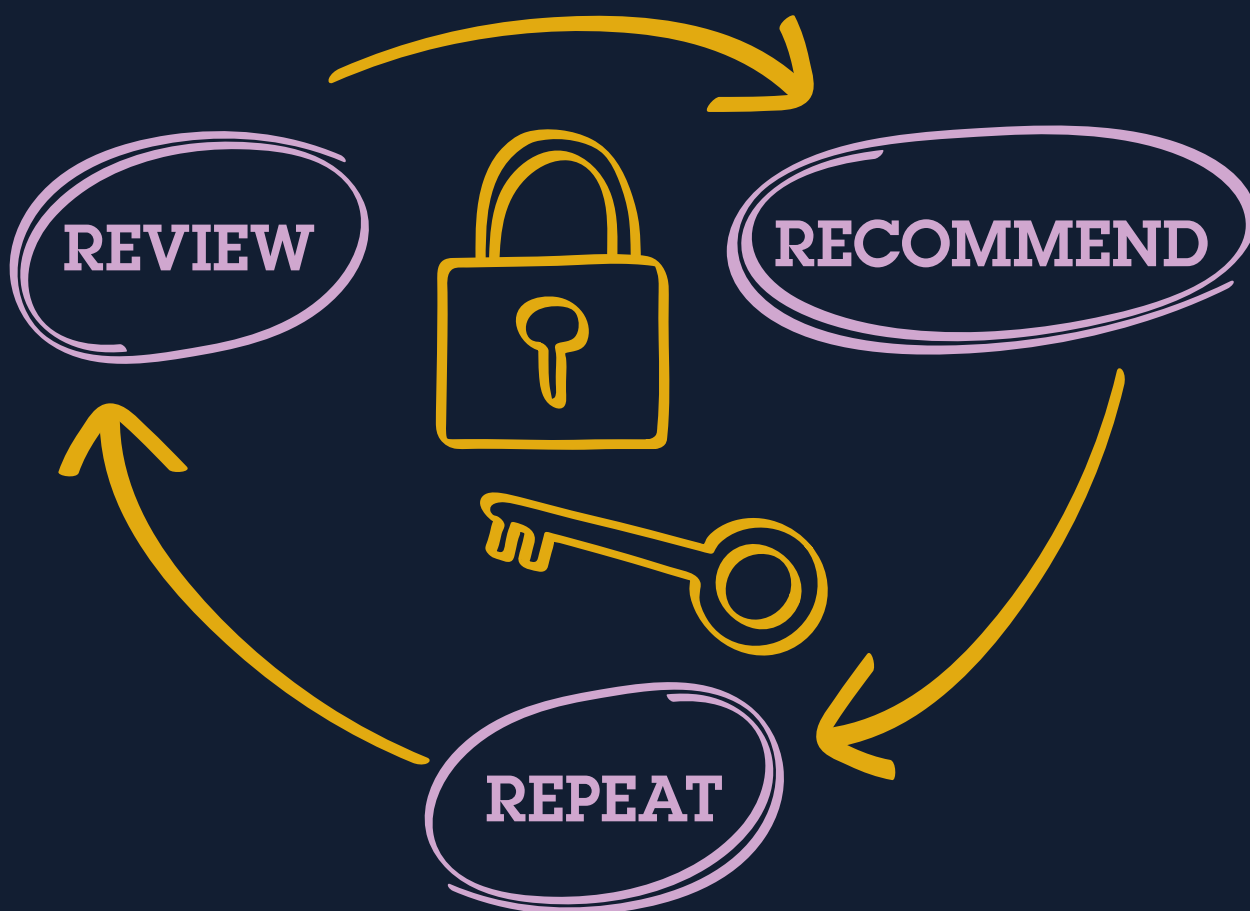


SHRC

Scottish
Human Rights
Commission



Review...
Recommend...
Repeat...

**An assessment of where human rights
have stalled in places of detention**

Published by the Scottish Human Rights Commission and the National Preventive Mechanism, July 2024.

The Scottish Human Rights Commission is a public body created by the Scottish Commission for Human Rights Act 2006 to protect and promote the human rights of all people in Scotland. We are an independent, expert body that works with and for the people of Scotland; we monitor, listen, speak up for all of our rights and respond when things go wrong.

The Commission is also part of the international human rights system. It is accredited by the United Nations as its trusted organisation to provide impartial evidence on the enjoyment of human rights in Scotland.

The UK National Preventive Mechanism was established in 2009 to strengthen the protection of people in detention through independent monitoring. It focuses attention on practices in detention that could amount to ill-treatment, and works to ensure its own approaches are consistent with international standards for independent detention monitoring. The Commission is a member of the National Preventive Mechanism Scotland Subgroup.

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Foreword

Human rights apply to you regardless of where you are from, how old you are, what you believe, or how you choose to live your life. Governments cannot pick or choose which rights to honour. They can't be taken away... All Scottish public authorities, including Scottish Ministers, must respect and protect your human rights when they plan services, make policies and take individual decisions.

Scottish Government ([What are my human rights? - mygov.scot](https://www.mygov.scot))

Scotland is a country where rights-respecting language is often used by our decision-makers. The Scottish Government has committed to being “a global leader in Equality, Inclusion, and Human Rights”.¹ *‘Governments cannot pick or choose which rights to honour’* is a welcome statement, that any human rights defender would want to hear from their government.

However, despite these commitments, the evidence available to us shows that, far too often, the rhetoric does not match the reality when government fails to translate warm words into action in people’s lives. Human rights in places of detention are in jeopardy, and when expert bodies tell the State how to fix it, they remain unaddressed for unacceptable amounts of time. Resources are expended in repeated reviews, short life working groups, and discussion. Human rights remain in jeopardy.

