SHRC
Scottish
Human Rights
Commission

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Criminal Justice Committee
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Dear Convener

Independent Review of the Response to Deaths in Prison Custody: Implementation of recommendations

As you are aware, the Independent Review of the Response to Deaths in Prison Custody (the "Review"), published in November 2021, was co-chaired by Wendy Sinclair-Gieben (Chief Inspector of His Majesty's Prisons in Scotland), Professor Nancy Loucks (Chief Executive of Families Outside) and Judith Robertson (former Chair of the Scottish Human Rights Commission).

The Commission listened with interest to the oral evidence of Gillian Imery, External Chair of the Deaths in Prison Custody Action Group, delivered to the Committee on Wednesday 20th September 2023. As co-chair of the Review, the Commission shares the concerns expressed by Ms Imery as to the slow progress in implementing the Review's recommendations. It is particularly concerning to hear Ms Imery's reflections on what she perceived as the lack of interest or willingness to implement the Review's evidence-based recommendations from duty-

bearers such as the Scottish Prison Service (SPS) and National Health Service (NHS).

During her evidence, Ms Imery confirmed that only five of the Review's recommendations and advisory points have been completed. The slow pace of progress is, in our view, unacceptable, particularly when viewed in the wider context of the increasing numbers of people dying in Scotland's prisons.[1]

Review's main recommendation

There was discussion during Ms Imery's evidence around the implementation of the Review's key recommendation, which is that a separate independent investigation should be undertaken into each death in prison custody. The investigation should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.

Although work is underway in developing the process for the key recommendation, the Commission is concerned that some important aspects may be overlooked.

The development of the key recommendation is based on the relevant human rights framework, most notably it would support compliance with Article 2 ECHR, which protects the right to life and sets out the need for an investigation to be independent, adequate, prompt, and undertaken with public scrutiny and with the participation of the deceased's next of kin. The full explanation of the reasoning behind the key recommendation, and a detailed account of the attributes the

[1] Deaths in Prison Custody in Scotland 2012-2022, analysis produced by the Deaths in Prison Custody Action Group (DiPCAG), August 2023.

investigation body should have, together with an account of comparable systems in other UK and Irish jurisdictions, are detailed at pgs. 75-79 of the Review.

The Commission wishes to highlight the following points to the Committee.

Statutory footing

The investigations were to be carried out by an independent body. The body's functions and remit – which includes timescales for investigations and the parties that must be involved in an investigation – should be set out in statute and explicitly linked to human rights standards. The body tasked with carrying out the investigations should be accountable to the Scottish Parliament, with appropriate reporting requirements also set out in statute. It appears to us that the importance of a statutory footing, with appropriate accountability and oversight mechanisms, may have, to date, been overlooked by Ministers.

Participation of next of kin and legal aid

Article 2 ECHR requires that the family or next of kin of a deceased person are provided the opportunity to participate in the investigation of a death where the responsibility of the state may have been engaged. We know that existing processes allow, in theory, for family participation. However, as the Review highlighted, in practice, that involvement is minimal. An independent investigation sitting alongside existing processes would allow families to raise concerns and questions at an early stage, perhaps with a wider focus on systemic issues leading up to their family member's death.

Another vital aspect of the Review's key recommendation was that families or next of kin of those who have died in custody should have access to free and immediate non-means-tested Legal Aid funding for

specialist representation to allow for their participation in the different processes that take place following a death in custody. Again, the Commission is concerned that focus on this crucial aspect of the recommendation has been lost.

The Fatal Accident Inquiry (FAI) process

The Commission recognises that the primary means to achieve compliance with Article 2 ECHR in Scotland is through the FAI process. The FAI process was specifically outwith the scope of the Review; however, due to our work on the Review and in our engagement with families and other stakeholders since, it is very clear to us that the current FAI process is neither providing what it should for families, nor is the FAI process in its current format delivering the systemic change, learning and improvement that is badly needed.

We know that the purpose of an FAI is to establish the circumstances of a death and to consider the steps (if any) that might be taken to prevent other deaths in similar circumstances. Despite this, we also know that in over 90% of all FAIs relating to deaths in custody, no finding of a reasonable precaution is made, no finding of defect is made, and no recommendations are made that might improve practice or prevent deaths.[2] FAIs currently consider relevant Death in Prison Learning, Audit & Review documentation (the SPS's own review into a death in custody); although this is no doubt useful, it represents the SPS's own account of events and their assessments of improvements they or the NHS need to make. An independent investigation could improve the FAI process by ensuring all relevant facts are brought before a court.

[2] Independent Review of the Response to Deaths in Prison Custody, at pgs. 69 & 76.

There is too often an extremely long time period between a death and an FAI. This is traumatic for all involved, most notably for families of people who have died. An independent investigation would be completed within a matter of months, ensuring a better chance of families receiving swift answers and supporting the SPS and NHS learning processes at a much earlier point, all with the aim of preventing future deaths in similar circumstances.

Other jurisdictions have in place comparable investigations alongside their equivalents of the FAI process.[3] Although we appreciate every legal system is different, the Commission questions why such a process envisaged by the Review's main recommendation should be so uniquely difficult to achieve in Scotland.

Separately, the Committee should be aware that the Review recommended that a review of the FAI process should be undertaken to consider alternative approaches to our current system. The time between the death occurring and the FAI must also be reduced. The Commission believes action on a more widescale review of the whole FAI process is urgently needed. The Commission would be pleased to explore this further with members of the Committee.

Lack of systemic focus and ongoing scrutiny and monitoring

Having reviewed a number of completed FAIs alongside internal SPS and NHS documentation as part of our work on the Review, and with regard to available research into the effectiveness of the FAI process in

[3] Further information and discussion on processes in comparable jurisdictions is set out at pgs. 77 and 78 of the Independent Review of the Response to Deaths in Prison Custody.

relation to deaths in custody[4], our view is that the current system lacks any real focus on identification of trends and systemic issues. Similarly, there is no transparent process in place to monitor implementation of recommendations arising from deaths in custody and to track progress. It was the Review's recommendation that there should be a regular independent review of data trends on deaths in prison, with the same independent body being tasked to collate, analyse, monitor and report on trends, systemic issues, recommendations and learning.

Suggested role of the Criminal Justice Committee

The Commission notes the discussion around the time remaining on Ms Imery's appointment as external chair. As a co-chair of the Review, the Commission is concerned that without an external focus on implementation, progress will further slow or halt.

In our view, there would be great value in ongoing Parliamentary scrutiny of implementation of the Review's recommendations, to complement and assist the work of the external chair and to ensure implementation once Ms Imery's term has come to an end. Should the Criminal Justice Committee agree to adopt this as part of its ongoing work, the Commission offers any assistance required in fulfilling a scrutiny role.

We hope the above information is helpful to the Committee. We would be happy to discuss further anything outlined above, should that be useful.

[4] S. Armstrong et al., *A Defective System: Case Analysis of 15 years of FAIs After Deaths in Prison*, October 2021, available at https://www.sccjr.ac.uk/publication/a-defective-system-case-analysis-of-15-years-of-fais-after-deaths-in-prison/

Yours sincerely

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