorsed by the SPS Suicide strategy 'Talk to Me' in which suicide is presented as a tragic, but often unpreventable and unpredictable occurrence. The question of whether suicides can even be viewed as preventable is disputed and there is apparent conflict between procedure and research assertions. Tomczak's (2019) review of suicide in prisons stresses that accumulated research in this field finds that "prison suicide is thus a *substantially* (although not entirely) *preventable crisis*" (Tomczak 2019: 2).

Responsibility for the provision of healthcare services to prisoners transferred from the SPS to Health Boards in November 2011 (Strang, 2011). Even prior to this transfer, and reflecting on the experience in England and Wales, Perry et al (2010) highlight that offender health care is complex and not understood by many in the wider community, sitting separate from the wider NHS. They draw attention to the unique challenges faced in the prison setting that can have a demoralising effect and make staff recruitment and retention in this area a challenge. In a review by the Royal College of Nursing (2016), concerns were raised regarding the sharing of information, low morale and lack of wider understanding in the wider NHS of the role of prison care. These challenges regarding staff recruitment were further emphasised by the Health and Sport Committee of the Scottish Parliament (2017). In 2016, the Public Bodies (Joint Working) (Scotland) Act 2014 led to the integration of health and social care. The legislation does not mention prisons specifically but that services should be more joined up and person-centred. This wider context is important to bear in mind in terms of how nursing and medical staff 'sit' within the

wider prison system and NHS, but there would need to be more research to understand the current position and how medical staff feel in terms of their position and support.

Each prison in England and Wales, as in Scotland has policies for staff to follow in relation to a death in custody, stating that in all areas of care there is a need to be person-centred (Perry et al 2010). Turner and Peacock (2017) report profound emotional strains for prison doctors and nursing staff in experiencing natural deaths in prison and the subsequent processes which follow. They report feeling conflicted in their desire to view the prisoner as a patient, illustrating "the moral conflict that can be engendered by the current practice of imprisoning increasing numbers of older, frail people, and how important it is for staff to maintain their humanity" (Turner and Peacock, 2017: 63). Medical staff reported that the moral conflict of providing care for prisoners, and the public view of this practice can add to a reluctance to share experiences or confront challenges through discussion: "Staff often feel unable to talk about their work or share models of good practice outside their workplace for fear of criticism by family, friends, and even sections of the media" (*ibid*). Similar to the work of Masterton (2016) on the impact on prisoners, staff in prisons also could be said to be confronted with 'disenfranchised grief' (Doka 1999), whereby they do not feel they have the permission to show it, or that their feelings of grief are not acknowledged by colleagues, those close to them or indeed the wider community. These attitudes in turn may mean that medical staff working in the prison may not necessarily see themselves as part of a wider NHS team.

Prison Staff Perspectives on Post-Death Review Processes

A consistent theme in research on prison staff perspectives was that "staff described feeling unfairly blamed 'when things go wrong' and unrecognised for their successes in preventing deaths" (Ludlow et al 2015: xi). Staff also described a defensiveness in the Prison Service and "erosion of confidence following a death in custody, stemming particularly from their fear of inquests" (*ibid*), ultimately hindering the feeding-forward of relevant accumulated staff knowledge that might improve future prevention of SIDs. This 'institutional anxiety' (Chiswick *et al*. 1985) was viewed by prison staff as having negative long-term effects on prison practices meant to prevent SIDs:

> "They [deaths in custody] tend to follow a pattern: after the first one or two incidents, both staff and inmates become sensitive to the possibility of suicidal behaviour; staff anxiety rises and leads to increased surveillance and security, which may be counter-productive; among inmates, the initial shock gives way to an acceptance of self-injury and suicide, so that at times of stress it becomes a more likely reaction" (Chiswick et al 1985: 6).

Staff also described a tendency for policies following a death in custody to become "over cautious" (Ludlow et al 2015: 58). This caution manifested itself either in restrictive 'Assessment, Care in Custody and Teamwork' (ACCT) frameworks or in coroner/PPO recommendations that were "inappropriate, unrealistic or a reflection of being poorly informed about the 'realities' of prison life" (*ibid*).

Some prison staff in the project suggested that attending inquests had helped those who had seen the review process to reflect on their daily practices:

> "Once staff have gone to an inquest it makes them more conscious about the quality of written evidence and its importance. Too many times I've heard coroners describe entries that are inadequate […] for example, looking through the spyhole and just writing 'on left hand side'. The then coroner thinks well was he breathing? Was he moving? They should write something like 'no movement, tapped on glass, got a response' (Prison Officer, Ludlow et al 2015: 59).

> "When I do risk work now I'm more cautious about explaining exactly what I'm doing and thinking because I know I won't be able to remember it one or two years on and be able to justify my actions. I check things now, and then check them again." (Manager, Ludlow et al 2015: 59)

Indeed, staff reflected that the best possible outcome from these tragedies was when they could be used "as catalysts for a process of thorough, institutional-level reflection upon processes and practices, which supported change that makes suicide prevention more likely" (Ludlow et al 2015: 58). However, staff below Manager level were sometimes sceptical of the likelihood of this kind of broad reflection and change, with worries that lessons were not being learned across the prison.

In their review of experiences of staff in Ireland Roulston et al. (2021) found that prison staff are inadequately trained, and reaffirming Hayes (1997), that the investigative nature of the inquest process can alienate them from their colleagues (Roulston et al 2021: 225). They note that in Ireland, the introduction of the Suicide Training Overview for Prisons (STOP) programme has been paired with palliative care training for prison staff in response to some of these perceived inadequacies.

Further research in Ireland from Barry (2017) aims to directly address the limited empirical evidence on this topic through work on prison staff culture. Barry found that emotions for staff following a death are "automatic and instinctive" (Barry 2017: 55), that staff members grapple with adrenaline in the immediate aftermath, often quickly turn to "getting the prison back to business" (*Ibid:* 56), and officers focus on projecting resilience. Building on earlier research by Crawley (2004), Barry's (2017) work found that officers in the Irish Prison Service had accepted and internalised 'feeling rules', with one participant stating: "let's put it this way, there's no way you'd be crying and whimpering about it, they'd think you were mad" (Barry 2017: 57). These testimonies are inextricably bound with expressions of masculinity, with prison officers reflecting overall that displays of empathy or grief were rare and restricted, with humour functioning as a replacement in prison culture.

On the experience of the prison after a self-inflicted death, Barry's work reported that this had a "transformative effect on participants' approach to their work" (Barry 2017: 59). It creates hesitancy towards working night shifts and inducing an increased vigilance around the availability of ligature knives for instance. Notably, Barry (2017) also found that the repressive nature of the prison culture meant that emotion could bleed into personal lives, particularly as they re-live trauma through persistent intrusive images of the death (Barry 2017: 59). Prison officers stressed

the need to be able to leave work behind and create a clear distinction between this and their personal life at the end of the day, or when they take the uniform off.

Support Available to Prison and NHS Staff

Training

In a study of the prevention of self-inflicted deaths in NOMS' custody amongst 18-24 year olds, staff participants reported that ACCT foundation training had been overly-focussed on procedure and left them feeling "underprepared or underinformed" (Ludlow et al 2015: xi). Still, on the content of training more generally, staff reported that it had been hindered by staff shortages and "delivered too much by way of presentation or e-learning rather than providing opportunities for discussion and reflection upon best practice" (Ludlow et al 2015: xi). This work conveys the high level of experience accumulated in this area by prison staff, and as such, opportunities to share examples of best practice should underpin any training or support for prison staff.

The Immediate Response

In Scotland, in the evaluation of TTM, the 'hot debrief' that staff partake in was seen as invaluable, as a way of offering one another support (Nugent, 2018).

The policy indicates that a Critical Incident Response and Support (CIRS) 1:1 and group meeting should take place three to 10 days following the death to provide an opportunity for staff to make sense of their reactions and ensure that appropriate follow-up support from SPS Occupational and/or Employee Assistance is provided where required. It is not compulsory for staff to attend, and the process is confidential. Of the 15 establishments in Scotland, two are privately run. In the private prisons, conversely, there is no group meeting, but rather individuals involved or deemed by the manager to warrant support through contact with the deceased are approached to ask if they want support individually and in private. The SPS, Serco, Sodexo and G4S offer counselling and access to the Employment Assistance Programme (EAP), which is available across all establishments and also open to NHS staff.

The EAP is delivered by an external company to provide support with emotional, health and social problems by phone or face to face and is available at any time (SPS, undated, c). In Scotland, the evaluation of TTM noted that the uptake of CIRS is low, and junior staff in particular may feel inhibited to ask for help (Nugent, 2018). At this time the focus was on providing support through the group meeting. According to the current CIRS Policy, a further 1:1 and group follow up takes place four to six weeks later (SPS, undated). NHS Staff also have their own confidential counselling service that staff can access. In the private prisons, staff are approached individually, and in the evaluation of TTM, an NHS Nurse reported that she had availed of the Prison Service's counselling service and found it very beneficial (Nugent, 2018). A specific study into the effectiveness of the CIRS is recommended. There is no information on the uptake of NHS support structures for nursing staff when a death happens in prison, so this would also be worth exploring further.

Preparation for FAIs

A 'Witness Information Leaflet' has been developed by the SPS (undated, b). This leaflet acknowledges that taking part in an FAI can be stressful for staff, and an overview of the process is outlined. It is clarified that witness statements are evidence and must be signed after being read over carefully, and witnesses may also be asked for 'precognitions', which are not evidence but used by a representative to find out what a witness is going to say.

Relevant documentation, such as health, residential location and SPS prison records, phone call recordings, Integrated Case Management, and any other relevant documents are prepared for the PF. The PF issues a witness citation, and failure to attend can result in a warrant being issued. It is also made clear that witnesses should be on time and sets out expectations of their involvement. The leaflet also outlines 'Do's' and 'Don'ts' such as dressing smartly, speaking clearly and not to speak to other witnesses. There is also 'helpful information' given, that they may have to wait in the witness room for several hours and to take a good book. Finally, support for staff is stated in terms of their Line Manager, Legal Services, Court Liaison Officer, Employee Assistance and the National Suicide Prevention Manager.

Preparation for Inquests

The following short section is based on research in England. It was identified that, specifically in the post-death process, "adequate support for staff in preparing for inquests was identified as important in securing positive oriented learning experiences from deaths in custody, although some staff reported that 'straightforward' lessons from inquests had not been learned" (Ludlow et al 2015: 60). Frustration was expressed particularly among managers that staff were not consistently incorporating basic lessons from inquests into practice (*ibid*). Staff reported that, where they were supported in preparing for Coroners' Courts or provided with 'pre-inquest booklets' (Ludlow et al 2015: 59), they felt better equipped overall.

Where support is available via the Staff Care Team, respondents in the NOMS' Custody study (Ludlow et al 2015) reported that they far preferred to take support from colleagues (*ibid*: xi). The respondents heavily criticised the deficiencies of Staff Care Teams and reported a low staff uptake as a result.

Deaths in Custody: Part of a Bigger Picture

Prison staff in the TTM evaluation in Scotland related that they get support mainly from other prison staff and conveyed their frustrations and helplessness with the challenges faced, such as overcrowding, the churn of prisoners and as a result being unable to build relationships with prisoners (Nugent, 2018). It was also highlighted that, within SPS, there is a high rate of staff sickness and not enough mental health nurses, and staff felt stretched, impeding a good flow of communication (*ibid*).

Tomczak's (2019) observations in England and Wales could also be said to apply in Scotland – that, particularly in relation to overcrowding, staff feel like they are being set up to fail. These challenges should be viewed within the context of the modern prison, in which staff report strain caused by an increasing range of roles they are expected to perform and the ways in which these can be undermined by prison culture. Peacock et al (2018) stress staff concerns at the erosion of 'jail craft', "a nostalgic, multi-layered, narrative or discourse, and set of tacit practices which are drawn on by officers to manage the affective and practical challenges [of the prison]" (Peacock et al 2018: 1152). It is argued that the demands of prison policy remove scope for prison officers to act responsively and intuitively, "connecting with skill, pride and notions of solidarity" (*ibid:* 1154). Ultimately, it is argued that the neoliberal project within prisons is one which by necessity undermines solidarity in favour of individualism and precarity, thereby creating new constraints for officers coping with deaths. Similarly, Barry's 2019 research into staff emotion management in post-death periods stresses the cultural tendency for the concealing of vulnerabilities as being maintained through 'shared expectations' (Barry 2019: 1). These are important reflections, reinforcing that deaths in prison occur as part of a broader but influential socio-economic contexts and their constituent policy landscapes.

Conclusion

Research on the effect of post-death processes on staff is lacking and should be a focus of concern. High levels of trauma were reported by staff who had been in contact with self-inflicted deaths in prison, and a range of research indicated the extensive emotional difficulties felt by staff in this context. In terms of post-death reviews, staff felt unfairly blamed and subject to 'institutional anxiety', where the perceived blame-attribution element of inquests meant that reflections on future good practice were limited.

The literature clearly indicates that addressing significant staff needs combined with information to convey to the broader prison is a fundamental requirement for staff support. The lack of timely justice, which has the effect of keeping prison staff in a position of having to justify their practices sometimes years after the event, had the effect of moving staff towards dependence on administrative process, again hindering their ability to employ significant accumulated experience in improving conditions. Therefore, as expressed by families and echoed by prison and NHS staff, broader reforms of the post-death process are required.

8. Impact on Prisoners of Deaths in Custody and Review Processes, and Current Support

Key Findings

- The emotional impact of the death of another person in prison can be extensive, with prisoners also feeling strains around delays and lack of transparency.
- The main source of support for prisoners appears to be among prisoners themselves, and it is important to recognise the limitations that the prison environment itself and dynamics among prisoners can have on communication and the grieving process.
- The importance of clear, accurate information being given about the death from staff is important, and should prioritise compassion, so that sanctioned ways of showing grief are organised, for example through a memorial service.
- The Listeners' Scheme, bereavement counselling, helplines such as the Samaritans and Breathing Space are invaluable. Past research has raised that, at times, the Listeners' Scheme has been suspended and helplines are not always accessible. It is therefore important that, as far as possible, prisoners have access to the support they need. At present, direct face-to-face support for prisoners has been heavily affected by restrictions due to COVID-19.
- There does not seem to be a consistent approach in terms of what prisoners are offered, pointing towards the need for guidelines and standards to be established about the support for prisoners.

Introduction

Ludlow et al argue that any understanding of the prisoner experience should consider the range of 'imported vulnerabilities' serving as a backdrop to any experience of a death in custody (2015: 2). Vaswani (2018) and Aday and Wahidin (2016) highlight the backgrounds of bereavement and loss many people in prison have experienced, making them a vulnerable population. People in prison are especially vulnerable to suicide in the immediate aftermath of another's suicide. Vaswani's 2019 work on women's experiences of bereavement in prison provides a detailed sense of the particular strains of this process. Drawing on Ferszt (2002), she notes that the physical and metaphorical distance from family support created by imprisonment means that individuals have to grieve "without access to traditional bereavement rites and rituals" (Vaswani 2019: 4). This can include small but meaningful customs like receiving flowers or being able to cope through listening to music, engaging in social and personal distractions. More broadly, she notes (drawing on Fraser 1988) that bereavement is often processed alongside imprisonment as an additional loss, thereby compounding the feelings of loss overall (Vaswani 2019: 4). Indeed, when considering the impact of death in custody review

processes, as detailed, the deeply felt personal and emotional nature of the death is a significant factor. This section outlines the ways in which people in prison can find support, research on palliative care, and the importance of clear communication and compassion in reform approaches.

Support Provided by Other Prisoners

Turner and Peacock (2017) emphasise the importance of interpersonal relationships in prison and particularly for those who perhaps because of the nature of their offence no longer have links with family and friends. Often the emotional impact of natural deaths or SIDs on the broader prison population is extensive, and as such, people in prison can face the same feelings of strain around delays and lack of transparency that are faced by the families of those in prison. Turner and Peacock (2017) note that a significant portion of the older population in prison, and those most likely to die of old age or illness, are people convicted of sexual offences. This is an especially isolated group, but Turner and Peacock note that 'regime constraints' often mean that terminally ill prisoners dying of cancer are regularly given pain relief and support by other prisoners as opposed to prison staff. As one prisoner states:

> "Well, in the past 3 or 4 months we've had two people on here [who] were dying of cancer […] Night-time there was no care at all for them and it was left for us to look after them, like lift them up, take them to the toilet, etc, etc. And as for this pain relief - what pain relief? That's a joke. You know, but it was basically left to our own devices because at night-time, as you know, we're locked up." (cited in Turner and Peacock 2017: 64)

Ultimately, they argue that a large amount of pastoral care of older, dying patients falls to other prisoners, so an important role of post-death processes is to acknowledge that a great deal of emotional support may be needed. As the account from one Prison Officer describes:

> "So we said a prayer with [Chaplain] and everybody sat quietly and we stayed with them and then, when he'd gone, I said, 'Well, he's gone now lads, let's go back to the landing and thank you very much'. And, you know, some of them had a bit of a cry, but we need to give them [pause] you see we give them support as well when somebody dies because it's their comrade, their [pause] family." (Turner and Peacock 2017: 64)

Although not a review of the impact of death on other prisoners, Wilson et al (forthcoming) highlight how, in times of bereavement, the prison regime itself emphasises 'institutional thoughtlessness'. Masterton (2014) observes that, although there is much emphasis on the support people in prison give to one another, the fear of being exploited or conflict of roles between prisoners can inhibit communication. Writing from the point of view of a bereavement counsellor in HMP Edinburgh for many years, Masterton (2014) describes people in prison, like prison staff in the previous chapter, as having 'disenfranchised' grief (Doka 1999), whereby there is not the same sense of community or they are unable to show what could be deemed 'weakness' in the same way as wider society.

Palliative Care

Turner et al (2010) found that the overarching philosophy of the very specific prison environment provided a range of challenges in the provision of end of life car. These included a "prevailing view (at the time) amongst custodial staff that all aspects of the prison experience should be focussed on punishing prisoners" (*Ibid:* 7), along with the growing ageing population creating a strain on resources meant to facilitate and improve provision of end of life care. This was supported in McParland and Johnston's systematic review of 'palliative and end of life care in prisons', where they emphasise that "inmate hospice volunteers can forge close bonds with the prisoners in their care, but can also experience a great deal of grief as a result of their job" (2019: 17). This accumulated research makes the case that support services for those providing official palliative care might be extended in a similar manner to prisoners, in order for them to cope better with the post-death process. There have been some trials of these types of schemes, for instance "in the North East of England, the Prison Service, the NHS, and Macmillan Cancer Support (a national cancer charity) have trained more than 90 health care and prison staff in palliative care' (House of Commons Justice Committee 2013 in Turner and Peacock 2017: 64). A similar collaboration between the NHS, SPS and Macmillan Cancer Support exists in Scotland. While these are currently aimed more at support in the palliative care setting, an acknowledgement of this important role might suggest this support could be extended to ensure the emotional challenges for prisoners in the death in custody review processes are also attended to.