This report examines the progress of the State on two fundamental, absolute rights of the people of Scotland who spend time in prisons and forensic mental health settings: The right to life, and the prohibition of torture and inhuman or degrading treatment or punishment. International and domestic law tells us that there can be no derogation or defence for violations of these rights; they are absolute. People in Scotland have a legitimate expectation that these rights be actively

protected by the State – and where violations are identified that quick remedies are actioned.

These violations can be compounded for people held in the total control of the State. Where somebody is detained in a prison or mental health setting, agency and autonomy are removed. They rely on the State to meet all their basic needs. And they are often some of the most vulnerable people in society.

The Scottish Government has accepted the jurisdiction of human rights bodies to assess its compliance with human rights obligations. The Scottish Government has, almost without exception, accepted the recommendations made by human rights bodies. And yet we observe a glacial pace of action. We evidence that recommendations are made repeatedly – we have been able to track some recommendations to 1994 – without remedy at a sufficient pace.

Our findings show that a worrying 83 per cent of recommendations by human rights bodies have yet to be implemented.

Scotland can and should be proud of a culture that opens the doors of closed institutions to independent bodies to report on the treatment and conditions of those held. The State recognises that those deprived of their

liberty are in a uniquely vulnerable position to be subject to ill-treatment and scrutiny plays a vital role in preventing this. But to what end? International human rights bodies, domestic inspection and monitoring bodies, and Government-appointed commissions continue to make recommendations to enable the fulfilment of accepted obligations. This review evidences the scale, depth and longevity of inaction on recommendations to Government from the very bodies it has asked to review progress. It does not however explore why this is the case. Scottish Government must identify the barriers to improvement and implement reform now. The Commission may explore further work to establish a clearer understanding of the systemic barriers.

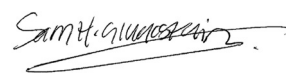
What is clear is that the impact of further delay in resolution, on these most fundamental of rights, cannot be understated. Outstanding recommendations exist on, amongst others, use of force in custody; investigating deaths in custody; overcrowding of the estate; mental health care; investigations of allegations of ill-treatment.

For example, for over three years it has been recommended that a specialised high-secure psychiatric unit for women be established in Scotland. This has not happened. The impact of this lack of action means that women in situations of severe mental distress and in need of a hospital setting are either held in prison environments entirely unsuited to their needs or transferred nearly 300 miles to a facility in England. Women are transferred far from their families and communities, in periods of already heightened distress. Scottish Government has accepted the need to develop a facility in Scotland – but has not acted.

In addition to the lack of progress in addressing recommendations, it is crucial to highlight the profound impact that these ongoing violations have on individuals, families and communities across Scotland. These violations not only undermine the dignity and rights of those directly affected, but also erode trust in the Government's ability to protect and uphold human rights for all people. By amplifying the voices of those impacted and shedding light on their experiences, we underscore the urgent need for meaningful action to address these systemic failures and ensure that every individual in Scotland is treated with the dignity and respect to which they have a right.

This report does not seek to oversimplify what we know are complicated and entrenched issues which can take time and resource to resolve. However, the sheer volume of inaction and delay is no longer acceptable.

Governments cannot pick or choose which rights to honour.


Shelley Gray, Member
of the Commission.
On behalf of the
Commission, July 2024



Sam Gluckstein, Head
of UK National
Preventive Mechanism

Executive Summary

The Scottish Human Rights Commission (the Commission) and the National Preventive Mechanism (NPM) have been concerned for many years about the pace of progress in remedying the serious issues facing places of detention in Scotland. International, European and domestic bodies have all pointed to gaps in the protection of human rights and made recommendations to remedy the issues. Many of those recommendations have been made repeatedly over a long period of time and yet the issues persist.

In 2021, the NPM published a follow-up report to track implementation of two visits by the European Committee on the Prevention of Torture (CPT) carried out between 2018 and 2019. The report found little progress. Over the course of this research, we have examined 29 recommendations for improvement made by international human rights bodies in respect of Scotland's prison and forensic mental health settings. Of these, we have found 83 per cent where little or no meaningful progress has been made in addressing the recommendation.

The report reviews recommendations made by international human rights bodies at the United Nations and the European Committee on the Prevention of Torture over a ten-year period. It focuses on two specific places of detention: **prisons** and the **forensic mental health estate**. It also focuses on two specific human rights:

- The **right to life**, which requires that everyone's life shall be protected by law. This right is protected by Article 2 of the European Convention on Human Rights and repeated across United Nations (UN) human rights treaties.

- The **prohibition of torture and inhuman or degrading treatment or punishment**. This right is protected by Article 3 of the European Convention on Human Rights and repeated across UN human rights treaties.

The recommendations cover ten thematic areas:

Right to life

- Investigating deaths in custody
- Suicides

Prohibition of torture and ill treatment

- Conditions of detention and overcrowding
- Investigating allegations of ill-treatment
- Training for prison staff
- Use of force and restraint
- Use of solitary confinement, seclusion and isolation
- Healthcare services
- Mental health
- Women prisoners

The key question we set out to answer was **whether the gaps in protection of absolute rights that have been identified by human rights bodies have been remedied**. In each theme we present a brief, accessible summary of the human rights standards at stake, the recommendations from international human rights bodies, and an assessment of the available evidence to indicate progress. Assessments are categorised as:



Recommendation making no meaningful progress.



Recommendation making significant progress.



Recommendation addressed.

