DATE AS POSTMARK

Dear _____,

INDEPENDENT REVIEW OF THE HANDLING OF DEATHS IN PRISON CUSTODY: VIEWS OF FAMILIES

On behalf of Families Outside, the Crown Office is contacting all families who have been involved in a Fatal Accident Inquiry following a death in prison custody in Scotland. Families Outside does not have access to your contact details, or they would have contacted you directly for such a sensitive and emotive topic.

As you may know, Prof Nancy Loucks (Chief Executive of Families Outside) has been asked to co-chair an Independent Review of the Handling of Deaths in Prison Custody alongside HM Chief Inspector of Prisons Wendy Sinclair-Gieben and Chair of the Scottish Human Rights Commission Judith Robertson. The co-chairs believe that the experiences and views of families who have been through this difficult experience should be first and foremost in informing the work of the Review and its recommendations.

Prof Loucks has asked the Crown Office to send this letter to ask for your input to this Review. This is an important opportunity to share your experiences and views in an effort to improve what happens in future. The remit for the Review is enclosed, and Prof Loucks welcomes any comments you may have on these, especially on the last three bullet points, which relate specifically to the experience of families.

Nancy would be very grateful if you would be willing to speak with her for the Review. Please get in touch with her at Nancy.Loucks@familiesoutside.org.uk or at 07958 451334 to arrange a time for this. Your input can be provided remotely via email or telephone / video call, or in person - individually as a family or in a small group with others – whatever makes you feel most comfortable. If you would be interested in participating in an advisory group for the Review, please let her know that as well.

Thank you in advance for sharing your thoughts and experience.

Yours sincerely,

{Crown Agent}

Independent Review into the Handing of Deaths in Prison Custody
Terms of Reference from Cabinet Secretary for Justice

On 7th 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 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.