The Scottish Partnership for Palliative Care (SPPC 2017) argues that bereavement should be considered an important element of the palliative care process and should be included in any training. Processes of bereavement are, as previously noted by Vaswani (2019), deeply impacted by the physical constraints of prison life. They are highly specific to the prison setting and so ought to be included in training processes. Aday and Wahidin's 2016 work on 'Grief Behind Bars' emphasises that this form of loss is not only common but highly distressing and requires specific support, as the normal grieving process can be exacerbated and emotional coping mechanisms blocked. The solitary experience of grieving a loved one in prison means that the process is often "frozen in time" (Aday and Wahidin, 2016: 318). Furthermore, it is observed that "not having the opportunity to grieve with other family members or to attend their loved one's viewing can lead to an element of disbelief" (*ibid*). Further, they describe the loss of a friend in prison as "a harrowing experience … prisoners may personally witness their friend's denials for health care, or may be physically present at the time of deterioration and death" (*ibid)*. Therefore, any palliative care approaches ought to prioritise an understanding of the complexity of this issue, which Aday and Wahidin describe as requiring a breaking down of "the divide between compassionate medical care and maintaining the boundaries of incarceration" (*ibid:* 321). They emphasise that, while small measures can make a difference (allowing access to funerals, allowing the prisoner to keep memorabilia), care measures around bereavement must also take seriously both the heightened emotions of the situation and the inability for prisoners to express these.

It is argued that the hyper-masculine setting of imprisonment often stifles natural expressions of grief. Greer (2002: 125) quotes a prisoner comment:

> "Crying is a sign of weakness in here for some stupid reason. They'd think you're soft or something. When you feel that way, you just stay to yourself. In here you have to put on a whole new face from what you were with your family and friends in the streets."

Aday and Wahidin (2016) are critical of the administrative approach to palliative support for prison bereavement. They argue that prison norms and security tend to take priority and that "mirroring mainstream society, prisons recognise specific 'grieving rules' defining the parameters of acceptable grief reactions" (Aday and Wahidin, 2016: 319). This is a crucial impediment to processing grief in prison, where non-familial relationships may have been far more meaningful to the prisoner than relatives.

The Scottish Government's 2011 framework for action on 'Shaping Bereavement Care' provides detailed advice on bereavement care that might be employed in helping people in prison come to terms with this loss. This includes understanding that bereavement is a process that occurs over time. It states that "for some the sense of disbelief at the fact of death may result in grief being delayed and grieving may only begin some days, or in exceptional circumstances months or even years following the death" (Scottish Government, 2011: 25). The attitude and leadership of staff is noted as crucial in facilitating acceptance of death. Spiritual and religious traditions should be considered and therapeutic intervention may be required (*ibid*).

Importance of Communication and Compassion

Where people in prison are dealing with administrative tasks or are active in the post-death process, "clear and accurate information, both verbally and in written form should always be given to people who have been bereaved" (Scottish Government, 2011: 27). Echoing the accounts in evidence previously given by families in the post-death process, it is also suggested that administrative tasks need to be handled delicately. This is about striking a balance, as "too much information will swamp the people it is intended to support while too little can leave them at a loss as to how to proceed" (*ibid*).

Ultimately, while there is a lack of direct research on prisoner experiences of the death in custody process, where a fellow prisoner dies, the emotional connection and impact this can have is clear (Wilson et al forthcoming; McParland and Johnston 2019, Turner and Peacock, 2017). Therefore, models of best practice in this area might apply the same considerations outlined for families to prisoners. Namely, to ensure the review processes are conducted in a timely manner, and when questioned on circumstances around the death, they understand they are engaged in a neutral process of obtaining information and not in damage limitation for the prison.

Any training on palliative care that takes seriously the complex processes of bereavement can help people in prison, particularly those who were actively engaged in care and support for the person who has died.

It is our view in light of the evidence, engagement with prisoners in the post-death review process should prioritise compassion. This can be done by providing

adequate information delivered carefully, providing a point of contact for the person in prison to obtain information in the same way that an FLO might for a family in the English and Welsh system, and allowing officially sanctioned opportunities to express grief, perhaps with the prison Chaplain as described above.

Published Support for Prisoners

The Chaplain, NHS Staff and Bereavement Counselling

People in prison can receive support from the Chaplain (SPS, 2002b), although as already pointed out, this may not be seen as an option for all. NHS staff can also give support. Bereavement counselling can also be provided by community or third sector services such as Quiet Waters or Cruse Bereavement Care. Some prisons report holding memorial services for the deceased in which those who wish to can attend and pay their respects. In the past, some prisoners have also held collections for the families of the deceased.

Listeners' Scheme and support from the Samaritans

Samaritans volunteers select, train and support people in prison to become Listeners. Listeners provide confidential, emotional support to their fellow inmates who are struggling to cope. At the time of writing the Samaritans report that there were 1,803 active prison Listeners across the UK and Ireland as of the end of 2015.[9] At the time of the TTM Evaluation, the Listeners' Scheme had been suspended and was reported as being missed by prisoners. Samaritans can also write to people in prison and offer a freepost service. As well as the prison Listeners, volunteers from the local Samaritans branch can also visit the prison to offer face-to-face support, although this will currently not be possible with the COVID-19 pandemic. As already noted, when a suicide in prison takes place, people in prison are more likely to commit suicide themselves.

Access to Free Helplines

All prisons provide access to free helplines such as the Samaritans and Breathing Space. The evaluation of TTM (Nugent, 2018) raised that access to phone lines was an issue in some prisons, and typically not all prisons offered direct access to helplines from prison cells. This however has shifted recently due to measures introduced to help prisoners cope with the COVID-19 pandemic, meaning that all prisoners in Scottish prisons now should have access to mobile phones. This represents a divergence from standard practice but provides a significant, meaningful way in which prisoners can now reach out for support. It is reported however by the Review Panel that this is not the case in HMP Kilmarnock. Moreover, the personal telephone provided in all establishments only has one helpline accessible, which is the Samaritans, with calls limited to four half hour sessions per day, and all other helplines accessible only through the communal phone in the public hall.

[9] https://www.samaritans.org/scotland/how-we-can-help/prisons/listener-scheme/

These are all ways in which people in prison may be able to access support in establishments following a death. Every death is different, and every individual's way of dealing with grief will differ, but importantly a consistent approach does not appear to exist in terms of what is offered across the prison estate. This points to the need for the development of guidelines and standards so that, within each establishment, staff are clear about how they can support people in prison following a death.

Conclusion

The background of people in prison is they have often experienced a high level of loss and bereavement already in their lives. Significant and meaningful interpersonal relationships can be developed in prison, and it would seem that palliative care often becomes the responsibility of fellow prisoners. When a death happens, the emotional impact can be extensive and can make people especially vulnerable to committing suicide. There is limited direct research with people in prison, but the evidence indicates that they feel the same strains and frustrations as families and staff about the delays and lack of transparency with current processes of investigation around deaths in custody, and this adds significant distress to an already difficult situation. Compassion can be extended to people in prison by acknowledging these difficulties, in particular through sanctioned acknowledgements of death and grief, as well as access to forms of bereavement counselling and support where possible.

9. Conclusion and Recommendations

Scotland has the highest rate of imprisonment and highest rate of mortality in prisons from across the UK. From January 2019 until the end of 2020 there were 71 deaths in prisons in Scotland. There have been 22 'natural sudden' deaths, 18 suicides, 13 natural expected deaths, 10 undetermined, drug-related deaths and one homicide. Over 30% of deaths take place within the first six months of an individual's sentence. Past research shows that those on remand are especially vulnerable to being at risk of suicide. Although statistics from across Europe should be treated with caution, Scotland has the highest mortality rate per 10,000 in the UK, at 47.6, compared to England and Wales, which is 39.5. In England and Wales, INQUEST has described the number of deaths in custody as a 'national scandal' requiring immediate and urgent attention, with understaffing, underfunding and a lack of government intervention as core reasons.

Scotland is subject to a number of international standards and review processes, including the European Convention on Human Rights and the UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules 2015). The case of *Edwards v UK* emphasised the importance of investigations into deaths in custody being independent, prompt and for the Next of Kin to have an opportunity to participate. These standards are not guidelines and not something Scotland could consider but legally must adhere to.

At the initial stage, the main process is carried out by the SPS internally through the DIPLAR process to learn from the incident. Recently, where there has been a death by suicide or is drug-related, the Chair is to be 'independent', which is defined solely as someone who is not employed by SPS but still chosen by the organisation, and therefore the level of independence they have is uncertain. Following the DIPLAR, the Governor and Healthcare Manager agree an action plan. In addition, where someone has been in touch with the NHS 12 months prior to committing suicide, each Board holds its own review process and reports to Healthcare Improvement Scotland with an action plan. It is not clear whether this information is shared with the SPS or how this is monitored. Suicide prevention co-ordinators meet quarterly and review all DIPLARs, and the NSPMG is a strategic group that reviews the Strategy and can escalate concerns to the Minister. The SPS creates an internal annual report providing an analysis of deaths in custody. There is no documentation about a formal process in place to follow-up and ensure actions are being taken forward.

Contact with the deceased's family by the SPS is minimal. The police make the first point of contact, and according to the Guidance, the prison Chaplain should liaise with the family to relay any concerns they have at the DIPLAR, as the family is not permitted to attend. SPS has only recently implemented that it is for the Governor to appoint a Senior Manager to contact the Next of Kin to communicate any necessary information following a DIPLAR, but there is no further information about what this actually means.

Immediately following a death, staff in Scotland are brought together through invitation to take part in the CIRS process and offered further support both on a one-to-one basis and in a group context. NHS staff also have their own support system. All staff are also offered the opportunity for independent support through the Employment Assistance Programme. There is limited information on the uptake or staff views on this process. There is reference made to supporting prisoners in the DIPLAR Guidance but no details about what that might mean or the process of follow-up, so it is up to different establishments how this is done.

At the second stage of review, the SFIU is the first wholly independent organisation that gathers information regarding the death and begins the process of the FAI. The final level of review is the FAI, which is about establishing the facts and the PF calls witnesses. Unlike the State bodies in the process, families are not immediately entitled to legal representation unless they can afford it or are aware and eligible to access Legal Aid. The PF makes contact with the family from the outset and should communicate with them throughout. The Crown Office and Procurator Fiscal Service's Family Liaison Charter is highlighted as good practice. Despite recommendations to improve this process, the time between a death and an FAI is still an average of two years, and in some cases even longer, putting stress on families and devaluing the impact of the process. The Sheriff makes a determination about the time, place and cause of death and recommendations as to how deaths in similar circumstances may be avoided in the future. However, there is a lack of clarity on enforcement and follow-up, and relevant agencies are only obliged to respond about how they may or may not fulfill the recommendations. In short, after this long and lengthy process, there is limited accountability in terms of the changes that may be needed.

Although the system in England and Wales is not without fault, in contrast to the Scottish system the process of review from the Coroner, PPO and Clinical Review is entirely independent. The number of agencies submitting their recommendations for change obfuscates the message, and the data are not brought together and analysed, so identifying or understanding trends is not possible. Similar to the Scottish system and on an international basis, there are delays and limited follow-up about recommendations made, so the same accountability gap exists. It is reported that the same recommendations are being made time and time again with little change, even for example in England with people in hospital dying in restraints. The literature shows a strong leaning towards having one single independent agency whose role is to monitor, recommend and follow-up on recommendations after reviews about deaths in custody have been concluded.

In theory, and on paper at least, although the reality is different (Tomczak, 2019), the communication with bereaved families is much more direct in England and Wales than it is in Scotland, and there is notional good practice that could be considered and adopted. Namely, although Scotland already has a similar Family Liaison Officer by way of the Family Contact Officer (FCO), at present when someone dies in custody it is the police who break the news to the family, and instead it would seem good practice that this is done by a representative from the prison. In the English and Welsh system, there should be open communication between the family and prison, relating how the person has died and other relevant information, so that suspicion or distress is not caused unnecessarily. In England and Wales, the

Governor making direct contact, passing on condolences, updating on action plans to prevent future deaths, offering help to pay for funeral costs, and handing back property sensitively is well-considered. The research points towards families having access to legal support, an opportunity to see the body, the provision of information in a sensitive manner, the acknowledgement of grief, an aim for more timely justice and, once again, compassion. The contact made by the PPO to the family is similar to what happens already in Scotland. It is good practice though that, after the inquest has been concluded, the prison Governor contacts the family again to inform them of any further action. Looking to other processes, and in particular the work of the CQC, which regularly asks patients about their experience, the same approach could be taken with families following an inquest or an FAI in the Scottish context.

In looking beyond the traditional family unit, it is clear that the post-death processes have the capacity to impact negatively upon staff and prisoners involved with deaths in custody. The existing literature indicates a capacity for serious trauma, particularly around self-inflicted deaths, for those in the prison setting while the formal and informal pastoral care roles taken on for dying prisoners are often unacknowledged. It is established that highly meaningful interpersonal relationships can flourish in these end-of-life settings, and so for those prisoners or staff to be excluded or feel alienated from the post-death review process could exacerbate grief further. Ultimately, these groups constitute an integral part of a deceased prisoner's broader care circle, so they can face the same strains as families when it comes to navigating the post-death process. 'Institutional anxiety' around assuming or deflecting blame can tend to be prioritised over important institutional expressions of grief, such as having officially-sanctioned memorial services in the prison. Evidence from palliative care professionals also suggests that the nature of caring for a person who is dying in prison, combined with post-death damage limitation, can mean that lessons for future better practice are not always learned. Support for staff and people in prison in this area should therefore apply better practice principles that would be afforded to families.

Recommendations

- In light of the international standards for review processes to be independent and transparent, the DIPLAR system should be reviewed, and this process shifted to being undertaken by an independent body.

- The contact with families post-death by the SPS is minimal and could be perceived as cold and unnecessarily defensive. The practices developed in theory in England and Wales, with the FLO and the Governor making contact and being open with families about the details of the death from the start, should be adopted in Scotland.

- The contact with families by the SFIU, as set out in the COPFS Family Liaison Charter, is good practice, and this proactive approach should be adopted by the Scottish Prison Service and any agencies developed in relation to review of deaths in custody in the future.

- At present, families have limited input into processes, and the connections to support in the community may not be happening. It has been observed that

families of people in prison are often regarded as no one's responsibility (Loucks, 2019), and this needs to end. Policy and practice need to be informed by those with lived experience who are affected by it.

- FAIs are still taking around two years to happen from the point of death, and therefore the legal standard for reviews to be prompt is not being met. This research brings to light that this lack of timely justice affects families, staff and prisoners adversely. Sheriffs make recommendations, but these are not legally binding, and follow-up does not currently happen. It is recommended that Sherriff's recommendations are placed on a statutory footing.

- This report supports the recommendations made by HMIPS (2019) for the need for co-ordination of reviews, with further analysis of comparative data on suicides, and to consider international evidence. It is further recommended that consideration be given to having one independent body that takes account of all deaths in custody, including natural deaths, and that is able to understand trends and follow-up on recommendations with statutory powers to make decisions legally binding. This body should also ensure that, at every stage, families are informed and their views taken into account.

- There are a number of particular gaps in research identified, namely the impact on families, prison staff, NHS staff, and prisoners of the death of someone in prison. These warrant specific studies to help explore and understand more about current challenges and mechanisms of support.

- This research brings to the fore the need for compassion and a human rights-based approach to inform processes. In this context, compassion relates to no death being seen as the same, with an acknowledgement that no individual deals with grief in the same way, and a person-centred approach taken. It is important that families, staff and prisoners get access to the support they need and that institutional and structural barriers to asking for help are challenged.

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Appendix 4

The Human Rights-Based Approach taken by the Review

1. The Review is taking a human rights-based approach. In practice, this means that human rights law and standards will inform all of the Review's analysis, conclusions and recommendations, but it also means that human rights principles will shape the Review's overall approach in how we conduct our work.

2. Taking a human rights-based approach is about using international human rights standards to ensure that people's human rights are put at the very centre of policies and practice. A human rights-based approach empowers people to know and claim their rights. It increases the ability or organisations, public bodies and businesses to fulfil their human rights obligations. It also creates solid accountability so people can seek remedies when their rights are violated.[10]

3. The central components to a human rights-based approach have been distilled into five principles: **P**articipation, **A**ccountability, **N**on-discrimination and equality, **E**mpowerment and **L**egality. These are commonly referred to as the **PANEL** principles.

> **Participation**: people should be involved in decisions that affect their rights.
>
> **Accountability**: there should be monitoring of how people's rights are being affected, as well as remedies when things go wrong.
>
> **Non-Discrimination and Equality**: all forms of discrimination must be prohibited, prevented and eliminated. People who face the biggest barriers to realising their rights should be prioritised.
>
> **Empowerment**: everyone should understand their rights, and be fully supported in developing the policies and practices which affect their lives.
>
> **Legality**: approaches should be grounded in the legal rights that are set out in domestic and international laws.

4. The Review has used the **PANEL** principles to develop a framework to analyse and assess the human rights impact of decision making and processes in relation to deaths in prison custody, which is contained in a separate document. This document sets out how the **PANEL** principles relate to the Review's overall approach.

How the Review takes a human rights approach to its work

5. The **PANEL** principles can be applied to all activities the Review undertakes and to our decision making processes:

[10] https://www.scottishhumanrights.com/media/1409/shrc_hrba_leaflet.pdf

Participation	The experience of families, staff and prisoners is central to the Review's work. The Review makes every effort to engage with those affected by deaths in custody and offer a variety of different ways for them to engage with our work. An Advisory Panel has been established to steer the Review's engagement with families who have experience of a death in custody. The Advisory Panel all have direct experience themselves.
Accountability	Records such as Steering Group minutes, documenting decisions and attributing action points, are kept. Significant issues, for example whether the Review can consider documentation in relation to cases that have yet to complete the FAI process, are communicated by letter to ensure records of decision making processes are kept. Recommendations will be appropriately evidenced and documented. Updates are provided on the Review's progress to the Cabinet Secretary. These updates, which consider all of the Review's work streams, are shared publicly on SHRC website. We respond to questions, whether those are posed by members of the public or organisations, with maximum transparency and clarity.
Non-discrimination and equality	The Review is, at all times, mindful of barriers that would impact people's ability to engage with our work. For example, in engaging with families and staff, various communication methods are offered. The methods available to us have been restricted by COVID-19, and the Review actively tries to mitigate those impacts at all stages. The Review gives active consideration to how it could facilitate engagement for those who may face the biggest barriers. Ensure all recommendations promote non-discrimination and equality to the maximum extent possible.
Empowerment	The Review supports professionals and families to engage with our work. Examples include engaging with professional networks and trade unions and seeking advice and involvement of those with particular expertise to ensure our work is relevant and accurate. This includes working with organisations such as Healthcare Improvement Scotland, HM Inspectorate of Constabulary Scotland and expert witnesses. The Review supports families to engage with our work. Our work is informed by a Family Advisory Group. The Review has provided a number of different ways for those affected by a death in custody to engage with our work. Examples include offering 1-1 virtual meetings, focus groups, phone calls, anonymous surveys.
Legality	The Review is underpinned by a human rights framework, which sets out human rights law relevant to deaths in custody. This includes law at the European and International level. A separate **PANEL** assessment framework has been developed to assess the human rights implications of policies and procedures in place. Recommendations will be grounded in human rights law.