Recommendations

Right to life



Investigating
deaths in custody



Suicides

Prohibition of torture and ill treatment



Conditions of
detention and
overcrowding



Investigations and
allegations of
ill-treatment



Training for
prison staff



Use of force
and restraint



Use of solitary
confinement,
seclusion and isolation



Healthcare
services



Mental
health

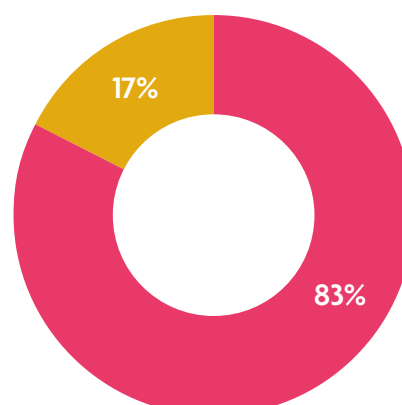


Women
prisoners

We have adopted the framework of human rights measurement to assess not only what **efforts** or discussions have happened on a particular issue, but also what specific **commitments** have been made, and what actual **outcomes** have been achieved. This approach aims to assess the gap between rhetoric and reality by looking at all the steps that are required to realise human rights – a State must not only commit to addressing a problem, but also make continuous efforts to do so, and make sure that those efforts achieve real results for rights holders.

We examined 29 specific recommendations made by human rights bodies about Scotland's prisons and forensic mental health estate since 2014. Of those 29:

- 24 were **RED** – recommendation making little or no progress.
- 5 were **ORANGE** – recommendation making significant progress.
- 0 were **GREEN** – recommendation complete.



The following table summarises our findings.

Recommendation	
Ensure an independent, prompt and impartial review of all deaths in custody	✗
Review the overall Fatal Accident Inquiry system to find ways to speed up the process	✗
Reduce the number of deaths by suicide	✗
Compile data to assess the effectiveness of suicide prevention strategies	✗
Tackle overcrowding and reduce the remand population	✗
Improve prison conditions – “dog boxes”, cell sizes, access to purposeful activity	✗
Ensure prompt and systematic investigation of all injuries and allegations of ill-treatment	✗
Collect, analyse and publish data	✗
Establish accessible complaints mechanisms	✗
Ensure ongoing, up-to-date training	✗
Ensure human rights standards are included in training	✗
Develop a methodology to assess the effectiveness of training	✗
Explicitly prohibit the use of harmful devices, disciplinary restraint and any technique designed to inflict pain on children	✗
Develop statutory guidance on the use of restraint on children	✗
Collect, analyse and publish data on restraint on children	✗

Recommendation	
Take urgent measures to protect minority ethnic groups from ill-treatment and disproportionate restraint	✗
Review behaviour management policies	↗
Consider measures to ensure body cameras for all control and restraint operations	↗
Stop using segregation for those with mental health needs	✗
Ensure appropriate use of segregation, adequate regimes and reintegration	✗
Address staffing issues	↗
Improve record sharing	✗
Address substance use	↗
Improve mental healthcare in all prisons	✗
Transfer prisoners with acute mental health problems to appropriate psychiatric facilities	✗
Provide training for prison personnel on recognising symptoms of mental health problems and appropriate referral	✗
Establish a high-secure psychiatric unit for women	✗
Improve admission screenings for women	✗
Upgrade the female prison estate	↗

This presents a dispiriting picture. Only one matter has been fully resolved, which is the removal of the so-called “dog boxes” used as holding cells in the reception area of HMP Barlinnie. Whilst this is welcome, we note that recommendation had been outstanding since 1994 and was finally addressed in 2023.

There are some issues which are complex and which we recognise take time, such as reducing the prison population and addressing substance use. In those areas, we do see substantial legislative and policy efforts being made, however, as yet the results show little sign of improvement. On overcrowding and deaths in custody for example, the situation is in fact worsening.

There are many other, arguably less complex issues, however, in which action appears to be completely lacking, never mind progress. Recommendations to ensure human rights standards are included in training, to ensure proper recording and follow-up of allegations of ill-treatment and to collect and publish data on allegations, are relatively straightforward matters of process on which we can find no evidence of commitment, let alone action. These may seem like procedural issues; however, they are fundamental building blocks of a system that adequately protects absolute human rights.

More concerningly, we have found that there are recommendations on specific matters such as providing high-secure care for women experiencing mental disorder, which are recognised as urgent human rights issues and yet we can find no evidence of any meaningful progress.

Overall, it is difficult to identify the state of progress on any given recommendation. This report required the collection of a wide range of information across publicly available sources in order to determine what had taken place since the recommendation was made. There is no simple or transparent way to track progress, which makes it difficult to even know the state of human rights in places of detention. In the NPM’s 2021 report, we called on the Scottish Government to implement all recommendations and regularly monitor progress. Three years later, it is clear this has not been done.

What will happen next?

We will share this report with a range of bodies to allow progress to be assessed and tracked over time. This includes:

- The Criminal Justice Committee of the Scottish Parliament
- Audit Scotland
- The European Committee on the Prevention of Torture
- The United Nations Human Rights Committee
- The United Nations Special Rapporteur on Torture

The NPM and the Scottish Human Rights Commission will also track progress on these recommendations and any new ones which arise. We intend to measure progress again in four years.

About this research

Who we are

The Scottish Human Rights Commission (the Commission) is Scotland's human rights watchdog.

We are an independent, expert body that works with and for the people of Scotland; we monitor, listen, speak up for all our rights and respond when things go wrong. We are a public body created by the Scottish Commission for Human Rights Act 2006 to protect and promote the human rights of all people in Scotland. We have carried out this research under sections 3 and 4 of our Act, which empower us to conduct research and to monitor laws, policies and practices in any area.

The Commission is also part of the international human rights system. It is accredited by the United Nations as its trusted organisation to provide impartial evidence on the enjoyment of human rights in Scotland. The Commission is independent of Government. We are accountable to the people of Scotland via the Scottish Parliament.

The UK National Preventive Mechanism (NPM) is made up of 21 bodies that monitor and inspect places of detention in the United Kingdom to prevent torture and ill-treatment for those deprived of their liberty. NPM members work collectively to fulfil the NPM's mandate under the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The NPM Scottish Subgroup exists to improve collaboration and pursue joint work as a cohesive body to meet the UK's obligations

under OPCAT in Scotland. Members identify areas of shared concern and take joint action on Scotland-specific issues.

The members of the NPM Scotland Subgroup are:

- Scottish Human Rights Commission
- His Majesty's Inspectorate of Prisons for Scotland
- Mental Welfare Commission for Scotland
- Care Inspectorate
- His Majesty's Inspectorate of Constabulary in Scotland
- Independent Custody Visitors Scotland.

The Commission is a member of the NPM, and we work together on issues of concern in places of detention in Scotland.

Why we did this project

The Commission and the NPM have been concerned for many years about the pace of progress in remedying the serious issues facing places of detention in Scotland. International, European and domestic bodies have all pointed to gaps in the protection of human rights and made recommendations to remedy the issues. Many of those recommendations have been made repeatedly over a long period of time and yet the issues persist. In 2021, the NPM published a follow-up report to track implementation of two visits by the European Committee on the Prevention of Torture (CPT) carried out between 2018 and 2019. The report found little progress. Since the inception of the NPM in 2009, scrutiny bodies have been raising repeated systemic recommendations which have remained unaddressed.

The NPM's first annual report in 2009 made the following statement:

"Many of the members who visit prisons have expressed concerns about the rising prison population and the overcrowding of prisons. This has an adverse effect on all aspects of a prisoner's life, including safety, the prison regime, their ability to maintain sufficient contact with their family and their preparation for release. Prisons may find themselves increasingly unable to deal with problems caused by overcrowding because of decreasing resources.

"Perhaps the most significant and recurring concern across all types of detention relates to detainees with mental health problems [...] despite the best efforts of staff, detainees did not receive the support and treatment required.

"In prisons, those with mental health problems were sometimes held for long periods in segregation units, often awaiting transfers to a more appropriate environment."

The findings reflect the same situation today, 15 years on.

We are looking at two human rights:

- The **right to life**, which requires that everyone's life shall be protected by law. This right is protected by Article 2 of the European Convention on Human Rights and repeated across United Nations (UN) human rights treaties.
- The **prohibition of torture and inhuman or degrading treatment or punishment**. This right is protected by Article 3 of the European Convention on Human Rights and repeated across UN human rights treaties.

Where a person is in the care of the State, certain protections must be in place to prevent loss of life and to prevent the occurrence of torture, inhuman or degrading treatment. These are absolute rights, which the UK has agreed to respect in countless international instruments and national legislation. The UK has accepted the jurisdiction of international human rights bodies to review compliance on the most fundamental of human rights issues. While ratification of treaties is reserved to the UK Parliament, Scotland has accepted the obligations contained within them. There can be no excuse for allowing breaches, or failing to act, when these rights are at risk.

These rights have been protected by the Human Rights Act since 1998. As Scotland moves to bring into law additional human rights in a Human Rights Bill, it is important to consider the state of progress on rights already long protected by law.

The findings of UN Committees and other human rights bodies tell us about concerns affecting the system of criminal justice detention. They raise issues that the State must address to prevent risks to life or of ill-treatment. If these issues are not addressed, there is a serious risk they will result in individual violations of human rights.

In this report, we examine the state of progress in remedying these gaps and highlight outstanding recommendations. Almost without exception, the Scottish Government has accepted the recommendations, meaning they accept that there is an issue and that they need to act. We are examining whether they have delivered. We want to see swifter, more urgent action where progress is insufficient.

Scope

This report covers prisons and the forensic mental health estate, both part of the criminal justice system of detention. Many of the recommendations of human rights bodies, particularly those of the CPT, relate to prisons. These include serious concerns relating to mental health provision, where there is a close connection to the forensic mental health estate. People experiencing mental health issues may be assessed as requiring treatment in the forensic estate and sent there at the start of a prison sentence. Others may move between prison and the forensic estate for treatment at points in their sentence.

Due to the breadth of issues, we were unable to examine all places of detention. We have elected to focus on prisons and the forensic mental health estate in Scotland. We are aware there are similar human rights concerns in immigration detention, secure care for children and young people and mental health detention settings but these were outwith the scope of our study.

The report covers recommendations made over a ten-year period, to allow us to assess progress over a significant period of time. Some recommendations date back even further, including a recommendation dating back to 2012 concerning levels of overcrowding in prisons. This recommendation remains outstanding and occurs again within the ten-year period.

How we carried out the research

The key question we set out to answer was **whether the gaps in protection of absolute rights that have been identified by human rights bodies have been remedied**. We know from previous NPM research that many recommendations made by human rights bodies are repeated over time and yet remain outstanding. That research also

pointed out an approach of establishing working groups and reviews as a way of addressing recommendations, which delays meaningful action.²

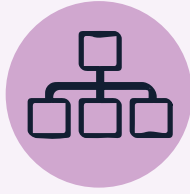
We recognise that addressing complex recommendations can take time, resource and effort. Processes need to be robust and working groups, when used correctly, can be an effective way to bring partners together to collaborate on solutions. However, our findings show that more often than not, Scottish Government prioritise process over purpose.

We have therefore adopted the framework of human rights measurement to assess not only what efforts or discussions have happened on a particular issue, but also what specific commitments have been made, and what actual outcomes have been achieved. This approach aims to assess the gap between rhetoric and reality by looking at all the steps that are required to realise human rights – a State must not only commit to addressing a problem, but also make continuous efforts to do so, and make sure that those efforts achieve real results for rights holders.

Human rights measurement looks at three levels: **Structure – Process – Outcome**.