Appendix 5

European Convention on Human Rights Framework Analysis

Article 2 – The right to life

1. Article 2 of the European Convention on Human Rights ("ECHR") protects the right to life. Article 2 "enshrines one of the basic values of the democratic societies making up the Council of Europe".[i] Article 2 is non-derogable, which means that the state cannot depart from its obligations even in times of war or other national emergency.

Article 2 ECHR

1. Everyone's right to life shall be protected by law. No one shall be deprived of [their] life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is necessary:

(a) in defence of any person from unlawful violence.

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained.

(c) in action lawfully taken for the purpose of quelling a riot or insurrection.

2. The state has a number of obligations under Article 2, which are substantive and procedural. The substantive obligations can be further divided into negative and positive obligations. The state must refrain from the taking of life, unless this occurs in the very narrow circumstances set out in paragraph (2) of Article 2. This is known as a negative duty.

3. The state also has positive obligations under Article 2. This means they must take particular action to comply with the right to life. These positive obligations can be summarised as:

- Ensuring the effective protection of the right to life through effective domestic law and punishment; and
- The duty to protect life through the taking of specific action.

4. Finally, 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 Article 2.

5. Deprivation of liberty creates particular vulnerabilities in terms of Article 2 ECHR, and the state's obligations are therefore heightened in these circumstances.

In the case of *Salman v Turkey*[ii] the European Court of Human Rights ("ECtHR") described the obligations as follows:

> "Persons in custody are in a vulnerable position and the authorities are under a duty to protect them …The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent where that individual dies.
>
> Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during such detention. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation."[iii]

Protection of the right to life through law

6. The state has a general obligation to protect the right to life through effective domestic law. The ECtHR has held that there is a "primary duty on the state to secure the right to life by putting in place an appropriate legal and administrative framework to deter the commission of offences against the person, backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions."[iv] The law that protects the right to life should be accessible and "formulated with sufficient precision to enable the citizen to regulate his conduct".[v] The need for a comprehensive legal and administrative framework regulating use of force is discussed below.

Protection of the right to life through the taking of specific action

7. States are under a positive obligation to take "appropriate steps" to protect life; this also requires the taking of preventive measures. The ECtHR has held that Article 2 imposes an obligation on the state to do "all that could have been required of it to prevent the applicant's life being avoidably put at risk".[vi] The obligation applies when the state knew or ought to have known of a threat to life[vii] and has been found to apply in a number of different contexts.

Protection of people from lethal use of force by non-state actors

8. Article 2 ECHR implies a positive obligation to take preventive operational measures to protect a person where their life is at risk from the criminal acts of another person.[viii] The ECtHR has acknowledged that the obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Therefore, not every claimed risk to life can carry with it a requirement under the ECHR to take operational measures to prevent that risk from materialising.[ix] For a positive obligation to arise, it must be established that the authorities knew or ought to have known of the existence of a real and immediate risk to a person's life from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.[x]

9. For example, in the case of *Paul and Audrey Edwards v UK*, the applicants' son was killed by a fellow prisoner ("RL"), who had a mental health issue and had a history of violence. The ECtHR examined whether the authorities knew or ought to have known of the existence of a real and immediate threat to the life of the applicants' son, Christopher. The ECtHR considered that sufficient information was available which identified RL as suffering from a mental illness with a history of violence which was serious enough to merit proposals for compulsory detention under the Mental Health Act 1983. That, combined with his behaviour on arrest, demonstrated that he posed a real and serious risk to others, particularly to Christopher Edwards when RL was placed in his cell. The ECtHR also examined the measures they might reasonably have been expected to take to avoid the risk to Christopher Edwards' life and concluded that there were a number of failures by different agencies (medical professionals, police, prosecution and court) regarding information sharing and the inadequate screening process on RL's arrival in prison.

Protection from self-harm

10. Article 2 ECHR also implies, in certain circumstances, a positive obligation on state authorities to take preventive operational measures to protect a person from themselves.[xi] Article 2 places a particular protection on people in custody, recognising that they are in a vulnerable position and placing a duty on state authorities to protect them. The ECtHR has held that prison authorities must discharge their duties in a way that is compatible with the other rights and freedoms of the person concerned, for example the right to liberty and security under Article 5, and the right to respect for private and family life under Article 8 ECHR. General measures and precautions are available to lessen opportunities for self-harm, without infringing on personal autonomy.[xii] Whether more stringent measures are necessary to protect a particular person and whether it is reasonable to apply them will depend on the circumstances of the case.[xiii] People with "mental disabilities" (the language of the Convention) are considered to be a particularly vulnerable group who require protection from self-harm.[xiv]

11. A positive obligation will arise where the risk to a person comes from self-harm, where it can be established that the authorities knew or ought to have known about the existence of a real and immediate risk to the life of the person, and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.[xv]

12. In assessing whether the authorities knew or ought to have known that the life of a particular individual was subject to a real and immediate risk the ECtHR has held that a number of factors are relevant, including:

- Whether the person had a history of mental health issues;
- The gravity of the mental health issue;
- Previous suicide attempts or self-harm;
- Suicidal thoughts or threats;
- Signs of physical or mental distress.[xvi]

Protection of people deprived of their liberty and healthcare

13. The state has an obligation to ensure that the health and well-being of detainees are adequately secured by, among other things, providing them with appropriate medical assistance. The ECtHR has held that authorities must ensure that the diagnoses and care afforded to prisoners are prompt and accurate, and that prisoners receive appropriate ongoing treatment to manage any health conditions.[xvii] For example, in the case of *Tarariyeva v Russia*[xviii], the ECtHR found a violation of Article 2 ECHR on account of the state's failure to protect the applicant's life. The ECtHR highlighted a catalogue of failures in medical care, including incomplete or missing medical records; failure to provide medical treatment; failure to respond to known post-operative needs; and the fact the prison hospital was not adequately equipped for dealing with large blood loss.[xix]

Use of lethal force by State agents

14. Article 2(2) ECHR states that deprivation of life "shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect lawful arrest or two prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

15. In general, where domestic proceedings have taken place, the ECtHR will not substitute its own findings of fact over those of the domestic courts.[xx] Where the parties disagree on the events surrounding a death, the factual findings should be based on the standard of proof "beyond reasonable doubt". Where the events lie mainly, or wholly, within the exclusive knowledge of state authorities, such as in the case of people within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring in detention. The burden of proof may be regarded as resting on the authorities to provide satisfactory and convincing explanations as to how death or injury occurred.[xxi]

16. Where use of force by state agents is concerned, a key duty on the state is to ensure an appropriate legal and administrative framework is in place defining the circumstances in which the use of force, and particularly firearms, are permitted.[xxii] A national legal framework must provide that recourse to firearms must be dependent on a careful assessment of the situation and on an evaluation of the nature of the offence committed by an individual and of the threat posed.[xxiii]

17. Effective training and vetting of law enforcement officials and other state agents is vital to enable assessments of whether or not there is an absolute necessity to use firearms, not only on the basis of domestic law, but also with regard to respect for human life as a core value.[xxiv]

18. Use of force must be no more than absolutely necessary. The force used must be strictly proportionate to the achievement of the aims set out in sub-paragraphs 2 (a)-(c).[xxv] In determining whether force was absolutely necessary, a stricter test of necessity will be used than when determining whether state action is "necessary in a democratic society" under Articles 8-11 ECHR[xxvi]. Use of force may be justified where it is based on an honest belief which is thought, for good reason, to be true at the time but later turns out to be mistaken. The ECtHR has stated that to hold otherwise would be to impose an unrealistic burden on law enforcement personnel which could endanger their own lives and the lives of others.[xxvii] When scrutinising the actions of state agents, the main question is whether the person had an honest and genuine belief that the use of force was necessary. This will include consideration of whether the belief was subjectively reasonable, having regard to all of the circumstances at the relevant time.[xxviii]

19. Where a death has occurred in the context of a planned law enforcement operation, the planning and control of the operation to minimise the recourse to lethal force or incidental loss of life will be examined.[xxix] In examining the planning of an operation, the ECtHR's concern will be in evaluating whether the authorities had taken appropriate care to ensure that any risk to life had been minimised.[xxx]

20. The ECtHR has considered a number of cases where death has been hastened by the use of restraint or arrest techniques. In these cases, the court examined whether there was a causal link between force used and the death of the person concerned, and whether authorities provided appropriate medical assistance. In the case of *Mojsiewjew v Poland*[xxxi] the applicant's son died in custody following pressure to his neck, most likely as the result of being restrained using a headlock.[xxxii] In finding a violation of Article 2, the court stated that the Polish authorities had failed to provide satisfactory explanation of the injuries and death of the applicant's son and had failed to account for whether custody staff had complied with domestic regulations aimed at protecting the health and life of detainees.

Article 2 ECHR – procedural obligations

21. Article 2 ECHR imposes a procedural obligation upon the state to investigate deaths where state responsibility is potentially engaged. This obligation extends to all cases of alleged breaches of the substantive limb of Article 2[xxxiii], whether they occur at the hands of state agents, private actors or unknown persons. Article 13 ECHR concerns the right to an effective remedy, and although failures in state responses to deaths may have consequences in terms of Article 13, the procedural obligation of Article 2 is seen as a separate, distinct obligation.[xxxiv] Failure to comply with the procedural arm of Article 2 can give rise to a finding of a separate interference with the right to life.

22. The purpose of an investigation under Article 2 is 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.[xxxv] It also allows "the facts to become known to the public and, in those cases involving state agents or bodies, in particular to the relatives of any victims".[xxxvi] Regardless of the form of the investigation, 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.[xxxvii] The standards of investigation are discussed in detail below, and can be summarised as follows:

- Independence
- Adequacy
- Promptness and reasonable expedition
- Public scrutiny and participation of Next of Kin

Independence

23. Investigations must be independent. This means that those who are responsible for and are carrying out the investigation must be independent from those implicated in events; this requires "not only a lack of hierarchical or institutional connection but also a practical independence".[xxxviii] Article 2 does not require absolute independence, but rather that those conducting the investigation are sufficiently independent of the people and structures being investigated.[xxxix] The Court has found a number of situations where investigations lacked independence. For example, where investigators were direct colleagues of people under investigation[xl], or where investigators were subordinates of those being investigated.[xli] In relation to the investigation itself, the ECtHR has found lack of independence when, for example, investigators put too much weight on the suspects' statements.[xlii]

Adequacy

24. Investigations must be "adequate". Investigating authorities must take reasonable steps to secure evidence concerning any incident; this includes eye witness testimony, forensic evidence and any clinical evidence obtained through autopsy.[xliii] 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.[xliv] The ECtHR has found investigations to be inadequate when, for example, investigators have failed to follow obvious lines of inquiry,[xlv] or when investigators accepted versions of events put forward by the accused state agents without hearing from any further witnesses.[xlvi]

Promptness

25. Investigations must be prompt and must proceed with "reasonable expedition".[xlvii] Of course, there may be some obstacles that prevent progress in particular situations; however the ECtHR 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.[xlviii] The ECtHR has also found that the passage of time is liable to undermine an investigation and will compromise definitively its chances of it being completed.[xlix]

Public scrutiny and participation of Next of Kin

26. There must be a sufficient element of public scrutiny around the investigation or its results. That said, this does not require all aspects of proceedings into a violent

death to be disclosed, and publication of police reports and investigation materials may concern sensitive facts or may be prejudicial to certain people.[l]

27. In all cases, there must be involvement of a deceased's Next of Kin to the extent necessary to safeguard their legitimate interests.[li] 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.[lii] The ECtHR has found that investigations were not accessible to Next of Kin or did not allow for real public scrutiny where, for example where the family of a victim had no access to the investigation or court documents,[liii] and where the father of the victim was not informed of the decision not to prosecute.[liv]

28. The procedural requirements go beyond the stage of the official investigation. If the investigation leads to court proceedings, then the whole procedure including the trial stage, must satisfy Article 2 requirements.[lv] In appropriate cases, a criminal trial, with an adversarial procedure before an independent judge provides the strongest safeguards of an effective procedure for the finding of facts and the attribution of criminal responsibility.

ECtHR Guidance

29. The European Court has produced a Guide on Article 2: The Right to Life, which was last updated in April 2021. It contains detailed information about how the court has interpreted the right to life and state obligations under Article 2. It covers the nature, scope and positive obligations by the state in relation to Article 2, including protections for different categories of people. There is a section on persons deprived of their liberty and vulnerable persons under the care of the state which examines case law in relation to this category. Much of the focus is on medical care and assistance. It also has a section on deaths in custody which highlights cases where state's explanation regarding the circumstances of death were not accepted by the court. The document has a chapter on procedural obligations, which covers the purpose, form and standards of any investigation and a list of cases at the end.

30. The court has also produced a Guide on the Case-Law of the ECHR: Prisoners' Rights, which was updated in April 2021 and touches on deaths in custody.

Article 3 ECHR – Freedom from torture or inhuman or degrading treatment or punishment

Article 3 ECHR
No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

31. Article 3 is non-derogable, meaning it cannot be derogated from in times of war or other public emergency.[lvi] Unlike most other rights contained in the ECHR, Article 3 is expressed in unqualified terms, meaning that treatment falling within the terms of Article 3 can never be permitted, even for the highest reasons of public interest.

32. Article 3 is engaged by ill-treatment which amounts to 'inhuman treatment'. For ill-treatment to amount to 'inhuman treatment' under Article 3, it must attain a minimum level of severity. In particular, inhuman treatment must cause "either actual bodily injury or intense physical or mental suffering".[lvii] The threshold level is relative.

33. "It depends on all the circumstances of the case, such as the nature and context of the treatment, the manner of its execution, its duration, its physical or mental effects and, in some cases, the sex, age and state of health of the victim".[lviii]

34. It is also relevant to consider whether the victim is within a further category of people who are "vulnerable", which includes people in detention.[lix] The term "treatment" for the purposes of Article 3 would also include a failure to act, or an omission.

35. Torture is a particularly severe form of inhuman treatment and has been defined by the ECtHR as "deliberate inhuman treatment causing very serious and cruel suffering".[lx] If the ill-treatment has a malign purpose such as vengeance or retaliation then it is more likely to be classed as torture.[lxi]

36. In contrast with torture, inhuman treatment does not need to be intended to cause suffering[lxii] and the suffering does not have to be inflicted for a purpose.[lxiii] The crucial distinction between torture and inhuman treatment is in the degree of suffering caused.[lxiv] It is not always necessary for the ECtHR to distinguish between the different types of ill-treatment listed in Article 3.

37. There is a wide range of treatment that could potentially fall within the ambit of Article 3 and it is important to note that the Convention is often referred to as a "living instrument" which "must be interpreted in light of present-day conditions".[lxv] This means that different types of treatment could now reach the minimum level of severity needed for Article 3, and those same practices may not have been considered a violation when the Convention was first drafted or even 20 years ago.

38. The ECtHR has previously found certain deaths in custody to amount to a breach of Article 3 without a finding of a violation of Article 2. Under Article 3, states must ensure that a person is detained in conditions which are compatible with respect for human dignity and:

> "that the manner and method of the execution of the measure do not subject her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, her health and well-being are adequately secured by, among other things, providing her with the requisite medical assistance".[lxvi]

39. The case of *Keenan v UK* concerned a young man who received intermittent psychiatric treatment for a number of years. Mr Keenan was admitted to prison to serve a four month sentence. Mr Keenan was initially admitted to the prison health care centre and attempts to move him to the general population were unsuccessful causing his mental health to deteriorate whenever he was transferred. After discussion of transfer to the main prison, Mr Keenan assaulted two prison officers

leading to him being placed in a segregation unit and having his prison sentence extended by 28 days. Shortly after the extension was communicated to him, Mr Keenan died by suicide. In examining the complaint in relation to the right to life, the ECtHR found that the authorities did everything that could reasonably be expected of them under Article 2, such as placing him in hospital care and under watch when he displayed suicidal tendencies. However, the ECtHR found a violation of Article 3. There was a lack of effective monitoring of Mr Keenan's condition and a lack of informed psychiatric input into his assessment and treatment which disclosed significant defects in the medical care provided to a person with mental health issues who was known to be a suicide risk.[lxvii]

40. In addition to the negative obligation not to subject a person to treatment contrary to Article 3, Article 3 contains positive obligations to protect against ill-treatment and the obligations to investigate and to enforce the law. As is the case with Article 2 ECHR, a state must have a framework of law in place, which is effectively enforced, that provides adequate protection against ill-treatment by either state or private parties.[lxviii] Similar to the obligation in Article 2, states must also take practical measures in order to avoid a known risk.

41. Article 3 also carries a procedural obligation to conduct a thorough and effective investigation where a person raises an arguable claim of ill-treatment in breach of Article 3.[lxix] The ECtHR has held that this procedural obligation has the same scope and meaning as the procedural obligation in Article 2, which is discussed above.

Article 8 ECHR - Right to respect for private and family life

42. Article 8 ECHR protects the right to respect for private and family life, home and correspondence. It is a qualified right, which means public authorities can impose such restrictions as are lawful, necessary and proportionate in order to meet certain specified needs such as protecting public safety and preventing disorder or crime.

43. The ECtHR has previously found violations of the Article 8 rights of persons held in prison custody in relation to their contact with the outside world, for instance in the arrangements made for visits and correspondence lxx. In other contexts, Article 8 has also been found to apply to family members regarding the way in which the body of a deceased relative is treated. lxxi

Article 14 ECHR – Freedom from discrimination in respect of Convention rights

Article 14 ECHR

The enjoyment of the rights and freedoms set forth in the Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social original, association with a national minority, property, birth or other status.

44. Article 14 protects the right not to be discriminated against in "the enjoyment of the rights and freedoms set out in the Convention". This means that the right not to be discriminated against does not exist independently under Article 14; it must be connected to the fulfilment of another Convention right. This does not mean that there must be a violation of another Convention right before Article 14 applies, simply that the right must be engaged.[lxxii]

45. The ECtHR has defined discrimination as "treating differently, without an objective and reasonable justification, persons in relatively similar situations".[lxxiii]

46. Article 2 right to life investigations require particular attention to be paid to questions of prejudice and discrimination. For example, where there is an allegation of racially motivated violence, it is particularly important that the investigation is pursued with "vigour and impartiality", having regard to the need to "reassert continuously society's condemnation of racism and to maintain the confidence of minorities in the ability of the authorities to protect them from the threat of racist violence".[lxxiv] Where state agents may be implicated in a death, there is a duty to take all reasonable steps to discover any racist motive.[lxxv] In particular, evidence of racist abuse by state officials in an operation involving the use of force must be fully investigated.[lxxvi]

Appendix 6

International Human Rights Standards and Guidance

1. International Human Rights Treaties

1.1 International Covenant on Civil and Political Rights (ICCPR)

The key articles of ICCPR relevant to deaths in custody are:

- **Article 6:** The right to life, including for people deprived of their liberty. Prohibition on the arbitrary deprivation of life.