Human rights measurement can be developed into a series of measurable indicators which track progress over time. This exercise is not currently undertaken in Scotland. We would like to see it developed, by the Scottish Government and other duty bearers, to enable everyone to transparently assess progress in delivering human rights and any gaps that emerge along the way.

We began this project by reviewing the recommendations made by human rights bodies, including UN Committees and the CPT (listed at Annex 3), as well as domestic reviews with a specific focus on human rights.



Structure

This looks at the concrete **commitments** made by the State in the legal, policy and institutional framework.

- Commitment to international human rights law
- Legislation in place
- Policies, strategies, action plans, guidelines, adopted
- Institutional framework
- Complaint and support mechanisms exist



Process

This looks at the **efforts** towards addressing the issue

- Budgetary allocations
- Implementation of policies, strategies, action plans, guidelines etc.
- Effectiveness of complaint and support mechanisms



Outcome

This looks at the actual **results** delivered

- Actual awareness of rights
- Actual impact of policies and other measures
- Actual occurrence of violations

We captured 29 recommendations, some of which have been combined as they covered the same issue.

We carried out desk-based research to collect publicly available information on any action and results relating to the recommendation. If data is not publicly available, then the State is not able to demonstrate that it has fulfilled a recommendation, and we cannot be assured that this is so. We gave the Scottish Government the opportunity to review the tables of evidence and to identify any evidence we had missed. All relevant evidence provided has been included.

Evidence was gathered up to the end of April 2024. Including information provided directly by Scottish Government, this report includes all available information available at 24 May 2024.

Annex 1 contains a summary of evidence for each recommendation. Based on that evidence, the state of progress in delivering the recommendation is assessed in the main report as follows



Recommendation making no meaningful progress



Recommendation making significant progress



Recommendation addressed

We have used some common acronyms. A list of acronyms is provided at Annex 2.

Context

People in the criminal justice estate



Prisons

8300

Approximate population
of prison estate

16

Establishments run
by Scottish Prison Service

1

Establishment run
by a private company



Forensic mental health

500

Approximate
population of
mental health
estate³

1

National high
secure unit

3

Regional medium
secure units

Low secure
provision across low
secure wards, locked
learning disability
wards, IPCUs, open
rehabilitation wards,
independent services⁴



Human rights standards

European Convention on Human Rights
and caselaw of the European Court of
Human Rights

International Covenant on Civil and
Political Rights

UN Convention against Torture and Other
Cruel, Inhuman or Degrading Treatment or
Punishment

UN Convention on the Elimination of All
Forms of Discrimination Against Women

UN Convention on the Rights of Persons
with Disabilities

International Convention on the
Elimination of All Forms of Racial
Discrimination

European Committee for the Prevention
of Torture and Inhuman or Degrading
Treatment or Punishment

Nelson Mandela Rules – United Nations
Standard Minimum Rules of the Treatment
of Prisoners (non-binding)

Bangkok Rules – The United Nations Rules
for the Treatment of Women Prisoners
and Non-custodial Measures for Women
Offenders (non-binding)

Beijing Rules – UN Standard Minimum
Rules for the Administration of Juvenile
Justice (non-binding)

European Prison Rules (non-binding)



Reviews covering Scotland by human rights bodies

UN Human Rights Committee (CCPR)

- 2024 Concluding observations on the eighth periodic report of United Kingdom of Great Britain and Northern Ireland (3 May 2024) CCPR/C/GBR/CO/8.
- 2015 Concluding Observations on the seventh periodic review of the United Kingdom of Great Britain and Northern Ireland (17 August 2015) CCPR/C/GBR/7.

UN Committee against Torture (CAT)

- 2019 Concluding Observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland (7 June 2019) CAT/C/GBR/CO/6.
- 2013 Concluding Observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland (24 June 2013) CAT/C/GBR/CO/5.

Subcommittee for the Prevention of Torture (SPT)

- 2021 Visit to the United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: recommendations and observations addressed to the State party (31 May 2021) CAT/OP/GBR/ROSP/1.

UN Committee on the Rights of the Child (CRC)

- 2023 Concluding Observations on the combined sixth and seventh periodic reports of the United Kingdom of Great Britain and Northern Ireland (22 June 2023) CRC/GBR/CO/6-7.
- 2016 Concluding Observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland (12 July 2016) CRC/C/GBR/CO/5.

UN Committee on the Elimination of Discrimination against Women (CEDAW)

- 2019 Concluding Observations on the eighth periodic report of the United Kingdom of Great Britain and Northern Ireland (14 March 2019) CEDAW/C/GBR/CO/8.
- 2013 Concluding Observations on the seventh periodic report of the United Kingdom of Great Britain and Northern Ireland (30 July 2013) CEDAW/C/GBR/CO/7.

European Committee for the Prevention of Torture (CPT)

- 2019 Report to the United Kingdom Government on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 14 to 18 October 2019 (8 October 2020) CPT/Inf (2020) 28
- 2018 Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 17 to 25 October 2018 (11 October 2019) CPT/Inf (2019) 29.

Key themes

The recommendations from international human rights bodies about the human rights of people in prisons and the forensic mental health estate over the last ten years can be summarised across the following themes across each absolute right:

Right to life



Investigating
deaths in custody



Suicides

Prohibition of torture and ill treatment



Conditions of
detention and
overcrowding



Investigations and
allegations of
ill-treatment



Training for
prison staff



Use of force
and restraint



Use of solitary
confinement,
seclusion and isolation



Healthcare
services



Mental
health



Women
prisoners

Analysis of each theme is presented on the following pages, where we give a brief, accessible summary of the human rights standards at stake, the recommendations from international human rights bodies, and an assessment of the available evidence to indicate progress. Further detail on each is provided at Annex 1. For ease of reading, we have not included reference to the source of each individual human rights standard.

1. Right to life



1.1. Investigating Deaths in Custody

To protect the right to life, States are required to investigate any death which occurs while an individual is in the custody of the State. Investigations must have six characteristics. They must be independent, instigated by the State, prompt, open to public scrutiny, effective, and give the deceased's next of kin an opportunity to participate.

Various human rights bodies have raised concerns about the adequacy of current processes to investigate deaths in places of detention. During the 2015 periodic review of the UK, the **UN Human Rights Committee (CCPR)** called upon the UK to ensure that cases of suicide and self-harm in custody are independently and thoroughly investigated and that lessons are learned.

The **UN Committee Against Torture (CAT)** directed the UK to take measures to ensure that all instances of death in custody are promptly and impartially investigated by an independent entity. The **Committee on the Rights of the Child (CRC)** further called on the UK to introduce automatic, independent and public reviews of all deaths of children in custody, care and mental healthcare institutions.

The **CPT**, following its visit to Scotland in 2018, noted that while it is positive that the joint National Health Service (NHS) and Scottish Prison Service (SPS) process for review of deaths (DIPLARs) and Fatal Accident Inquiry (FAI) systems are in place, it recommends that the State review the operation of the overall FAI system to find solutions to speed up the process.

While FAIs provide a system aimed at the investigatory obligations of the right to life, human rights bodies have identified the following gaps:

- An FAI does not take place in all detention settings. The **CRC** calls for investigatory coverage of all deaths in custody, care and mental healthcare institutions.
- FAIs take an 'excessive' amount of time and the overall system should be reviewed (**CPT**).

Recommendations are summarised and assessed as follows:

Recommendation 1

Ensure an independent, prompt and impartial review of all deaths in custody [CCPR 2015; CAT 2019; CRC 2016; 2023]



Assessment: In prison settings, an Independent Review recommended 27 actions, all of which were accepted in principle by the Scottish Government. However, at the time of publication, only 12 have been completed over a period of two years. The main recommendation, that an independent body should carry out a separate independent investigation into every death in prison custody, has been under development but has not been implemented and there is no timeline to do so. Concerns remain about whether, in our current system, it can or will be fully implemented to deliver a truly independent investigation. In mental health settings, proposals to introduce a system of investigation have not been put into action and there remains no requirement for automatic, independent review of deaths in mental health detention.

Commitment: The Independent Review into the Response to Deaths in Prison Custody was commissioned and its recommendations were entirely accepted in principle by the Scottish Government. The Scottish Government carried out a review of investigations of deaths in mental health detention in 2018.

Efforts: Only 12 of the 27 recommendations of the Independent Review have been implemented over two years and the key recommendation remains unimplemented. No action has been taken to put in place a new system for investigating deaths in mental health detention despite proposals by the Mental Welfare Commission.

Results: There is no evidence of changed outcomes for rights holders in either prisons or the forensic mental health estate.

Recommendation 2

Review the overall FAI system to find ways to speed up the process [CPT 2019]



Assessment: No State-level review of the FAI system has taken place since the CPT made its recommendation in 2018. The Scottish Government has not accepted the need for further review although figures show that the process of an FAI continues to be lengthy and several other concerns about the effectiveness of the process have since been raised.

Commitment: The Scottish Government has stated that it is confident in the current FAI system and does not plan further review. The Crown Office and Procurator Fiscal Service (COPFS) has made some commitments to improving FAIs and has established a specialist Custody Deaths Investigation Unit. It has committed to establishing a programme to reduce the time for concluding investigations, including FAIs.

Efforts: The Inspectorate of Prosecution in Scotland have identified some progress through a thematic review, of which most of the recommendations were implemented. However, they expressed continuing concern over the timeliness of investigations and the quality of communication with next of kin.

Results: The time to complete FAIs is still, on average, more than three years. Families continue to report being failed. Research discloses additional structural issues with FAIs including a lack of systemic findings, a lack of enforcement of recommendations and poor family involvement.



1.2. Suicides

The right to life requires that the State take positive steps to protect life where they knew or ought to have known of a real and immediate risk to life, including from self-harm. The State has a heightened duty of care to protect the right to life for those in its custody or care including by taking measures to prevent suicide.

Various UN Committees have raised concerns about the high number of suicides in custody in the UK, and in Scotland specifically. In the last two reviews of the UK in 2015 and 2024, the **CCPR** called upon the UK, including Scotland, to take action to prevent suicides in places of detention. The **CAT** requested the UK to compile data on suicides in detention to assess the effectiveness of suicide prevention and risk identification strategies and programmes.

Recommendations are summarised and assessed as follows:

Recommendation 3

Reduce the number of deaths by suicide by addressing root causes of suicide, improving identification of persons at risk, improving access to mental health support, improving training for prison staff, and ensuring independent investigations into death by suicide [CCPR 2015 & 2024]



Assessment: While both SPS and the Scottish Government have introduced strategies to address suicide in prisons and within the wider community, there has been an increase in the number of suicides in prisons during the course of the strategies.

Commitment: The Scottish Government and the Convention of Scottish Local Authorities (COSLA) are working on a Scotland-wide Suicide Prevention Strategy which includes a specific action to focus on suicide prevention plans in high-risk settings, such as prisons. SPS has a suicide prevention strategy. We have not been able to identify specific actions to address the root causes of suicide in mental health detention or to consider suicide prevention in the forensic mental health estate.

Efforts: The SPS strategy (Talk to Me) has been in operation within prisons for a number of years. Recommendations have been made for its improvement; however, a review of its operation is yet to be completed.

Results: The number of suicides in prisons has increased by 42 per cent. There is no published data on the rate of suicide in the forensic mental health estate.

Recommendation 4

Compile data on suicides in places of detention to assess the effectiveness of prevention and risk identification strategies and programmes [CAT 2019]



Assessment: There is no publicly available data on the effectiveness of suicide prevention strategies in either prisons or the forensic estate.