- **Article 7:** Right to be protected from torture or cruel, inhuman or degrading treatment or punishment.

- **Article 10:** Persons deprived of liberty should be treated with humanity and respect.

Articles 6 and 7 are non-derogable.

General Comments produced by the Human Rights Committee in relation to the above articles provide further detail.

General Comment No. 36 on the Right to Life has various sections of relevance. For example:

- **Paragraph 13** states that State parties are expected to take all necessary measures to prevent arbitrary deprivation of life by law enforcement officials, which includes measures controlling the use of lethal force, mandatory reporting and review and investigation of lethal incidences.

- **Paragraph 25** stipulates that states have a heightened duty of care to take any necessary measures to protect the lives of individuals deprived of their liberty by the state, which includes providing necessary medical care, shielding from inter-prisoner violence, preventing suicide and providing reasonable accommodation to those with disabilities.

- **Paragraph 28** states that investigations into alleged breaches of Article 6 must always be independent, impartial, prompt, thorough, effective, credible and transparent. It also details what should happen when a violation is found including steps taken to prevent occurrence of a similar violation in the future, investigations should include an autopsy, measure to establish truth relating to events leading up to the incident, disclose of details to Next of Kin and giving Next of Kin legal standing in any investigations and making details of the investigation transparent.

- **Paragraph 29** relates to loss of life in custody in unnatural circumstances, which creates a presumption of arbitrary deprivation of life, and can only be rebutted on the basis of a proper investigation that establishes the state's compliance with its obligations under Article 6 ICCPR.

General Comment No. 20 on Prohibition of Torture highlights the requirement of states to provide information on safeguards for the protection of particularly vulnerable persons and should systematically keep under review interrogation rules, instructions, methods and practices, as well as arrangements for custody and those subject to detention.

General Comment No. 21 on Article 10 (Humane treatment of persons deprived of their liberty) acknowledges the vulnerable state of people deprived of their liberty and stresses the positive obligation of states to ban torture, and other cruel, inhuman or degrading treatment.

1.2 Convention Against Torture and other Cruel, inhuman or degrading treatment or punishment

The Convention Against Torture and other Cruel, inhuman or degrading treatment or punishment (CAT) prohibits the use of torture, cruel or inhuman treatment or punishment in all settings. While the convention in general is relevant, particular articles to note are:

> **Article 14:** competent authorities should proceed to a prompt and impartial investigation when there are grounds to believe torture has been committed.
>
> **Article 10:** information on prohibiting torture should be fully included in training of law enforcement personnel and anyone involved in custody, interrogation or treatment of individuals subject to arrest, detention or imprisonment.
>
> **Article 11:** the requirement to keep under systematic review interrogation rules, instructions, methods, practices, as well as arrangements for custody and detention with a view to preventing torture and ill treatment.

General Comment No. 3 on the right to redress for victims of torture (2012), while not specifically being about deaths in custody may be of some relevance, as it focuses on effective remedy and reparation for victims of torture. Under **Paragraph 3**, it stipulates that the term 'victim' also includes immediate family or dependents of the victim, as well as people suffering harm interfering or assisting the victim. The comment also covers satisfaction and the right to truth (paras 16-17), effective mechanisms for complaints and investigations (paras 23-28), and access to mechanisms for obtaining redress.

Sub-committee for the Prevention of Torture (SPT)

The SPT adopted a provisional statement on The role of judicial overview and due process in the prevention of torture in prisons in 2012, which argues for states to provide a special judicial or similar body, in addition to complaints procedures and supervision of places of detention, to monitor the enforcements of custodial

measures. The document suggests that there is a lack of due process and organisational and procedural legal framework for realising the rights of inmates.

1.3 Convention on the Rights of the Child

The Convention on the Rights of the Child enshrines the right to life under Article 6:

> **Article 6**
>
> 1. States Parties recognize that every child has the inherent right to life.
>
> 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

It also prohibits torture on other cruel, inhuman or degrading treatment or punishment under Article 37, which goes on to set out some important protections for children in relation to criminal justice:

> **Article 37**
>
> States Parties shall ensure that:
>
> (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;
>
> (b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;
>
> (c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;
>
> (d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Other articles of relevance include:

> **Article 40**
>
> States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.
>
> **Article 9(4)**
>
> Where such separation [from parents] results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.
>
> **Article 12(2):** the right to be heard in any judicial or administrative proceedings affecting the child.
>
> **Article 19(1):** protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

In General Comment No. 24 (2019) the Committee on the Rights of the Child elaborated on the meaning of the protections set out in Article 37, on Children in the Criminal justice system. One of the aims of the Committee was to reiterating the importance of prevention, early intervention and protecting children's rights at all stages of the system. The Committee emphasised a number of points that are of particular note in relation to the work of the Review:

- States should promote strategies for reducing the especially harmful effects of contact with the criminal justice system, in line with increased knowledge about children's development;
- States should scale up the diversion of children away from formal justice processes and to effective programmes;
- States should expand the use of non-custodial measures to ensure that detention of children is a measure of last resort;

- For the few situations where deprivation of liberty is justified as a last resort, states should ensure that its application is for older children only, is strictly time limited and is subject to regular review;

- The Committee drew the attention of states to the 2018 report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, in which they noted that the scale and magnitude of children's suffering in detention and confinement called for a global commitment to the abolition of child prisons and large care institutions, alongside scaled-up investment in community-based services (A/HRC/38/36, para. 53);

- States should immediately embark on a process to reduce reliance on detention to a minimum;

- Pre-trial detention (in Scotland referred to as remand) should not be used except in the most serious cases, and even then only after community placement has been carefully considered; All actors in the child justice system should prioritize cases of children in pretrial detention;

- The Committee recommends that no child be deprived of liberty, unless there are genuine public safety or public health concerns;

- The Committee also recommends that states ensure that pre-trial detention is reviewed regularly with a view to ending it;

- States should establish separate facilities for children deprived of their liberty that are staffed by appropriately trained personnel and that operate according to child-friendly policies and practices;

- Every child has the right to be examined by a physician or a health practitioner upon admission to the detention or correctional facility and is to receive adequate physical and mental health care throughout their stay in the facility, which should be provided, where possible, by the health facilities and services of the community;

- Restraint or force can be used only when the child poses an imminent threat of injury to himself or herself or others, and only when all other means of control have been exhausted and under close, direct and continuous control of a medical and/or psychological professional;

- It is essential for the quality of the administration of child justice that all the professionals involved receive appropriate multidisciplinary training on the content and meaning of the Convention;

- States should promote the strengthening of systems through improved organization, capacity-building, data collection, evaluation and research.

1.4 International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights (ICESCR) does not explicitly reference detention or custody. However, articles which may be relevant include:

> **Article 11:** the right to an adequate Standard of Living (which includes adequate food, clothing and housing and continuous improvement in living conditions).
>
> **Article 12:** enjoyment of the highest attainable standard of physical and mental health (which includes all aspects of environmental hygiene; prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure medical service and medical attention in the event of sickness).
>
> **Article 2:** Non-discrimination.

General Comment No. 14 on the **right to the highest attainable standard of health** (2000) elaborates on Article 12 further. It acknowledges that the right is closely linked to other rights, including human dignity, life, non-discrimination, prohibition against torture, privacy and access to information.

Paragraph 34 specifies that states have an obligation to protect the right to health by refraining from denying or limiting equal access to health for all persons (including prisoners and detainees) to preventative, curative and palliative health services and abstaining from enforcing discriminatory practices.

1.5 Convention on the Elimination of All forms of Racial Discrimination

The International Convention on the Elimination of all forms of Racial Discrimination (ICERD) is relevant in its entirety to the situation of deaths in prison custody. However, the most relevant articles are:

> **Article 5(b)**: the right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution;
>
> **Article 6:** States Parties shall assure to everyone within their jurisdiction effective protection and remedies, through the competent national tribunals and other State institutions, against any acts of racial discrimination which violate his human rights and fundamental freedoms contrary to this Convention, as well as the right to seek from such tribunals just and adequate reparation or satisfaction for any damage suffered as a result of such discrimination.
>
> **Article 2:** State parties shall condemn racial discrimination in all its forms and not engage in any act or practice of racial discrimination against persons.

A number of General Recommendations made by the Committee are relevant.

General Recommendation No. 36 (2020) on **Preventing and Combatting Racial Profiling by Law Enforcement Officials** notes the recent increase in racial profiling, particularly in light of concerns about terrorism and migration, which have exacerbated prejudice and intolerance. It recognises that certain groups (for example people of African descent, ethnic minorities, indigenous peoples and migrants, refugees and asylum-seekers) are more vulnerable to racial profiling, which can result in discriminatory decision-making and disproportionate incarceration of groups protected by the convention.

The Committee highlights that State parties have an obligation to guarantee effective protection against acts of discrimination under Article 6 of the Convention. It further notes that racial profiling can impact on people's enjoyment of ICCPR rights (including the right to life and the right to effective remedy) and ICESCR rights (such as right to health).

The role of teaching, education, culture and information in combatting racial discrimination is noted, as well as the importance of human rights education and training for law enforcement officials.

Paragraphs 52-57 focus on ***accountability***, which covers reporting, independent oversight, investigation, penalties and the role of NHRIs.

General Recommendation No. 34 (2011) on **Discrimination against People of African Descent** further acknowledges the links between racism/ structural discrimination and the disproportionate presence of people of African descent in the prison population. It recommends a number of measures states should take to prevent discrimination, including:

- 'measures to prevent illegal use of force, torture, inhuman or degrading treatment or punishment by police or other law enforcement agencies and officials against people of African descent, especially in connection with arrest or detention'

- 'training programmes for public officials and law enforcement agencies with a view to preventing injustices based on prejudice against people of African descent'

General Recommendation No. 31 (2005) on **Prevention of racial discrimination in the administration and functioning of the criminal justice system** acknowledges the risks of discrimination in the administration and functioning of the criminal justice system and recommends steps to be taken to address this. Of relevance to deaths in custody is the recommendation which states:

> 'In cases of allegations of torture, ill-treatment or executions, investigations should be conducted in accordance with the principles on the Effective Investigations of Extra-legal, Arbitrary and Summary Executions and the Principle on the 'Effective Investigation and Documentation of torture and other cruel, inhuman or degrading treatment or punishment'.

General Recommendation No. 26 (2000) on Article 6 of the Convention reiterates the right to seek just and adequate reparation or satisfaction for damage suffered as a result of discrimination.

In additional to the General Recommendations, the Committee has also made recommendations about deaths in custody during its **Concluding Observations** of State reviews.

1.6 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

The Convention on the Elimination of all forms of Discrimination Against Women does not contain any specific references to prison or detention. However, articles of potential relevance include:

> **Article 12:** elimination of discrimination of women in the field of healthcare.
>
> **Article 15:** equality with men before the law, which includes all stages of procedure in courts and tribunals.

Some of the Committee's General Recommendations also have relevant commentary.

General Recommendation No. 35 (2017) on **Tackling Violence Against Women** highlights that there are high levels of impunity for acts of gender-based violence committed by both state and non-state actors, and acknowledges that such acts or omissions on the part of the state can 'result in death'.

The Committee specifies that State parties have responsibilities for preventing acts or omissions by their own organs or agents, including through the training, adoption, implementation and monitoring of legal provisions, administrative regulations and codes of conduct, and by investigating, prosecuting and amplifying appropriate legal or disciplinary sanctions, as well as providing reparations.

State parties should provide 'mandatory', recurrent and effective training to law enforcement officers, forensic medical personnel, healthcare professionals and those working in prisons to enable them to prevent and address violence against women.

The Committee also specifies that:

> 'State parties must eliminate the institutional practices and individual conduct and behaviour of public officials that constitute gender based violence against women ... This includes adequate investigations of and sanction for inefficiency, complicity and negligence by public authorities responsible'.

General Recommendation No. 33 (2015) on **Women's access to Justice** acknowledges that women in the criminal justice system experience discrimination, as well as heightened vulnerability to physical and mental abuse. This is in part due to a failure of states to offer alternatives to detention or to meet the specific needs of

women in prison, as well as an absence of gender-sensitive monitoring and independent review mechanisms. The Committee recommends that mechanisms in place to monitor places of detention pay special attention to the situation of women prisoners and apply international guidance and standards to the treatment of women in detention.

It also recommends that the state 'protect women complainants, witnesses, defendants and prisoners from threats, harassment and other forms of harm before, during and after legal proceedings and provide budgets, resources, guidelines and monitoring and legislative frameworks necessary to ensure that protective measures function efficiently'.

General Recommendation No. 31 (2014) on **Women and Health** is concerned with maximising the extent of available resources to ensure women's right to healthcare. It also specifies that State parties should ensure the adequate protection and health services for women in difficult circumstances, including provision of trauma treatment and counselling.

1.7 Convention on the Rights of Persons with Disabilities

The Convention of the Rights of Persons with Disabilities (CRPD) has a number of relevant articles:

> **Article 5**: equality and non-discrimination - equal protection and equal benefit of the law, prohibition of discrimination based on disability.
>
> **Article 10**: the right to life- enjoyment of the right to life on an equal basis with others.
>
> **Article 13**: access to Justice- effective access to justice for those with disabilities on an equal basis with others-including the promotion of appropriate training for those in the field of administration of justice, including police and prison staff.
>
> **Article 14:** liberty and security of person.
>
> **Article 15**: freedom from torture, or cruel, in human or degrading treatment or punishment.
>
> **Article 16**: freedom from exploitation, violence or abuse- state shall put in place policies to ensure exploitation, violence and abuse against persons with disabilities are identified, investigated and where appropriate, prosecuted.
>
> **Article 25**: right to health.

General Comment No 6 on Article 5 Equality and Non-Discrimination (2018) describes the relationship between non-discrimination and other specific articles in the convention. In relation to **Article 13** (access to justice), it specifies that measures should be adopted to ensure effective training of personnel, including prison staff, police and penitentiary systems on the rights of disabled people. In

relation to Article 14 (Liberty and Security), it recognises that disabled people are disproportionately affected by violence and abuse and other cruel, inhuman and degrading treatment or punishment, including restraint and segregation, as well as violent assault.

2. United Nations Mechanisms

2.1 High Commissioner for Human Rights

A report on Human Rights in the Administration of Justice was published by the UN High Commissioner for Human Rights in Sept 2019. This was in response to resolution 36/6 of the Human Rights Council, which requested the high commissioner to submit a report on violence, death and injury in situations of deprivation of liberty.

The report addresses the intersection of deprivation of liberty and violence, death and serious injury. The second part of the report considers measures taken to address such violence and prevent deaths and serious injury in custody (page 10 onwards).

It covers:

Violence, deaths and serious injury resulting from actions of state actors

- Torture, ill-treatment and sexual violence
- Use of Force/Restraint
- Sentencing

Violence between persons deprived of their liberty resulting in death or serious injury

- Inter-prisoner violence
- Contributing factors
- Violence Against Prison Staff

Violence and death resulting from Environmental Factors

- Conditions of detention
- Self-harm
- Lack of access to adequate healthcare

Measures to address violence and prevent deaths and serious injury

- Accountability: Complaints mechanisms, Investigation and Data collection
- Practical Measures: Training of detention facility personnel, Management of Facility
- A series of recommendations including on the collection and disaggregation of data around deaths in custody and importance of independent and prompt investigations into deaths in custody

2.2 Special Procedures

2.2.1 Special Rapporteur on extrajudicial, summary or arbitrary executions

The Special Rapporteur is mandated to investigate all acts and omissions of state representatives that constitute a violation of the right to life and is guided by various international legal standards protecting the right to life, including the Principles on the Effective Prevention and Investigation of extra-legal, arbitrary and summary executions, which was adopted the Economic and Social Council in 1989.

Principles 9-17 of this document relate to the 'Investigation' of death and include:

- The requirement for a prompt, impartial and thorough investigation to determine cause, manner and time of death, person responsible and any pattern or practice which may have brought about the death. The investigation should distinguish between natural death, accidental death, suicide and homicide.

- The investigative authority should have the power to obtain all the information necessary to the inquiry, including an entitlement to summon witnesses.

- Governments should pursue investigations through independent commissions or inquiry in cases where investigation procedures are inadequate- this should be independent and impartial.

- The body should not be disposed of until an autopsy is complete and those conducting the autopsy should be independent and impartial and have access to investigative data.

- Protection should be provided to complainants, witnesses and those conducting the investigation. Those implicated should be removed from positions of power.

- Families have right to be notified of death promptly. Families and legal reps should have access to any hearing and information.

- A written report of any inquiry should be made within a reasonable amount of time and government should respond within reasonable time, indicating steps to be taken.

The UN Manual on the Effective Prevention of Extra-legal, Arbitrary and Summary Executions (also known as the Minnesota Protocol) was originally published in 1991 as a supplement to the Principles on the Effective Prevention and Investigation of extra-legal, arbitrary and summary executions and was updated in 2016.

In her annual report of 2018, the Special Rapporteur provides an overview of activities undertaken between March 2017 and Feb 2018 and of communications with states and their replies. Its describes the nature of violations alleged, including

cause of deaths. The UK is cited three times in relation to communications with the Special Rapporteur:

- An acknowledgement that the UK had replied substantively (addressing all or some of questions raised) and within required time period during reporting period.

- Reference to a case on 18 Jan 2018 concerning one female and 14 males (people of African descent).

- Reference to a case on 05 Feb 2018 concerning two females and four males (HRD).

2.2.2 Special Rapporteur on Torture

The role of the SR on torture is to transmit appeals to states regarding alleged cases of torture or risk of torture and undertake fact-finding country visits.

In his most recent report to the human rights council, published in January 2019, the SR on torture examined the relationship between corruption and torture/ill-treatment, looking at the patterns, root causes and recommendations. The section on 'Systematic governance failures conducive to corruption and torture or ill treatment' could be relevant for deaths in custody. Emphasis is placed on the importance of monitoring and reporting in the recommendations.

The SR released a statement in June 2020 on the increased risks of COVID-19 for those in detention, highlighting the vulnerable situation of those in detention or confined closed spaces where social distancing is hard for contracting the virus. The increased risk of inhuman or degrading treatment was also highlighted.

2.2.3 News items from Special Rapporteurs

- Statement: (27 April 2018): 'UN human rights experts say deaths in custody reinforce concerns about 'structural racism' in UK.

3. Inspection standards

3.1 Body of Principles

The Body of Principles for the Protection of all persons under any form of detention or imprisonment was adopted by the UN General Assembly in Dec 1988.
There are a number of the principles that may be relevant, most notably:

- **Principle 34**: '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 instance 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 jeopardize an ongoing criminal investigation'.

- **Principle 6:** no person under any form of detention shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.

- **Principle 7:** impartial investigation of complaints and Principle 33 -- the right to make a complaint.

- **Principle 21:** prohibition of violence during interrogation.