Commitment: There is a statutory obligation to publish data on deaths in prisons, including suicides. There is no equivalent obligation for the forensic estate.

Efforts: The SPS records how many prisoners have died in custody while on the Talk to Me programme, however, it is not clear how this data contributes to assessing the effectiveness of the strategy. There is no specific strategy regarding suicides in mental health detention for which data could be collected.

Results: There is no publicly available data to assess the effectiveness of suicide prevention strategies in either prisons or the forensic estate.

It is crucial to highlight the profound impact that these ongoing violations have on individuals, families and communities across Scotland.

2. Prohibition of torture and ill-treatment



2.1. Conditions of detention and overcrowding

Human rights standards detail a range of requirements which prison conditions must meet to avoid ill-treatment, including minimum cell sizes, lighting, time out of cell and access to one hour's open-air exercise.

UN Committees, the CPT and UK NPM members have consistently raised overcrowding, and the lack of a clear plan to tackle the issue, as a key criticism for decades. The overcrowding of the estate is compounded by Victorian establishments which are not fit for purpose. Human rights bodies have noted that overcrowding negatively impacts almost all outcomes of a prison – from purposeful activity, right to fresh air, right to healthcare, rehabilitation, and right to two hours of meaningful contact.

The **CPT** has criticised the size of cells across the estate, two individuals held in cells designed for one, and specifically, the use of holding cells in HMP Barlinnie reception.

The **CPT** prescribes a minimum cell size (excluding sanitation) of 6m² of personal space for one person in a single cell and a minimum cell size of 8m² for a double cell with two people excluding sanitary areas. This is the minimum standard to ensure that the conditions of detention themselves do not constitute a form of ill-treatment. The space available to each individual must be viewed alongside time spent in cell, provision of out-of-cell eating spaces, and other contextual factors.

In June 2023, a High Court judge refused to extradite an Irish National to Scotland on humanitarian grounds, noting that prison overcrowding would see him locked up for 22 hours a day with less than three square meters of space, while authorities in Scotland also had “poor recognition” of neuro-developmental disorders.⁵

In March 2024, the **CCPR** expressed concern about the cumulative effects on the lives of prisoners due to chronic overcrowding, poor living conditions and a lack of purposeful regimes and recommended that the State intensify its efforts to improve conditions of detention.

Recommendations are summarised and assessed as follows:

Recommendation 5

Take urgent measures to reduce overcrowding, including through the use of non-custodial measures and measures to reduce the use of remand [CEDAW 2019; CAT 2013, 2019; CPT 2019; CCPR 2024]



Assessment: While there has been a range of legal and policy initiatives to address overcrowding and provide alternatives to sentencing, these mechanisms have not succeeded in reducing prison numbers. The prison population continues to rise well beyond the capacity of the prison estate.

Commitment: There has been substantial focus on legal and policy measures aimed at increasing community disposals and tackling the court backlog.

Efforts: The use of community sentencing has been increasing and efforts are underway to address the court backlogs which

contribute to the high remand population. The budget for community justice services and court operations is insufficient for a reimagined justice system with increased community sentencing.

Results: Prison numbers have risen over time and are predicted to rise further. Scotland still has one of the highest rates of incarceration in Europe.

Recommendation 6

Improve conditions in prisons [CAT 2019; CPT 2019]:



- End the use of holding cells known as “dog boxes” at HMP Barlinnie
- Ensure minimum CPT standards on cell size are adhered to (6m² for one person and 8m² for two people)
- Develop purposeful activities for remand prisoners
- Collect accurate data on purposeful activity and time out of cell and increase time out of cell appropriately.

Assessment: While areas of the prison estate have been upgraded through a programme of work commencing in 2002, the replacement of some of Scotland’s oldest prisons (HMP Barlinnie, Greenock and Inverness) is behind schedule. Prisons are operating over capacity and the impact is being felt by prisoners and staff alike. One recommendation has been completed, in removing the “dog-boxes” from HMP Barlinnie. However, the recommendations on ensuring minimum cell size are not adhered to and improvements to purposeful activity have not been fulfilled.

Commitment: The Scottish Government has committed to a 20-year programme of development of the prison estate, although its viability is uncertain due to repeated changes to the justice portfolio budget. There are some commitments to improve purposeful activity for women prisoners and young people but none for the prison population overall.

Efforts: The women’s estate has seen substantial improvement but the replacement of some of Scotland’s oldest prisons is significantly delayed. The commitments to improve purposeful activity for women and young people have little central concrete action attached to them and efforts in this regard are on an establishment-by-establishment basis.

Results: The minimum cell size requirement for double occupancy cells is not being met for almost one third of prisoners. Although there was evidence of some good practices and effective management within challenging operating environments, there is little evidence that the situation for prisoners is improving, and pressure will continue to grow as numbers increase.

“The minimum cell size requirement for double occupancy cells is not being met for almost one third of prisoners.”



2.2. Investigating allegations of ill-treatment

States are under an obligation to conduct an official investigation where an individual makes an allegation that they have suffered ill-treatment. Allegations must be investigated promptly and effectively by an independent authority.

Various human rights bodies have raised serious concerns about violence in prisons, and the lack of documentation, reporting, medical examination, investigation and sanction or prosecution thereof. The **CPT**, in its 2018 visit, heard some allegations of excessive use of force during control and restraint operations. In its 2019 visit report, the CPT also noted two allegations of ill-treatment from a female prisoner, which were corroborated by medical records, and where no formal investigation or response to the complaint occurred.