3.2 The Mandela Rules

The United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules) lays out minimum standards for the treatment of prisoners and covers a broad range of areas.

The rules of general application stipulate that all prisoners should be treated with respect and be free from torture, inhuman or degrading treatment or punishment, and that the safety of all prisoners and staff should be ensured at all times. It also states that the rules should be applied impartially and without discrimination.

Many of the rules relate to the material conditions of detention (such accommodation, clothing and bedding, food), as well as access to things such as exercise and healthcare. They also cover restrictions, disciplines and sanctions.

Rules 71 and 72 refer to 'Investigations' and stipulate:

Rule 71

1. Notwithstanding the initiation of an internal investigation, the prison director shall report, without delay, any custodial death, disappearance or serious injury to a judicial or other competent authority that is independent of the prison administration and mandated to conduct prompt, impartial and

effective investigations into the circumstances and causes of such cases. The prison administration shall fully co-operate with that authority and ensure that all evidence is preserved.

2. The obligation in paragraph 1 of this rule shall equally apply whenever there are reasonable grounds to believe that an act of torture or other cruel, inhuman or degrading treatment or punishment has been committed in prison, irrespective of whether a formal complaint has been received.

3. Whenever there are reasonable grounds to believe that an act referred to in paragraph 2 of this rule has been committed, steps shall be taken immediately to ensure that all potentially implicated persons have no involvement in the investigation and no contact with the witnesses, the victim or the victim's family.

Rule 72

The prison administration shall treat the body of a deceased prisoner with respect and dignity. The body of a deceased prisoner should be returned to his or her Next of Kin as soon as reasonably possible, at the latest upon completion of the investigation. The prison administration shall facilitate a culturally appropriate funeral if there is no other responsible party willing or able to do so and shall keep a full record of the matter.

The UN Pocketbook of International Human Rights Standards for Prison Officials states on its section on complaints and inspection procedures: 'There shall be thorough, prompt and impartial investigation of all suspected cases of extra-legal, arbitrary and summary execution, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances'.

3.3 Beijing Rules

The UN Rules for the Protection of Juveniles deprived of their Liberty, (Beijing Rules), adopted in 1990, has a section on 'Notification of Illness, Injury and death' which states:

56. The family or guardian of a juvenile and any other person designated by the juvenile have the right to be informed of the state of health of the juvenile on request and in the event of any important changes in the health of the juvenile. The director of the detention facility should notify immediately the family or guardian of the juvenile concerned, or other designated person, in case of death, illness requiring transfer of the juvenile to an outside medical facility, or a condition requiring clinical care within the detention facility for more than 48 hours. Notification should also be given to the consular authorities of the State of which a foreign juvenile is a citizen.

57. Upon the death of a juvenile during the period of deprivation of liberty, the nearest relative should have the right to inspect the death certificate, see the body and determine the method of disposal of the body. Upon the death of a juvenile in detention, there should be an independent inquiry into the causes of

death, the report of which should be made accessible to the nearest relative. This inquiry should also be made when the death of a juvenile occurs within six months from the date of his or her release from the detention facility and there is reason to believe that the death is related to the period of detention.

58. A juvenile should be informed at the earliest possible time of the death, serious illness or injury of any immediate family member and should be provided with the opportunity to attend the funeral of the deceased or go to the bedside of a critically ill relative.

Other sections of the rules which may be relevant include:

- **Rule 4**: all rules should be applied impartially without discrimination.
- **Section IV. A**. Requirement of safe record keeping of all legal records, medical records and records of disciplinary proceedings.
- **Rule 31**: access to facilities that meet full requirement for health.
- **Section H** (rules 49-55)- section on medical care.
- **Section K** (rules 63-65): limitations on use of restraint and physical force.
- **Section L** (rules 66-71): disciplinary procedures.
- **Section M** (rules 72-78): inspection and complaints.
- **Rule 85**: personnel should receive training to carry out their responsibilities effectively, including in child psychology, child welfare and human rights standards.

3.4 The Bangkok Rules

The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) was produced in 2010. It doesn't contain anything specific on deaths in custody, but some rules of potential relevance include:

- **Rule 7** concerns sexual abuse or other forms of violence before or during detention and the requirement to refer to competent authority for investigation.
- **Rule 16** concerns suicide and self-harm.
- **Rule 24** is about instruments of restraint.
- **Rule 25** is about information to and complaints by prisoners.

- **Rule 31** is about having clear policies and regulations on conduct of staff aimed at providing maximum protection from gender based physical or verbal violence and abuse.

3.5 The European Prison Rules

The European Prison Rules, produced by the Council of Europe in 2006 are based on the Mandela rules. Although there is nothing specific on deaths in custody, it covers disciplines and punishment, use of force, instruments of restraint, weapons, complaints, training of staff and inspection and monitoring.

Revised prison rules: new guidance to prison services on the humane treatment of prisoners was adopted by the Committee of Ministers and updates the 2006 rules above.

4. European Committee for the Prevention of Torture

The CPT published 'Effective Investigation of Ill-treatment: Guidelines on European Standards' in 2009. This is a very comprehensive guidance document and while the focus is on ill-treatment, death as a consequence of ill-treatment is referenced throughout. It covers:

- The origins of obligations to investigate ill-treatment
- Facilitating prospects for effective investigations
- Access to investigative mechanisms
- The grounds and purpose of investigations
- Measuring Effectiveness
- Forms of investigation and punishment

These guidelines are also integrated into the general CPT standards which are applied by CPT during their visits to states.

The CPT also produced a handbook on 'Combatting ill-treatment in Prisons'.

The CPT has published a range of standards and tools, which can be accessed here.

The CPT report of the visit to Scotland is available here.

The CPT's Third General Report (1992) includes a section on healthcare in prisons, which includes preventative healthcare (such as suicide prevention and prevention of violence).

The CPT's Fourteenth General Report (2003-04) includes a section on combatting impunity.

5. Other international guidance

- The International Committee for the Red Cross (ICRC) launched a process in 2008 to develop a set of concise guidelines for investigating deaths in custody, acknowledging at that stage that there was no one internationally accepted document offering practical guidance for detaining authorities or humanitarian organisations to follow. Many different actors were involved in process and the Guidelines for Investigation Deaths in Custody, was subsequently published in 2013.

- The Ugandan Human Rights Commission published the Human Rights Investigators' Handbook in 2014, which has a chapter on 'Investigating incidents of deaths in custody', which covers the mandate to investigate deaths in custody, duty of the detaining authority, steps to take and gathering and handling material evidence. It also contains a chapter on investigating killings by state agents.

- The UK Parliament Joint Committee on Human Rights Report 'Human Rights Standards and Deaths in Custody'.

- A report on the Independent Advisory Panel on Deaths in Custody's workstream considering investigations of deaths in custody- compliance with Article 2 of the ECHR (2012)

- Treaty provisions on the right to life - Breakdown of relevant treaty provisions

- Report of Special Rapporteur on Racism from visit to UK in 2018 highlights that deaths in custody in England and Wales affects racial and ethnic minorities more than white people, that of these deaths in custody, the highest proportion occurs in prisons and that there has been a failure to investigate deaths and prosecute those responsible.

- Article on human rights approaches to suicide in prisons.

Appendix 7

Expert Review Philip Wheatley CB

Review of Scottish Policy on Deaths in Custody

Introduction

The Cabinet Secretary for Justice commissioned an Independent Review into the Handling of Deaths in Custody in Scotland. I have been commissioned by the joint chairs of the inquiry to contribute to their review by providing an assessment of all relevant Scottish Policies.

The majority of deaths in Scottish Prisons are from natural causes, but the next most common cause of death is suicide[1]. The Report in May 2019 by the Chief Inspector of Scottish Prison on an Expert Review of the Provision of Mental Health Services, for Young People Entering and in Custody at HMP YOI Polmont noted that risk of suicide in Scottish Prisons is comparatively higher than in other UK jurisdictions.

Before examining the policies dealing with the aftermath of any deaths in custody it is important to recognise that actions and policies leading up to the death in custody have bearing and must be considered. Deaths from natural causes have to take into account many factors but this element of the review looks specifically at suicide prevention as suicide is the second leading cause of death in Scottish Prisons.

Relevant policies for Suicide Prevention

Deaths from suicide and the aftermath can best be handled with the grieving family where the Scottish Prison Service (SPS) can demonstrate that they have provided good and appropriately caring treatment to the deceased prisoner throughout the period of custody and especially before the death.

Good prison policy to prevent suicide must therefore ensure that prisoners who have psychological, medical, mental health or other vulnerabilities are dealt with a far as practicable in ways that reduce any reasonably foreseeable risks of suicide and concomitantly reduce the distress for the families post death.

Prison policies are only effective if they are fully implemented and operated with care and good judgement, therefore any review of policy must also consider whether practice in prisons is consistent with the policy and its purposes.

To prevent suicide, prison staff and healthcare staff have to work collaboratively and in an integrated way. This is crucial because many prisoners have a combination of medical, addiction, mental health and social problems that make them particularly vulnerable and require well co-ordinated actions during periods of crisis if the risk of suicide is to be reduced. These periods of acute crisis may be short and intervention has to be immediate to be effective. This makes the role of staff like prison officers who are in day-to-day contact with the prisoner particularly important.

Sources of evidence used

In order to assess policies and how they have been implemented I have examined:

- Published policy documents and accompanying documents which provide additional guidance to prison staff.
- Previous policy reviews.
- Fatal Accident Inquiries.
- Inspectorate of Prison Reports.
- Memorandums of Understandings.

Key Policies Relevant to Suicide prevention

INTEGRATION OF PRISON AND HEALTH WORK

Memorandum of Understanding between Scottish Ministers and nine Scottish Health Boards, October 2011

Responsibility for providing Healthcare to Scottish Prisoners rests with the NHS Health Board responsible for the area in which the prison is located. A memorandum of understanding between Scottish Ministers and the nine Health Boards was agreed in October 2011. It commits all parties to the agreement to preserve life and reduce harm. It also commits the parties to appropriate exchange of information including necessary clinically related information.

Both prison and healthcare staff need to routinely make use of confidential information about those they work with. The memorandum of understanding provides a very clear guide on information sharing for professionally qualified medical staff working in prisons and for prison staff.

There is an absolute recognition that prison and healthcare staff will be able to work more successfully if they share relevant information from their respective organisations in the interests of preserving life and reducing harm. For example, medical staff need to have access to security information about illicit drug use by their patients that may compromise the efficacy of prescribed drug use. They also need to know if their patients are either trading prescribed drugs or being bullied to hand over those drugs to other prisoners. Residential staff working in the Halls need to know which prisoners are on treatment for mental health problems, what signs to look out for if they see a deterioration in mental health and who in healthcare should be alerted to this.

This ‘need to know’ is particularly important where otherwise confidential information may help to identify a prisoner’s increased risk of self-harm or suicide.

Regrettably the information from Inspections, special reviews and from Fatal Accident Inquiries suggests that there is sometimes an unwillingness to share relevant medical information about prisoners with prison staff.

The reasons for this failure to live up to the standard set in the Memorandum of Understanding is unclear but there is little doubt that it can put lives at risk. In the

context of a situation where the State is imprisoning so many vulnerable prisoners with complex mental health and addiction problems any such failure or weakness should be a matter of great concern.

SPS Suicide Prevention Policies

The SPS Suicide Prevention policy and the action required after a suicide is set out in the SPS policy "Talk to Me, Prevention of Suicide in Prison Strategy 2016-2021". This document is supported by unpublished guidance which provides the more detailed instructions for those operating the policy.

Talk to Me replaces an earlier version of the policy called ACT 2 Care Suicide Risk Management Strategy (revised 2005); this document unlike the Talk to Me strategy includes detailed information on factors that increase the risk of suicide in the strategy document rather than simply including this in the internal guidelines for those operating the policy.

Benchmark for assessing policy and practice

I set out below my relevant experience of suicide prevention in prison. I have also provided a summary of the conclusions of the most up to date academic research on prison suicide. I have drawn on both my own knowledge and the research in judging the adequacy of policy and practice to prevent suicide in Scottish Prisons.

My Background and Knowledge of Suicide in Prison

Much research has been carried out into the risk of suicide and self-harm in the UK Prisons, mostly those in in England and Wales. Both public sector and private sector prisons have been involved in the research which has been carried out by independent academic researchers. In the course of my career in Her Majesty's Prison Service (HMPS) as a Prison Governor, Senior Manager and Director General (2003-2010) I gained experience and knowledge about suicide prevention. I commissioned much of the academic research and worked with the researchers, policy developers and prison governors in order to develop and implement policies to reduce suicide in prison.

Since 2010 I have worked providing advice on prison management, including close involvement with Northern Ireland's Prison Service as member of a team tasked by the Northern Ireland Government with reviewing prisons and as a Non-Executive Director on the Northern Ireland Prison Service Board (2010-2017). I work as a prison expert witness and have provided evidence for a number of Scottish Fatal Accident Inquiries into deaths in prison. This range of experience has kept me up to date with the development of policy and practice on preventing suicide in all the UK jurisdictions.

I retain a close involvement with the academic research on prison issues, including on suicide in prison. I am a member of the Management Committee of the Cambridge University Institute of Criminology. Professor Alison Liebling of the Cambridge Institute of Criminology is one of the lead researchers on suicide in prison. She has shared with me her most up to date thinking on the prevention of

suicide in prison and provided me with her most recent presentation she delivered to the Institute's Masters Course on the Sociology of Prisons on this topic.

Main Research lessons

The prison population includes a high proportion with a background or history of previous behaviour that research indicates places them at a higher risk of committing suicide.

The following pre-custody factors have a small but statistically significant link to a higher risk of suicide in prison:

- Pessimistic pre-sentence report prior to sentence
- A high number of pre-convictions
- Have been at liberty for less than 3 months before being imprisoned
- No formal educational qualifications
- Bullied when at school
- Been a looked after child
- Victim of or witness to parental violence

Two additional pre-prison factors have a stronger statistical link with suicide in prison:

- Major problems with drink or drugs
- History of previous self-harm

Factors from the experience of imprisonment which have a strong relationship with prison suicide are:

- Dislike of physical education
- Unable to occupy oneself in cell
- Experiences boredom in prison, which the prisoner cannot relieve
- Has spent time in isolation
- Has been referred to a Doctor or Psychiatrist for assessment / treatment
- Is experiencing many current problems

Six other factors from prison experience have a statistically significant link with suicide:

- Prefers to share a cell
- Has few friends in prison
- Their only friends were met in prison
- Has difficulties with other prisoners
- Has disciplinary problems
- Feels the disciplinary system is unfair

The ability to cope during sentence is important. Indicators which suggest coping skills are not working well and which have a statistically strong link with the risk of suicide are:

- Having major problems sleeping
- Has a high score when assessed on the hopelessness scale
- Has serious thoughts about suicide during sentence

Other factors which have a strong link are:

- Wanting to change something about oneself
- Not being hopeful about prospects on release
- Finds being locked up difficult
- Daydreams
- Thinks others attempts at suicide are serious

The research indicates a strong link between suicide and self-harming. Those who feel so badly about themselves that they feel they need to self-harm often do not care strongly about whether they live or die as a result of their behavior. It is also a relatively small escalation to move from fairly minor injury to such serious self-harm that death is possible, especially if a response to the distress communicated is not forthcoming.

Treating self-harm in prison as serious and trying to help by reducing the feelings that underlie the self-harming behavior is likely to reduce suicide.

Comparative research looking at prisons and their suicide levels indicates that prisons which have the lowest suicide rate are those where prisoners assess their treatment as being fair, humane, where staff are approachable, and in which staff power and authority are used in a careful and fair way. Such prisons balance the key dimensions of their work providing an orderly safe and fair internal environment; an active regime with provision of opportunities for personal development; respectful and courteous interactions from highly motivated staff. Particular care needs to be taken in dealing with prisoners during times when the risks of distress and suicide are known to be especially high. These include:

- the first few days in prison
- the period immediately after sentence
- after losing an appeal or being refused parole
- when unexpected bad news is received from outside prison like the death of a loved one or the breakdown of a previously loving relationship

It is not surprising that decent humane and fair prisons are better at preventing suicide than those which are seem unfair, treat prisoners inhumanely and where there is excessive, capricious or abusive use of power and authority by staff. Poor treatment is likely to provoke a negative reaction from prisoners and to induce distress in poor copers and those with problems. Such negative reactions may make suicide feel like a good option for removing the pain they are feeling.

Scottish Suicide Prevention Policies discussion and assessment

ACT 2 Care (Revised 2005)

The original Scottish policy to reduce suicide was devised and introduced in 1998. It was reviewed by an external team led by Professor Kevin Power in 2003. Professor Power is now Honorary Professor of Psychology at The University of Stirling and Area Head of NHS Tayside Psychological Therapy Services. His review fed into a revised strategy in 2005. This confirmed the importance of the original key principles but with greater encouragement to drive forward some of the principles that were described "as not fully implemented since 1998" These areas that required driving forward are listed as:

- Improved family involvement
- Improved care planning and communication
- Less dependence on anti-ligature clothing and accommodation
- Improved recognition of a safe environment
- More use of daycare and other out of cell activities
- Improved culture of contact and support

These key principles were entirely consistent with my summary above of the main lessons from research into prison suicide.

Care is described as central to everything and it is noted that it requires effective multi-disciplinary teamwork with residential staff teams in the lead, using partners both internal and external to support their work.

There is a strong emphasis on sharing information within the multidisciplinary team and the need for decisions to be team based and reflecting the prisoner's risk.

Isolation, it is stressed, should be avoided and only used as a last resort in very exceptional circumstances. The use of safe cells is strongly discouraged as a routine response and there is a clear emphasis of not keeping at risk prisoners confined in a safe cell during the daytime.

The emphasis is on supportive care from staff who are vigilant in noting any changes to risk.

It is specified that prisoners should have access to day care facilities which are safe therapeutic and interactive.

It is made quite clear that assessment on its own does not prevent suicide but depends on creating a context where prisoners feel safe and confident to ask for help.

As part of that context the policy explicitly encourages the involvement of prisoners' families and developing support from the whole prison community.

In clear language the policy spells out what care means and highlights all the issues that research indicates are important, for example requiring care to involve

interactive supportive contact, not just observation and emphasizing early intervention before a crisis builds up and results in self-harm or an attempted suicide. It is quite clear that it is not helpful to talk of behavior as manipulative or attention seeking but instead to be aware that feelings of worthlessness or despair can lead to increased risk

There is a helpful explanation of the key issues in assessment of suicide and self-harm risk.

The importance of context and the need to create a safe and decent environment for prisoners in which other prisoners, staff, families, visitors and the regime all have a part to play is clearly set out.

For effective teamwork it is noted that confidentiality must not be used as a barrier to prevent essential information exchange.

The policy provides further detailed information on:

- Awareness
- Communication
- Predisposing factors for suicide risk
- Precipitating factors that might create an increased risk
- Verbal and non-verbal clues that might suggest risk is increasing
- Key issues in regime provision
- The role of Samaritans and Listeners (prisoners trained by the Samaritans to provide support to at risk prisoners)
- Families Outside and its helpline is also identified as an organisation which can assist and which SPS staff should respond to positively

Assessment of the Act 2 Care Policy

This is a really good example of a realistic policy, set out clearly and based on the best available research evidence. It is very much to the SPS's credit. This policy was widely recognized as excellent and the principles adopted by other jurisdictions. HMPS in England and Wales and NIPS in Northern Ireland adopted new suicide prevention policies which were almost entirely based on the Scottish ACT 2 Care policy.

Talk to Me Strategy 2015

This new strategy for preventing suicide in prison replaced the previous ACT 2 Care strategy in November 2015.

The previous revision of the strategy set out that its purpose was to drive forward improvements in practice in those areas where existing policy had not yet been fully implemented.

There is no mention in the Talk to Me strategy of whether the improvements in implementation sought had been delivered. Instead, the foreword lists some general policy changes (the introduction of first night in custody suites, national prisoner

induction programmes, pre-release programmes, increased access to purposeful activity, improved information sharing protocols, national guidance on the management of substance abusing offenders, and effective through-care arrangements).

This list includes some policy changes such as first night in custody suites that might, if well designed and properly implemented, have a link to suicide prevention but includes others like pre-release programmes which do not have an obvious link to preventing suicide in prison. Nevertheless, the claim is made that all "these improvements contribute to the prevention of suicide in custody".

No explanation is offered in either the foreword or introduction about what elements of performance require improvement or what new evidence on reducing suicide in prison has required changes to be made.

A surprising change of emphasis in the introduction is the statement that "the focus of this strategy is on preventing suicide" rather than on preventing self-harm, which the strategy suggests is a separate issue, though it acknowledges self-harm may sometimes be a risk factor for suicide.

This change of emphasis runs counter to the research evidence that it is dangerous to distinguish between what is self-harm and what is a suicide attempt. This is because the feelings of hopelessness and distress that drive both behaviors makes a suicide attempt more likely.

It is therefore important that urgent action needs to be taken to help reduce the feelings of distress regardless of whether the prisoner is believed to be self-harming or attempting suicide. Putting effort into distinguishing whether at a given moment the prisoner's intent is to self-harm or to commit suicide risks being a distraction which may inhibit effective intervention.

A close reading of the document suggests the main motivations for the new strategy was the organisational change in November 2011 when the NHS became responsible for delivery of Healthcare and the presentational need to align suicide prevention in prison with a new Scottish Government Strategy for reducing suicide in Scotland called "Choose Life".

The Talk to Me Strategy identifies twelve changes to existing policy:

- Five simply rename existing posts, meetings and classifications
- Three introduce minor procedural changes (new forms, new locations to send paperwork to, additional audit arrangements)
- One notes that Doctors no longer need to assess all new admissions within 24 hours of admission
- Three introduce additional procedural requirements for some case conferences

Unlike its predecessor strategy ACT 2 Care, the new Talk to Me only makes available to the general public the document setting out a broad overview of the policy.

The published document is strong on aspirational language. For example, the strategy sets out key principles which include:

- "An improved person-centered approach to prevention of suicide"

- "A multi-disciplinary approach enables the whole prison community to work together to identify vulnerable individuals, share information and encourage those at risk to accept help and support"

- "The SPS will promote and encourage improved family involvement where the person concerned has given consent"

- "The strategy promotes an asset-based approach which focuses on the strengths of the individual while addressing their needs"

- "We create a positive environment which reduces stigma and discrimination regarding mental health and encourages those at increased risk to seek help and talk about issues"

The language used is highly aspirational and the content unexceptionable but there is almost nothing in the Talk to Me Strategy that was not expressed more clearly and directly in the ACT 2 Care Policy.

Unlike ACT 2 Care the document does not recognize any weaknesses in previous performance where change is required. Instead it lists the following existing policies which it suggests are successfully contributing to suicide prevention:

- drug treatment
- mental health provision
- sharing health information where appropriate with prison staff
- providing purposeful activity for prisoners
- planning and preparation for release

The overall message is that all is well with existing practice. The new policy introduces no substantial change, and this is clearly demonstrated in the conclusion which states:

> "The SPS and partner agencies are all committed to caring for those in distress and those at risk of suicide. Whilst not every suicide is preventable, enactment of this strategy will assist the identification of those who are vulnerable and ensure an individualised care plan is provided to maximise support through this difficult time.
>
> We will continue the ethos of the previous ACT 2 Care strategy by encouraging engagement with those at risk and facilitating opportunities for open discussion to reduce the stigma surrounding suicide and ultimately decrease the incidence of suicide in prison".

The two additional guidance documents (Part 1 and Part 2) are only available on the SPS intranet. They add little of substance to the policy. Part 1 provides detailed advice on process, assessment, care (case conferencing and planning, talking about suicide, active listening), supportive environment and regime. Part 2 provides detailed instructions on how to complete the new forms that accompany the new policy.

This advice is less comprehensive in scope than in the ACT 2 document and the language is not as direct. Gone are the lists of predisposing factors and precipitating factors. These are replaced by more generic summaries which omit key factors like the raised risk of suicide for those in prison for the first time in prison. There is a change of emphasis, whereas ACT 2 stressed the need to find out how prisoners felt and to identify those who were anxious and had problems, Talk to Me Guidance concentrates more on identifying those who are actively suicidal.

Assessment of the Talk to Me Strategy

Because the Talk to Me Strategy is presented in three separate documents rather than the previous single document it is less easy to use. The overall result is a less clear and directive document than its predecessor. It provides much less guidance to prison staff to help them identify who may be at the high risk of committing suicide and to alert them to what predisposing factors may be relevant to judging risk.

It directs staff to concentrate on identifying the actively suicidal rather than the ACT 2 Care approach of identifying prisoners who were experiencing such a level of distress that might create a crisis resulting in suicide. This shift in emphasis goes against the research evidence on suicide in prison.

By separating out the more detailed guidance and not making it available to families and the public, Talk to Me is a less transparent than ACT 2 Care. This makes it less easy for families to be well informed and in the event of a death to ensure the SPS is held to account.

It is troubling that the Talk to Me Strategy does not evidence whether the known weaknesses in implementation identified in ACT 2 Care had been successfully remedied.

Evidence of the impact of Talk to Me Strategy on practice

The SPS does not routinely survey prisoners using a methodology that enables their views about Scottish Prisons to be compared with prisons in other jurisdictions.

The existing SPS Prisoner Survey was not designed to provide an assessment of the prisoners' views on whether the key elements essential for preventing suicide were being successfully delivered. Such surveys are available, for example the Measurement of the Quality of Prisons Life Survey used by HMPPS which has also been used in a number of other jurisdictions.

In the absence of reliable survey work I have examined recent Inspection Reports for relevant information. I have looked at available information from relevant Fatal Accident Inquiries.

I have read the 2019 Report on an Expert View of the Provision of Mental Health Service, For Young People Entering and Leaving Custody at HMP YOI Polmont by the Chief Inspector of Prisons, the 2018 Report from Dr Briege Nugent on the Evaluation of the Scottish Prison Service's Suicide Prevention Strategy and the 1996 Review of Suicide Prevention in Scottish Prisons by Professor John Gunn one of the UK's leading psychiatrists.

I have used this information to try to assess how far the weaknesses of implementation described in the ACT 2 Care Strategy in 2005 have been addressed.

(a) Evidence of the overuse of strip conditions/safer cells.

For over twenty-five years the SPS policy for use of strip conditions an anti-ligature clothing in safer cells for prisoners at risk of suicide has been that they should only be used in very exceptional circumstances.

The information from FAIs, Inspection Reports, Professor John Gunn's 1996 Report, the ACT 2 Care Strategy which includes a summary of Professor Kevin Power's Review work in 2003 and Dr Briege Nugent's 2018 Report is that this instruction has never been consistently followed in Scottish Prisons.

The Review of an Expert Review of the Provision of Mental Health Service for Young People at HMP Polmont reported in May 2019 that strip conditions were used in 21% of the cases where young prisoners were being managed under the Talk to Me strategy. Dr Briege Nugent's Review in 2018 noted that prison staff were often using strip conditions in an over cautious way when there was no evidence of an exceptional risk. The 2018 Inspection Report on Polmont recorded that prisoners had been located in safer cells wearing un-tearable clothing on 114 separate occasions between May and October of that year.

All the independent reviewers of the Scottish Prison Service Suicide prevention strategy since 1996 have commented adversely on the overuse of strip conditions for prisoners believed to be at a heightened risk of suicide. The ACT 2 Care Revision in 2005 made it clear that this overuse of strip cells was counterproductive to preventing suicide and that this overuse should be terminated. Talk to Me continued to affirm the existing policy on strip conditions in safer cells but no longer acknowledged that there was a gap between policy and practice. The two most recent reports from the chief Inspector of Prisons and Dr Briege Nugent confirm this gap between policy and practice still exists

This gap matters. Until it is addressed prisoners who are experiencing great distress and who need positive activity, effective interventions and emotional and psychological support are instead left in social isolation in barren cells subjected to sensory deprivation and social isolation.

No other UK jurisdiction treats the actively suicidal in this way. It is also clear from FAI evidence that the risk of being placed in such conditions deters prisoners from being open with staff about the extent of their distress and their risk of suicide.

(b) Evidence of positive engagement of prisoners' families in suicide prevention

ACT 2 Care sought greater family involvement in the prevention of suicide alongside improvements in care planning and support. There is no evidence of significant improvement on either of these issues. Families report difficulty in getting through to the prison and finding someone to listen to them. FAI information suggests that even when prisons have passed on family concerns to those involved in care planning, there had been little feedback to the family.

(c) Improvement in care planning and an improved culture of contact and support

Inspection reports provide evidence that some Governors have made improvements in this area of suicide prevention, but these improvements are fragile and have not become firmly embedded into practice. It appears that some prisons manage really good work, but others struggle to provide effective care. There is still far too much reliance on use of safer cells and frequent observation rather than positive interaction that Talk to Me requires.

(d) Evidence about implementation of safer environments improved daycare access to more out of cell activities.

The general improvements to prison performance sought in ACT 2 Care were the creation of safer environment, more daycare, an increase in out of cell activity for those believed to be at risk. The evidence provided in the Talk to Me Strategy of improvement was limited, it did not address the central issue of making the whole experience of prison feel fairer and more supportive. It simply asserted that some specific schemes were now available. These were first night in custody suites, a national prisoner induction programme and increased access to purposeful activity.

There is some evidence from Inspections that first night suites have been provided but there has not been universal implementation of these at a high enough standard.

To be effective, first night in custody suites, must provide immediate and good quality support to those arriving in custody, with addiction, mental health issues as well as immediate and pressing domestic/relationship problems. The evidence is quite clear that the risk of suicide is highest in the first days in custody primarily because prisoners arrive with complex personal and practical problems which appear so overwhelming to them that suicide appears to offer a way of escaping their pain and worry. First night centres have to help prisoners to begin to grapple with and solve their problems and adjust to the prison environment. At the moment prison inspections suggest that current provision

is not fully effective, or consistently available, in all prisons. In particular a number of Inspection report delays, in the case of Polmont Inspected in 2018 for a minimum of ten weeks, for opiate addicted prisoners in accessing addiction services.

There is a separate important issue. Suicide risk is particularly high for prisoners on remand awaiting court hearings. The stress of worrying about what is going to happen at court is understandable and obvious. However, this risky group of prisoners has least access to positive interventions or purposeful activity. Prison rules do not require remand prisoners to work. This is a longstanding policy position based on the assumption of the prisoner's innocence before trial and that compulsory work cannot be justified in these circumstances. The Prison Rules do not prevent unconvicted prisoners being offered work or other positive activities. However current SPS practice is not to offer work or any form of programmes to remand prisoners. As a result, a group of prisoners who are most likely to commit suicide have the most restricted regime with fewest opportunities for positive out of cell activities which would provide opportunities for contact with staff.

Overall Progress Made on Suicide Prevention

It appears that over the last fifteen years there has been limited progress in consistently delivering the promised improvements of a culture of contact and support for those at risk of suicide and self-harm. The Talk to Me Strategy rather weakened the clearer message for prison staff of ACT 2 Care. Talk to Me in particular failed to either recognise or deal with the gap between policy and practice. The continued regular use of safer cells and strip conditions for such a high proportion of prisoners is indefensible. It provides a clear indicator of the failure to fully implement the SPS suicide prevention policy.

POLICY IN THE EVENT OF A DEATH IN PRISON

All deaths in Scottish Prisons are immediately reported to the police and are subject to an investigation directed by the Procurator Fiscal Service followed by a Fatal Accident Inquiry. This ensures there is an open and independent process of Inquiry into all deaths. What it does not ensure is that lessons learnt from prison deaths is pulled together and then made available not only to policy makers and prison staff but is also to those who investigate prison deaths so they can do their work in a more informed way.

In practice a number of different Procurator Fiscal Deputes lead the death in prison work alongside dealing with other non-prison deaths. The actual leg work of taking statements is done by police officers working with the Procurator Fiscal Service, most of whom have no expertise in prison custody. Fatal Accident Inquiries in prison cases are heard by different Sheriffs depending on which area the death has occurred in and the availability of Sheriffs. Only in a very small number of cases is an expert opinion sought on prison management issues and that opinion is sought after the initial inquiries have been completed so the expert has little influence on the inquiry process. Nowhere in this process is there an opportunity to identify emerging

problems including changes to the vulnerability of prisoners or to uncover systemic weaknesses in operational performance in prisons.

Data showing the reasons for deaths in custody has not until very recently been published until after the conclusion of the FAI process. As this can be years after the death it has meant that information about suicide in Scottish Prisons has been very limited, so it has not been possible for there to be informed public discussion about the extent of the problem. The recent change to releasing data each quarter showing the reason for deaths in prison as recorded on the death certificate has reduced the delay. However, it is still difficult to interpret accurately from the technical language of death certificates what is the extent of self-inflicted death in Scottish Prisons.

This process is in contrast to that used in both England and Wales and also in Northern Ireland. In these jurisdictions all deaths in custody are investigated by the Independent Prison Ombudsman. The Prisons Ombudsman and staff build up an expertise in prison deaths. Their existing work gives them a detailed understanding of the prison context. Reports are produced rapidly. The family are contacted so they can contribute to the process and their reports are thorough and well informed. Full reports, which have been fully anonymised, are published on the Ombudsman's websites after the conclusion of the inquest and made available for all to see.

The Ombudsman's report on a death in custody is provided to the Coroner who carries out the equivalent of a Scottish Fatal Accident Inquiry. The report provides a useful assistance to the Coroner as to the key issues in this death and helps to identify the evidence to call. Coroners regard these reports as a useful additional source of information rather than a replacement to the normal enquires carried out by the police officers acting on behalf of the coroner.

This system enables the Prison Ombudsman to keep a close watch on emerging trends and can independently publish bulletins identifying areas that need additional attention. These can include emerging information on new or changed vulnerabilities or deteriorating areas of operational performance.

In England and Wales data on suicide, deaths from all causes, self-harm and assaults is published in a quarterly bulletin and later in greater detail in an annual report. Both Quarterly and Annual publications are prepared by the Government Statistical Service and are National Statistics. Deaths are recorded as "apparently self-inflicted" rather than suicide so there is no need to wait for a Coroner's verdict before the deaths are classified. This category includes self-administered drug overdoses. The only delay is caused when there is a need to wait for the results of toxicology reports when it is not clear if the death is caused by natural causes or an overdose of drugs.

Internal Inquiries into Deaths in Custody

The Scottish Prison Service have since 2008 had a policy of internally considering each apparent suicide in order to learn lessons that may help prevent future deaths. This process was originally called Self Inflicted Death in Custody: Audit Analysis & Review (SIDCAAR). The intention stated was to adopt a critical appraisal process

which facilitates the reviewing of a suicide in prison from a lesson learned perspective. This policy was developed after prompting from the Scottish National Suicide Risk Management Group. The policy had a battery of standard forms that must be filled in but at its heart is a meeting attended by all those who were involved in dealing with the prisoner which is to be chaired by the Governor or Deputy Governor of the prison. The conclusions are then fed into HQ so that wider implications for the SPS can be considered. It is a speedy process with all the work including collation of information at HQ and a discussion at the National Suicide Risk Management Group within 12 weeks of the death.

The policy was expanded to cover all deaths in custody and renamed when the Talk to Me Strategy was introduced in November 2015. SIDCAARs became DIPLARs (Death in Prison Learning, Audit & Review).

The DIPLAR process was amended in February of this year to introduce a requirement for the first time of some oversight external to the prison. If the death is apparently self-inflicted the DIPLAR hearing must be chaired by a Non-Executive Member of the SPS Advisory Board.

This change was prompted by two recent reports, Dr Briege Nugent's Report which evaluated the Talk to Me policy and a separate report that provided an Expert Review of Mental Health at Polmont.

The obvious risk to the integrity of this process was that Governors might tend to be defensive in their approach and reluctant to think critically enough about either policy or practice, not least because Governors may be held responsible for operational failings that are identified. Governors are also likely to be influenced by the fact that they will have to personally explain any failings at the FAI.

If the process had been working well it should have been evidenced by regular feedback from SPS HQ to Governors about the lessons learned with changes to the Talk to Me policy incorporating lessons learned into the policy. I can find no evidence that this has actually been the case. This is confirmed by own experience in that some of the DIPLAR and SIDCAAR reviews I have read did not thoroughly examine all the issues that may have contributed to the death.

It is too early to judge what difference it will make having a Non-Executive chair of the DIPLAR process. My assessment is that it is unlikely to provide added value to a level that matched the independent inquiries carried out by the Prison Ombudsmen in England and Wales and in Northern Ireland.

A more radical approach would be to adopt a variant of this independent system perhaps by asking the Scottish Prison Inspectorate to conduct an inquiry into all deaths in custody. The Prison Inspectorate have the prison knowledge required and the independence to mount credible investigations. Such a change of approach would also help to deal with some of the concerns of families about the existing system.

FAMILY INVOLVEMENT

Although the importance of the contribution a prisoner's family can make to preventing suicide has been emphasised in policy for many years, there is little or no evidence in any of the reviews into suicide prevention that this emphasis has consistently been translated into practice.

A role of Family Contact Officer has been created with at least one such Officer at each Scottish Prison. Those in this role have approached the broad task of linking with families with enthusiasm, however there are very limited resources devoted to this work.

This work is regarded by Hall staff as a specialist task rather than one for them to take up. As it is the Hall staff who are in the lead on dealing with most at risk prisoners, particularly during the early period in custody, this probably explains the problems relatives have experienced getting meaningful contact with staff about potential suicide risks.

If aspirational policy was to match operational reality it would need to be much clearer both to family and prison staff about how contact was to be made. It would also need to be resourced adequately and predictably so that urgent concerns could be raised and issues promptly discussed. In my view it is not reasonable to simply graft this on to existing Hall staff work during busy periods like the early evening as new admissions are arriving at the prison.

Contact with the family after a death has occurred

The policy arrangements for dealing with the family after a death are delegated away from the Governor and the prisons operational staff. The police rather than the prison staff inform the family of the death. In most cases this means that there is no opportunity for passing on detail and explanation at this first stage.

Thereafter the Chaplain is expected to be in the lead on making contact with the family. The detailed guidance emphasises that information should be shared with the family on the principle of openness. This is rather contradicted by the statement where the Governor will tell the Chaplain what can be disclosed and what cannot. The Chaplain is advised that he or she should be sensitive to giving too much detail.

This contradictory advice falls short of a commitment to fully sharing information openly with the family. It is likely this ambiguous advice may result in families feeling they are being handled in an overly defensive way. In my experience there is value in adopting a consistently open and supportive approach to the family. Such an approach helps the family by answering their questions quickly, so they do not have to wait for the FAI. Honestly admitting mistakes at an early stage make it much less likely that issues fester and become contentious.

CONCLUSION

Ensuring that each prisoner's right to life is properly protected by all prisons is a difficult task. It is however a touchstone test of a whether the Scottish Prison Service is providing the humane and decent conditions required to meet its legal obligations in its prisons.

Self-inflicted deaths both by suicide and by drug overdose present particularly challenging issues. The aftermath of such deaths can only be handled well if policies are fit for purpose and operational practice is properly resourced and fully aligned with the policies.

My conclusion is that the ACT 2 Care policy was very good and represented the best policy practice in the UK. Talk to Me rather weakened the excellent clear direction provided by ACT 2 Care though it did not fundamentally change the thrust of the earlier strategy.

Unfortunately, neither Strategy appears has been consistently delivered in all Scottish Prisons. Instead, for at least the last 20 years practice has continued to rely too frequently on simple observation rather than intervention and on far too many occasions involved isolating distressed prisoners in very restricted and deprived conditions. Such prolonged failure to follow policy is simply indefensible. Any move to improve engagement with families will fail until this problem is confronted and dealt with.

There are other important areas where existing policy does not match with practice. Perhaps the most important is the persistent failure to appropriately share confidential information between health and prison staff. The cross-over between problems of addiction, mental health and social problems in the prison population is so common that this failure to communicate relevant information must be confronted.

Communication with families is another area where the policy looks good but is not fully matched in reality. Better communication with the many supportive families of the most vulnerable prisoners should help to prevent suicide. To be more effective this policy needs to be backed by sufficient resourcing, training and supervision so that not just specialist officers but also the Hall officers play their full part in mobilising families as a resource to support the prisoner.

In the event of a death the existing policies pay lip service to openness but in practice both the in-service inquiry into incidents and the dealings with families have been too often characterised by a defensive approach rather than a commitment to learning lessons, making changes and openly communicating with the family.

The heavy reliance on the FAI as providing the only proper process for discovering the facts and learning lessons has in my view prevented the SPS from learning lessons from suicides and the lack of expert prison knowledge by all those who play key roles in the FAI process has meant it has neither provided a timely and thorough analysis of individual deaths nor an effective way of drawing together the learning from other similar cases.

The addition of an important role for Non-Executive SPS Board members may help but a much bigger impact could be achieved if there was a genuinely independent organisation like the Inspectorate of Prisons to inquire into all prison deaths.

Philip Wheatley CB
29 May 2020

Appendix 8

Review Research Methodology and Policy Mapping Overview

Human Rights Framework

From inception, a human rights framework has run throughout the review process. This includes a specialist section on the national and international human rights framework, use of PANEL principles to help devise questions for families, people in prison, SPS (including private sector prison staff) and NHS staff, as well as providing an analysis structure for evaluating policies and procedures, to help identify good practice, gaps in the documentation and help to inform recommendations.

Literature Review

A comprehensive review of both local, national and international literature was commissioned from Dr Briege Nugent and Dr Gemma Flynn. This was used to inform and further substantiate the information received from speaking with families, people in prison and SPS/NHS staff, and included throughout the report.

Engagement

Collectively, the Review Team undertook the following engagement activities:

- Families
- People held in prison
- Staff in the SPS and private prison providers
- Staff in the NHS
- People with lived experience

Engagement methodology

A semi-structured interview schedule was used for all interviews and focus groups and was replicated as far as possible in an online survey. Interviews and focus groups were conducted by two members of the Review Team; one to lead the conversation, and the other to transcribe detailed notes.

Restrictions in contact were in place throughout the Review period due to the COVID-19 pandemic. The Review Team delayed the interviews with families as long as possible in the hope that restrictions would be lifted in time to conduct such difficult conversations in person.

Thematic analysis was used to analyse the information received through all interviews, focus groups and survey responses. The analysis for each group (families, people held in prison, SPS and NHS staff) was then triangulated, with major cross-cutting themes identified and used to inform the final report write-up and review recommendations.

Family engagement

The Crown Office wrote to all 63 families who had been involved in a Fatal Accident Inquiry (FAI) regarding a death in prison custody over a two-year period (1 April 2018 to 31 March 2020). The Co-Chairs also put out a call on social media. In response, 23 people from 17 families (about a quarter of those who had been through a FAI in the relevant time period, plus one family that had not yet been through an FAI) came forward to take part in the Review.

Alongside speaking with families individually, the Review Team also asked families to volunteer to take part in a Family Advisory Group if they wished. The Family Advisory Group met monthly for the duration of the Review, with a total of 12 people from eight of these families taking part, and family members acting as Chair and Vice-Chair. The Family Advisory Group assured the Review Team that interviews by video link or telephone would be acceptable in the circumstances.

The Family Advisory Group informed the work of the Review throughout, suggesting and commenting on the questions for families, staff, and people held in prison alike as well as on the information produced for families and the aims and methods of the Review Team.

In the end, the Review Team spoke with 20 people from 14 families (a fifth of all families that had been through a FAI, plus one additional family). Of the remainder, one withdrew due to being too upset about the death and felt unable to speak about it at this time; one only wanted to speak face-to-face as part of a group, which was not possible in pandemic conditions; and one stopped communicating and could not be reached again following initial contact.

In addition to the direct interviews and discussions with families, the Helpline Team from Families Outside collated inquiries from families from 1 January 2019 to 1 January 2020 regarding concerns for someone in prison.

People held in prison engagement

Six prisons across the prison estate were approached (based on an algorithm that looked at the rate of death, cross-section of particular populations, etc) to provide a long list of people with experience of a death in custody within the timeframe of the Review. The Review Team's intention (after extensive liaison with the SPS) was for the Suicide Prevention Officer for each prison to create a long list of (five to 10) names of potential participants and for an Independent Prison Monitor (IPM) to then make the initial face-to-face approach with the person in prison, offering information around the review, the privacy notice, and to obtain consent from the person to participate in an interview about their experience with a member of the Review Team.

However, whilst this process was followed by the SPS in one prison this was not replicated across all the establishments identified; a reminder was sent to SPS about the agreed approach to be taken once it had been identified that there had been a departure from the methodology proposed. The outcome of this departure was that Suicide Prevention Officers or other SPS staff identified potential

participants, spoke with them directly and then emailed the Review Team with the names of people who had agreed to be spoken to for the Review. The impact of this was two-fold:

- The Review Team was unable to exercise control around ensuring randomised selection of participants based on a longer list of potential people to approach, and therefore unable to ensure impartiality and independence from the prison service.

- Ensuring informed consent was more problematic (this is a point outlined further in the section on the views of people with lived experience), with several participants notifying the Review Team that they had received minimal to no information about the scope or purpose of the interview prior to meeting with the Review Team at the time of the interview. This also had the unfortunate consequence of raising participants' anxiety levels, as some were worried that the meeting had been scheduled in order to inform them of a friend or relative's death, or a formal interview conducted by the police in relation to a previous death in prison.

However, 10 male prisoners from across five prison establishments were interviewed, with a further five individuals (four male and one female) previously agreeing to take part and then withdrawing from the process prior to meeting with the Review Team.

Females currently in held in prison engagement

As noted above, only one female currently in prison was put forward to the Review Team for interview; however, the participant subsequently declined to take part. The Review Team also approached Shine, Tomorrow's Women, Willow, 218, and families who had experienced the death of a female relative in an attempt to find female participants (either currently in prison custody or who had previously been in prison custody, and experienced a death whilst in prison). One participant was identified in this way, however the potential participant did not respond to email contact and so an interview was not able to be arranged. The Review Team acknowledge that this is an area in urgent need of further research, in order to identify areas of commonality and difference between different demographics of the population who are currently in prison custody or have prior experience of this.

People who had previous experience of prison custody engagement

An invitation to participate in a focus group was circulated to members of the HMIPS Prisoner Advisory Group, and Peer Mentors. However, despite best efforts (such as extending the date for the focus group and recirculating the information) no one came forward to take part. It is recommended that research into the experience of those who have previously been in prison custody would be a valuable addition to the information gained around responses to death in prison.

Prison Staff Engagement (Management, Front-line and Chaplains)

In total, the Review Team heard from 78 individuals in the prison service; 69 staff and nine Chaplains. Of these 78, 39 staff took part in 26 one-to-one or focus group sessions.

COVID-19 pandemic restrictions required all interviews and focus groups to be undertaken remotely using a combination of video link and telephone. Those who participated involved senior management and operational staff in both SPS and private prisons. This included 19 SPS and 11 Private staff, comprising 18 Senior Management Team and 12 Operational Staff.

The Review Team requested that an SPS Governors and Managers Action (GMA) Notice was circulated to all staff, informing them of the Review and inviting them to be involved, either via one-to-one interview, focus group, or through the online staff survey. The Review Team raised their concern with SPS, Sodexo and Serco about the low number of staff initially coming forward (both in terms of interviews and especially completing the survey). In response, SPS informed the Review Team that targeted letters had been sent to members of staff who had been involved in a DIPLAR within the scope of the Review and that whilst an initial GMA was circulated, this may not be best way of contacting staff. SPS were concerned by the Review Team's repeated requests for a follow-up GMA to be circulated to all staff, though when this was finally circulated this resulted in a dramatic increase in staff survey responses.

NHS Staff Engagement (Management and Front-line)

An introductory letter was drafted, in partnership with Healthcare Improvement Scotland (HIS) colleagues. This was then circulated, via the Prison Healthcare Network, to all Health Board Leads with a request for potential participants to contact the Review Team directly. Once Health Board Leads were happy for us to contact staff, a direct email was sent introducing the Review, why we wanted to talk with them, and included a consent form and privacy notice.

A trial staff focus group was conducted with a small number of participants from one Health Board to:

- Check whether participants felt the session flowed.
- Check whether participants felt the questions were appropriate.
- Gather any other general feedback.

Following successful completion of the trial focus group, the Review Team progressed with further interviews and focus groups, and an online survey was also created, replicating the questions used in the one-to-one and focus group sessions. The survey link was included in the correspondence to the Health Board Leads for dissemination to the NHS Prison healthcare staff.

In total, 44 NHS staff members took part; 41 NHS staff members took part in 16 one-to-one focus group sessions, along with three people completing the online survey. The one-to-one and focus group sessions were facilitated by Healthcare

Improvement Scotland staff, with a clinical background to ensure that the context being discussed was best understood and considered. A thematic analysis of the data coming out of the sessions and the survey was completed by the same Healthcare Improvement Scotland staff, with support from research staff within the Review Team to ensure the consistency of approach.

Reviews

The following Reviews were undertaken:

- SPS and Private Prison Provider Policy Review
- NHS Policy, and SAER, Review
- DIPLAR/FAI Review
- Expert Review
- Policy Mapping Review

SPS and Private Prison Provider Policy Review

SPS were emailed to request all policies appropriate/applicable to deaths in custody. The Review Team received the following four policies:

- Death in Prison Learning Audit and Review (DIPLAR) Guidance – Revised December 2020. Note DIPLAR guidance has been updated a number of times in recent years.
- Critical Incident Response and Support (CIRS).
- Guidance on the role of the Chaplain following a death in custody.
- Family support booklet.

Some policies have been frequently updated, and the analysis relates to the most recent iteration unless otherwise stated. The Review Team also reviewed relevant policies of Scotland's two privately run prisons, HMP Addiewell run by Sodexo, and HMP Kilmarnock run by Serco. Both privately run prisons follow the DIPLAR process; however, any supplementary policies in operation in each establishment were reviewed:

- **Sodexo** – HMP Addiewell policies: Operational Procedures following a Death in Custody.

- **Serco** – HMP Kilmarnock policies: Standard Operating Procedure – Operational Procedures following a Death in Custody (Kilmarnock Standard Operating Procedure (KSOP) 35 Death in Custody).

NHS Policy, and SAER, Review

A letter was sent on behalf of the Review Team on 23 April 2020 to the nine Health Boards with a prison in their area. The letter offered background to the Review and asked for copies of all policies and operating procedures used with regard to:

- a death in custody, whether in prison or in hospital;
- any learning reviews that take place, whether jointly with the SPS or within their own governance, for example critical incident chronology; and
- policies that evidence support to staff.

A follow-up letter was also sent on 7 January 2021 requesting updated policies; minor revisions were noted, along with delays to reviews due to the ongoing COVID-19 pandemic. Whilst most boards sent their (S)AER policies and procedures into the Review Team, there was wide variation in the other documentation submitted. In total, 71 documents were reviewed across the nine Health Boards; this shows that there is no one policy or consistent approach which guides Health Boards' responses to Deaths in Custody and that staff will be required to consult and navigate a range of policies and procedures once a death has occurred.

An additional letter, requesting Good Practice examples and/or recent improvements was also sent on 19 May 2021 which yielded a response from a third of the Health Boards, and a separate log was kept of these. Copies of SAERs were also requested from all nine Health Boards, with two Health Boards sending completed Reviews (a total of 10 SAERs in total) with a separate analysis undertaken and included at the end of the NHS Policy section.

DIPLAR/FAI Review

The Review Team conducted a comparison of the learning and action points detailed in the initial 20 DIPLARs sent from SPS, against the (concluded) FAI recommendations.

Expert Review

Phil Wheatley, the retired Director General of the National Offender Management Service, and frequently an expert witness used by the Crown Office and Procurator Fiscal Service (COPFS) undertook a review of current policy and approaches to deaths in prison custody in Scotland. Dr Alan Mitchell, President of the Committee of Prevention of Torture of the Council of Europe, former Scottish Human Rights Commissioner and practicing GP, advised the Review on the findings of the healthcare policies and documentation.

Policy Mapping Review

Rationale for policy mapping.

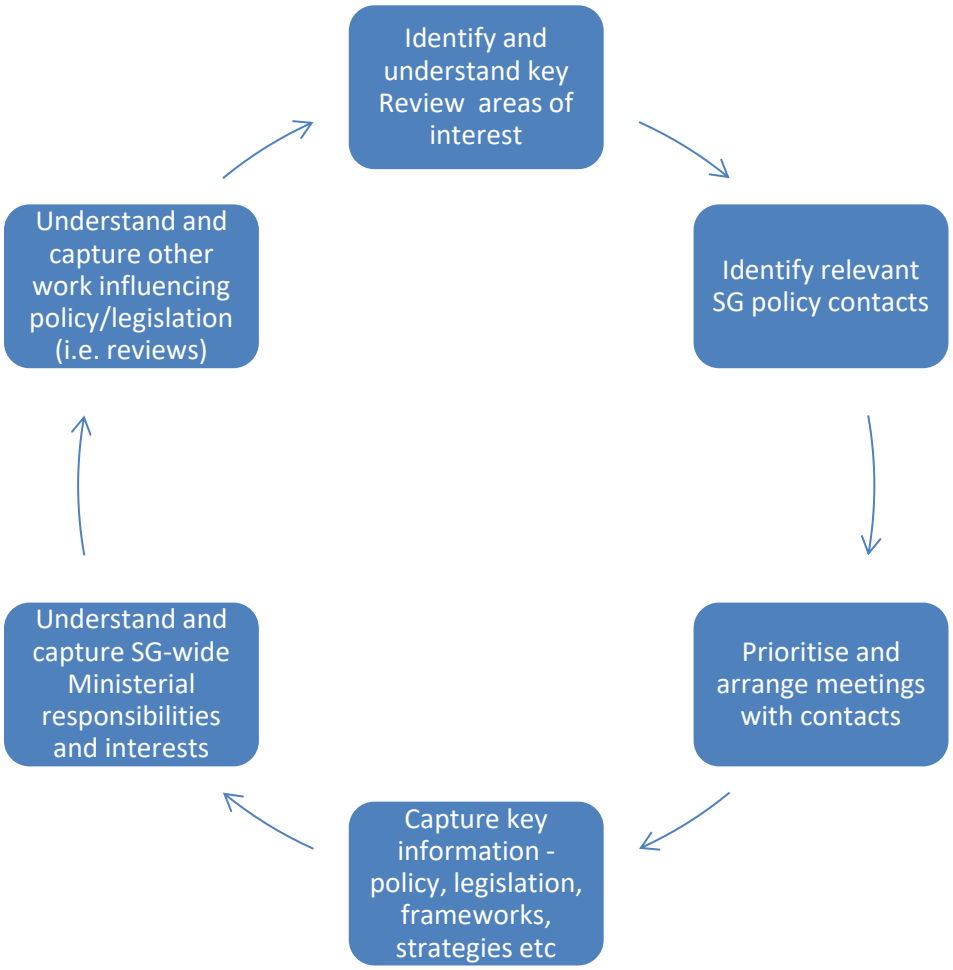
The purpose of undertaking policy mapping is two-fold to ensure that:

- The Review is aware of current Scottish Government priorities and work in order to understand the current policy and legislative landscape as well as to avoid unnecessary duplication; and

- There is a collective understanding of the range of legislation, policy and relevant strategies, etc, informing the wider work across Justice, Children and Young People and Mental Health policy. Ministers are thus in a position to quickly understand the potential implications of recommendations arising from the Review as relevant links have already been made.

Methodology behind policy mapping

The following cycle has been established to continually review and capture relevant knowledge as the Review and Government work progress and is consistent with the approach to policy mapping taken by other ongoing reviews.



The Review is cognisant of and makes its recommendations with regard to Scottish Government commitments set out in the current strategies and legislation.

Legislation

Adult Support and Protection (Scotland) Act 2007 defines adults at risk as those adults who are unable to safeguard their own wellbeing, or are engaging (or are likely to engage) in conduct which causes (or is likely to cause) self-harm. The Act places a responsibility on all public bodies to report the circumstances of any adult they believe may be at risk of harm.

Children and Young People (Scotland) Act 2014 places a definition of child wellbeing in legislation; provides a clear definition of corporate parenting, and defines the bodies to which it will apply; and places a duty on local authorities to assess a care leaver's request for assistance up to and including the age of 25. It also creates a new right to appeal a local authority decision to place a child in secure accommodation, and makes procedural changes in the areas of Children's Hearings support arrangements.

Criminal Justice (Scotland) Act 2016 modernises the criminal justice system. It sets out changes to Police powers and makes provision on the powers of the Police to arrest, hold in custody and question a person who is suspected of committing an offence. It also provides for the rights of those in custody, including for vulnerable adults and children.

Criminal Justice and Licensing (Scotland) Act 2010. The extension of the presumption against short-term sentences in the Act extends the presumption against short-term sentences from three months to one year.

Criminal Procedure (Scotland) Act 1995 consolidates certain enactments relating to criminal procedure in Scotland. Part V has a specific focus on children and young people and includes the detention of children and young offenders. Part VI has a focus on mental disorders and criminal responsibility. Section 207 includes a presumption against custodial sentences for those aged under 21.

Human Rights Act 1998 gives further effect to rights and freedoms guaranteed under the European Convention on Human Rights. The Review also recognises the likelihood of the new human rights framework currently in consultation.

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. This Act notes that under Section 29 of the Act Scottish Ministers are required to report on inquiries that concluded in the previous financial year.

Management of Offenders (Scotland) Act 2019 includes greater powers around electronic monitoring and is a key part of wider work to reform the justice system, enhance public safety and support greater use of community alternatives to custody, including supervised bail.

Mental Health (Scotland) Act 2015 includes provisions for mental health disposals in criminal cases.

Mental Health (Care and Treatment) (Scotland) Act 2003 promotes the human rights of people experiencing mental health problems and establishes arrangements for the detention, care and treatment of persons who have a mental disorder.

Prisoners (Control of Release) (Scotland) Act 2015 (legislation.gov.uk) makes provision for flexible release for the purposes of reintegration. Early Release Request information using this legislation from HMP YOI Polmont indicates that although the process is not used regularly, applications have been made in order to alleviate mental health concerns and for those with complex needs and learning difficulties.

The Legal Aid (Scotland) Act 1986 (legislation.gov.uk). An Act to establish the Scottish Legal Aid Board and the Scottish Legal Aid Fund; to make new provision in connection with the availability of criminal legal aid in Scotland; to repeal and re-enact with modifications certain enactments relating to legal aid and to advice and assistance in Scotland; and for connected purposes.

Scottish Government Strategies and Approaches

Strategy	Published Date	Lead Policy Area	Ministerial Responsibility
Suicide Prevention Strategy: Every Life Matters This sets out our ambition to reduce suicides in Scotland by 20% by 2022. Suicide prevention action plan 2018 - 2020: review - gov.scot (www.gov.scot). This was recently extended to September 2022 in acknowledgement of the impact of COVID on delivery of some of the actions. The Suicide Prevention Action Plan (SPAP) will be replaced with a new longer-term Suicide Prevention Strategy in September 2022. A two-year bereavement support pilot service went live in NHS Ayrshire and Arran and NHS Highland health board areas on 12 August 2021 to cover Action 4 of the SPAP which states that the Scottish Government will **ensure timely and effective support for those affected by suicide is available across Scotland by working to develop a Scottish Crisis Care Agreement**.	09/08/2018 03/02/2021	Mental Health	**Kevin Stewart MSP**, Minister for Mental Wellbeing and Social Care
Getting It Right for Every Child (GIRFEC) GIRFEC is the Scottish Government's approach to supporting children and young people. It is intended as a framework that will allow organisations who work on behalf of the country's children and their families to provide a consistent, supportive approach for all.		Children and Families	**Clare Haughey MSP**, Minister for Children and Young People

Youth Justice Vision and Priorities The Youth Justice Vision and Priorities document builds on the youth justice strategy which came to an end in 2020. The priorities have been developed based on feedback from young people, partners and stakeholders. Reducing the number of under 18s in HMP YOI Polmont, including those on remand, is a key priority of the new vision along with continuing to deliver a whole system approach to those under 18 years old and expansion beyond to those up to the age of 26. The Standards for those working with children in conflict with the law 2021 were published alongside the Youth Justice Vision to guide strategic and operational services' understanding of what is expected at each stage of a child's journey through the justice system.	16/06/2021 16/06/2021	Youth Justice	**Keith Brown MSP**, Cabinet Secretary for Justice **Clare Haughey MSP**, Minister for Children and Young People
Justice in Scotland Vision and Priorities This sets out the plan for a just, safe and resilient Scotland, with priorities for 2017-2020.	11/07/2017	Justice	**Keith Brown MSP**, Cabinet Secretary for Justice and Veterans
Whole Systems Approach This aims to reduce youth offending by putting children – and their families – at the centre, delivering early and effective (multidisciplinary) interventions, and diverting young people from prosecution wherever possible. Whilst the WSA currently focusses on young people up to the age of 18 (and 26 in the instance of care experienced young people), it is recognised that much of the approach could be expanded beyond the age of 18. Expanding WSA beyond the age of 18 features in the new vision for youth justice published in 2021.	2011	Children and Families	**Keith Brown MSP**, Cabinet Secretary for Justice and Veterans **Clare Haughey MSP**, Minister for Children and Young People

Rights, Respect and Recovery: alcohol and drug treatment strategy 2018 This strategy recognises the high prevalence of problematic alcohol and drug use of people involved in the criminal justice system and the links between this and poor mental health. The accompanying Rights, respect and recovery; action plan covers the time period until 31 March 2021.	28/11/2018 31/10/2019	Health	**Maree Todd MSP**, Minister for Public Health, Sport and Wellbeing
Preventing drug related deaths in Scotland: emergency response strategies - January 2020 - gov.scot (www.gov.scot) Tackling and reducing the harm of drug misuse, supporting the rehabilitation and recovery of those living with drug addiction, and reducing the unacceptable number of deaths from drugs.	07/02/2020	Health – Drug Policy	**Angela Constance MSP**, Minister for Drug Policy
Review of the arrangements for investigating deaths of patients being treated for mental disorders The aim of this Review was to establish whether the current arrangements for investigating the deaths of people being treated for mental disorder are adequate, and how well hospitals and other organisations support and engage with the families of people who have died.	17/12/2018	Mental Health	**Kevin Stewart MSP**, Minister for Mental Wellbeing and Social Care
Healthcare Improvement Scotland's National guidance when a child or young person dies The National Hub ensures reviews are conducted on all deaths of children up to their 18th birthday, or 26th birthday for care leavers in receipt of aftercare or continuing care at the time of their death, for the purpose of learning from the circumstances of the deaths.	26/01/2021	HIS	
Trauma-informed practice: toolkit This was developed as part of the National Trauma Training Programme, to support all sectors of the workforce, in planning and developing trauma informed services.	15/03/2021	Mental Health	**Kevin Stewart MSP**, Minister for Mental Wellbeing and Social Care

Policing - complaints handling, investigations and misconduct issues: independent review First independent review of complaint handling, misconduct and investigations since the creation of new policing structures in 2013. Dame Elish Angiolini reviewed the effectiveness of the new systems for dealing with complaints against the Police, how well complaints are investigated and the processes involved.	11/11/2020	Justice	**Keith Brown MSP**, Cabinet Secretary for Justice and Veterans
Inquiry into the death of Sheku Bayoh The COVID-19 pandemic, including lockdown restrictions, has had an impact on the ability to take forward aspects of work for the public inquiry as resources have had to be focused on essential coronavirus priorities.	11/11/2020	Justice	**Keith Brown MSP**, Cabinet Secretary for Justice and Veterans
Fatal Accident Inquiries: follow up review - gov.scot (www.gov.scot) The thematic report on FAIs was published in August 2016, with a follow-up review published in August 2019. A primary aim of the report was to obtain factual data on the causes of delay, to identify recurring themes and make recommendations to improve the efficiency and effectiveness of deaths investigations and the FAI process. The report made 12 recommendations, with the follow-up review making a further three recommendations. A further follow-up was due in 2020/21 but has been postponed.	07/08/2019	Justice	**Keith Brown MSP**, Cabinet Secretary for Justice and Veterans
Mental health Transition and Recovery Plan This plan outlines our response to the mental health impacts of COVID-19.	08/10/2020	Mental Health	**Kevin Stewart MSP**, Minister for Mental Wellbeing and Social Care

Funeral Support Payment This is available to those who are in receipt of benefits such as Universal Credit or Tax Credits and will assist with the costs of a funeral.	01/04/2021	Social Security Scotland	**Ben Macpherson MSP**, Minister for Social Security and Local Government
Information on death and end of life This includes: • Burial, cremation and death certification, as well as • bereavement care and support Bereavement Charter This was developed to support individuals and communities who struggle with the death of someone they know or someone in their community.	04/2020 2020	Health and social care NES	**Maree Todd MSP**, Minister for Public Health, Women's Health and Sport
Palliative care: Scottish Palliative care guidelines – published by Healthcare Improvement Scotland, these reflect good practice in the management of adult patients with life-limiting illness, with a focus on patients and families. Palliative and end of life care by Integration Authorities. NHS Inform – Palliative care – provides information on palliative care, including emotional and practical support. Palliative and end of life care: strategic framework This sets out a vision of palliative and end of life care to all who need it by 2021. Palliative and End-of-life Care by Integration authorities: advice note	2019 18/12/2015	HIS NHS Inform Health and social care	**Maree Todd MSP**, Minister for Public Health, Women's Health and Sport

The Promise This impacts on the youth justice landscape, with key areas being: • The disproportionate criminalisation of care experienced children and young people will end; • 16 and 17 year olds will no longer be placed in YOI for sentence or on remand; • There will be sufficient community-based alternatives so that detention is a last resort; • Children who do need to have their liberty restricted will be cared for in small, secure, safe, trauma-informed environments that uphold their rights.	31/03/2021		
Programme for Government https://www.gov.scot/publications/fairer-greener-scotland-programme-government-2021-22/	2021		
National Performance Framework Included in this are outcomes which relate to youth justice, such as: • We grow up loved, safe and respected so we realise our full potential; • We live in communities that are inclusive, empowered, resilient and safe; • We are well educated, skilled and able to contribute to society; • We are healthy and active; • We respect, protect and fulfil human rights and live free from discrimination.	2018		

Reviews

Review/Advisory Group
Council of Europe's Report to the UK Government on the visit to UK carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) 2018. This reported on the visit to 5 Scottish prisons as well as 5 Police custody facilities over the period 17-25 October 2018.
Mental Welfare Commission for Scotland: Concerns about the care of women with mental ill health in prison in Scotland. Published in July 2021, this document reviewed the records of nine women who received mental health care in prison custody in Scotland 2017-2020.
Review into the delivery of forensic mental health services (Barron Review). Published in February 2021, this included a review of forensic mental health services and the justice system.
NICE Preventing suicide in community and custodial settings Guideline (2018) covers ways to reduce suicide and help those bereaved or affected by suicide.
Health and Social Care needs assessments – the first (social care) report was published in January 2021, with publication of substance use report expected in spring 2022 and final synthesis report in summer 2022.
Independent review of Adult Social Care in Scotland (February 2021) – led by Derek Feeley, supported by an Advisory Panel comprising Scottish and international experts.

Advisory Groups

Advisory Group	Timescales	Chair
Health and Justice Collaboration Improvement Board	Ongoing	
Youth Justice Improvement Board	Concluded June 2020	
Secure Care Strategic Board – this met for the last time in December 2018, giving rise to a new working group, the Secure Care Group, which exists to provide oversight to ensure the remaining tasks of the Secure Care Strategic Board are completed.		Nicola Dickie, COSLA and Tom McNamara, SG (Joint Chairs)
National Suicide Prevention Leadership Group (NSPLG) – to remain in place until end of SPAP. Annual reports can be found here.	Sep 2018-Sep 2022	Rose Fitzpatrick
Youth Commission on Mental Health		
Scottish Health in Custody Network		
Dying well in Custody Charter (2018). The charter published by the Ambitions Partnership applies the Ambitions for Palliative and End of Life Care Framework to the context of the prison setting.		

[i] *McCann and Others v UK*, no. 18984/91, 27 September 1995.
[ii] No. 21986/93, 27 June 2000.
[iii] No. 21986/93, 27 June 2000 at paras 99-100.
[iv] *Makaratzis v Greece*, no. 50385/99, 20 December 2004 at para. 57.
[v] *Sunday Times v UK*, no. 6538/74, 26 April 1979. Interpreting the meaning of the word 'law' at para. 49.
[vi] *LCB v UK*, no. 23413/94, 9 June 1998.
[vii] *Osman v UK*, no. 23452/94, 28 October 1998.
[viii] *Osman v UK*, no. 23452/94, 28 October 1998
[ix] *Osman v UK*, no. 23452/94, 28 October 1998 at para. 116.
[x] *Paul and Audrey Edwards v UK*, no. 46477/99, 14 June 2002.
[xi] *Renolde v France*, no. 5608/05, 16 January 2009.
[xii] *Keenan v UK*, no 27229/95, 3 April 2001, at para. 92.
[xiii] *Keenan v UK*, no 27229/95, 3 April 2001
[xiv] *Renolde v France* no. 5608/05, 16 January 2009.
[xv] *Younger v UK*, no.57420/00, 7 January 2003.
[xvi] *Fernandes de Oliveira v Portugal*, no. 78103/14, 31 January 2019.
[xvii] See, for example, *Dzieciak v Poland*, no. 77766/01, 9 March 2009.
[xviii] No. 4353/03, 14 December 2006.
[xix] Re access to healthcare, see also *Kats and Others v Ukraine*, no. 29971/04, 18 12 2008.
[xx] *Edwards v UK*, no. 13071/87, 16 December 1992.
[xxi] *Salman v Turkey* no. 21986/93, 27 Jun 2000.
[xxii] *Makaratzis v Greece*, no. 50385/99, 20 December 2004.
[xxiii] *Nachova and Others v Bulgaria*, nos. 43577/98 and 43579/98, 6 July 2005; *Guiliani and Gaggio v Italy*, no. 23458/02, 24 March 2011.
[xxiv] *Nachova and Others v Bulgaria*. See also *Simsek and Others v Turkey*, no. 35072/97 and 37194/97, 26 October 2005 regarding effective training around use of force to quell a riot or insurrection.
[xxv] *McCann and Others v UK*, no. 18984/91, 27 September 1995.
[xxvi] These articles protect the following rights: Respect for your private and family life, home and correspondence (Article 8), Freedom of thought, belief and religion (Article 9), Freedom of expression (Article 10) and Freedom of assembly and association (Article 11)
[xxvii] *McCann and Others v UK*, no. 18984/91, 27 September 1995
[xxviii] *Armani da Silva v UK*, no. 5878/08, 30 March 2016.
[xxix] *Bubbins v UK*, no. 50196/99, 17 June 2005.
[xxx] *Bubbins v UK*, no. 50196/99, 17 June 2005. In the context of excessive use of lethal force during an anti-riot operation in prison, see *Kukhalashvili and Others v Georgia*, nos. 8938/07 and 41891/07, 2 August 2020.
[xxxi] No. 11818/02, 24 March 2009.
[xxxii] See also for example, *Angulova v Bulgaria*, no. 38361/97, 13 June 2002; *Kismir v Turkey*, no. 27306/95, 31 August 2005.
[xxxiii] *Armani da Silva v UK*, no. 5878/08, 30 March 2016.
[xxxiv] *Ilhan v Turkey*, no. 22277/93, 27 June 2000.
[xxxv] *Nachova v Bulgaria*, no. 43577/98, 6 July 2005, at para. 110.
[xxxvi] *Sieminska v Poland*, no. 37602/97, 29 Mar 2001
[xxxvii] *Al-Skeini and Others v UK*, no. 55721/07, 7 July 2011.
[xxxviii] *Armani da Silva v UK*, no. 5878/08, 30 March 2016 at para. 232.
[xxxix] *Mustafa Tunc and Fecire Tunc v Turkey*, no. 24014/05, 14 April 2015
[xl] *Ramsahai and Others v the Netherlands* no. 52391/99 , 15 May 2007
[xli] *Enukidze and Girgvliani v Georgia*, no. 25091/07, 26 April 2011
[xlii] *Kaya v Turkey*, no. 4451/02, 24 January 2007
[xliii] *Armani Da Silva v UK,* no. 5878/08, 30 March 2016.
[xliv] *Armani Da Silva v UK,* no. 5878/08, 30 March 2016
[xlv] *Mustafa Tunc and Fecire Tunc v Turkey,* no. 24014/05, 14 April 2015
[xlvi] *Ozalp and Others v Turkey*, no. 32457/96 , 8 April 2004
[xlvii] *Armani Da Silva v UK,* no. 5878/08, 30 March 2016; *Giuliani and Gaggio v Italy*, no. 23458/02, 24 March 2011
[xlviii] *Al-Skeini and Others v UK*, no. 55721/07, 7 July 2011.

[xlix] *Mocanu and Others v Romania*,nos. 10865/09, 45886/07 and 32431/08 , 17 September 2014
[l] *Ramsahai and Others v the Netherlands*, no. 52391/99 , 15 May 2007
[li] *Al-Skeini and Others v UK,* no. 55721/07, 7 July 2011
[lii] *Hugh Jordon v UK*, no. 24746/94
[liii] *Ogur v Turkey*, no 21594/93, 20 May 1999
[liv] *Gulec v Turkey*, no. 54/1997/838/1044, 27 July 1998
[lv] *Oneryildiz v Turkey,* no 48939/99, 30 November 2004
[lvi] Article 15(2) ECHR.
[lvii] *Kudla v Poland*, no 30210/96, 26 October 2000.
[lviii] *Kudla v Poland*, no 30210/96, 26 October 2000
[lix] *Khlaifia and Others v Italy,* no. 16483/12, 15 December 2016
[lx] *Ireland v UK*, no. 5310/71, 18 January 1978.
[lxi] See Romanov v Russia, no. 41461/02, 24 July 2008 at para 70
[lxii] *Ireland v UK*, no. 5310/71, 18 Jan 1978
[lxiii] *Denizci and Others v Cyprus,* nos. 25316-25321/94 and 27207/95, 23 August 2001.
[lxiv] *Ireland v UK*, , no. 5310/71, 18 Jan 1978
[lxv] *Tyrer v UK*, no. 5856/72, 25 April 1978.
[lxvi] *McGlinchey and Others v UK*, no. 50390/99, 29 July 2003 at para. 46.
[lxvii] See also *McGlinchey and Others v UK*, no. 50390/99, 29 July 2003 regarding lack of access to appropriate medical treatment in violation of Article 3.
[lxviii] *MC v Bulgaria*, no. 39272/98, 4 March 2004.
[lxix] *Gafgen v Germany,* no. 22978/05, 1 June 2010 at para 117.
[lxx] See Guide on the Case-Law of the ECHR: Prisoners' Rights for further discussion of Article 8 caselaw
[lxxi] *Girard v France*, no. 22590/04, 30 June 2011 and *Pannullo and Forte v France,* No. 37794/97, 30 October 2001
[lxxii] This is referred to as the Court's 'ambit test'. See *Rasmussen v Denmark*, no. 8777/79, 28 November 1984.
[lxxiii] *Zarb Adami v Malta*, no. 17209/02, 20 September 2006.
[lxxiv] *Menson v UK*, no. 47916/99, 6 May 2003.
[lxxv] *Nachova v Bulgaria*, nos 43577/98 and 43579/98, 6 July 2005
[lxxvi] *Nachova v Bulgaria*, nos 43577/98 and 43579/98, 6 July 2005