Both the CPT and UN Committees have repeatedly called for a systematic response to all complaints of violence in detention settings, including proper medical examination, documentation, reporting to authorities, investigation and follow-through. The **Subcommittee for the Prevention of Torture (SPT)** has made observations about lack of medical safeguards in relation to torture prevention in the UK. Following its visit in 2021, it noted that compliance with medical screening and physical examination, which are a fundamental requirement in safeguarding against torture, are lacking. It noted:

- Poor documentation of injuries and lack of follow-up or further investigation
- Lack of information on risk assessment in prisoner records
- Inadequacy of forensic training of medical staff, specifically, a lack of awareness of the Manual on the Effective Investigation and Documentation of Torture (The Istanbul Protocol) or the Nelson Mandela Rules.

The **CPT** raised concerns about the practice of healthcare staff observing prisoners through a hatch or open door following a violent incident in prison, rather than conducting a proper physical examination. They also found that there was no specific form or register for recording of injuries on the inter-prison health-care recording system.

Recommendations are summarised and assessed as follows:

Recommendation 7

Ensure that all injuries and allegations of violence in detention, including sexual abuse against children, are promptly and systematically investigated [CAT 2013, 2019; SPT 2021; CRC 2023; CPT 2019]



- Examined by an appropriate healthcare professional in line with the Manual on the Effective Investigation and Documentation of Torture (The Istanbul Protocol)
- Correctly documented
- Reported to the appropriate authorities
- Investigated, with appropriate prosecution and sanction of perpetrators, and reparation made to victims.
- Followed up until their conclusion, with documentation thereof.

Assessment: No specific action aimed at addressing the specific gaps identified by human rights bodies can be identified.

Commitment: None. Violent incident reporting does not appear to focus on allegations of torture or ill-treatment of duty bearers.

Efforts: None

Results: Documentation of incidents of violence is inconsistent and depends on the practices of individual prisons.

Recommendation 8

Regularly collect, analyse and publish comprehensive disaggregated data on all complaints and reports received of torture or ill-treatment, including information on whether such complaints led to investigations and, if so, by which authority, whether the investigations resulted in the imposition of disciplinary measures and/or prosecutions and whether the victims obtained redress, including compensation and rehabilitation [CAT 2013, 2019; CRC 2023]



Assessment: No specific action aimed at addressing the specific gaps identified by human rights bodies can be identified.

Commitment: General commitments to data collection do not make specific mention of allegations of torture and ill-treatment by duty bearers and no such data can be identified in the public domain.

Efforts: None

Results: Gaps in recording and handling of complaints have been identified and prisoner confidence in complaints processes is low.

Recommendation 9

Establish effective inspection and complaints mechanisms that are genuinely accessible to people in detention, particularly women, children and foreign nationals, and maintain effective monitoring [CAT 2019]



Assessment: No specific action aimed at addressing the specific gaps identified by human rights bodies can be identified.

Commitment: None

Efforts: None

Results: Concerns persist with regards to the accessibility of complaints processes, including for particular groups such as those with literacy issues or who do not speak English.



Human rights in places of detention are in jeopardy, and when expert bodies tell the State how to fix it, they remain unaddressed for unacceptable amounts of time.





2.3. Training for prison staff

Human rights standards require training for staff in prison settings on a range of issues necessary to prevent ill-treatment occurring. These include, searches, minimal use of force, and general duties. They should also, at a minimum, include applicable regional and international human rights standards, for example, the UN Convention Against Torture, Nelson Mandela Rules and the Istanbul Protocol on the effective investigation into and documentation of torture and ill-treatment. Staff working with vulnerable groups, such as women, young people, foreign nationals and mentally ill prisoners should receive specific training. Management should ensure that staff maintain and improve their knowledge throughout their career.

The **CAT** and **CPT** have raised concerns about the quality, consistency, quantity and content of training provided to staff working in places of detention in Scotland. There are also concerns with the lack of evaluation and measurement of training programme effectiveness, as well as a need for more training on the use of force, and bespoke training for working with women.

The **CPT** and **SPT** have repeatedly called for efforts to incorporate the UN Convention Against Torture, Nelson Mandela Rules and Istanbul Protocol into training programmes, as well as to ensure training is consistent across the Scottish prisons and includes regular refresher courses. They identified specific attention needed to address issues relating to women, the use of force and the identification and reduction of cases of ill-treatment and torture.

Recommendations are summarised and assessed as follows:

Recommendation 10

Ensure that all staff, including police and health-care staff, receive ongoing, up-to-date training and refresher courses [CAT 2019, 2013; CPT 2019]



Assessment: While various efforts have and continue to be made by the SPS, the NHS and individual prisons and young offender institutions to develop and improve training programmes, these can be viewed as a resource for staff, as opposed to mandatory training. The onus must be on the State to ensure all staff receive ongoing and up-to-date training to comply with this recommendation. There is no evidence of a direction from SPS or NHS headquarters to ensure staff carry out this training as contingent to carrying out their duties.

Commitment: SPS has made commitments to rollout trauma-informed training and developed specific strategies related to women and young people. However, it has also placed the onus on staff to ensure they remain in competency.

Efforts: Take-up of new training resources is variable and there is no evidence of efforts by the State to ensure take-up. Some training on the use of force is provided by the pilot of non-pain inducing restraint (detailed at Recommendation 17). New training resources have been developed and provided, but there is an absence of mandatory requirements to comply, which inhibit the State's ability to ensure adequate on-going, up-to-date training.

Results: There is an ongoing prevalence of staff being out of competency on core training courses. Healthcare staff demonstrate higher overall training compliance but lower compliance on equality, diversity and human rights.

Recommendation 11

Ensure that the training curriculum includes information on the UN Convention Against Torture, Nelson Mandela Rules and Istanbul Protocol, and that all relevant staff, including medical personnel, are specifically trained to identify cases of torture and ill-treatment. It should also include reminders that no more force than is strictly necessary should be used to control prisoners; such training should include a reminder about oversight measures and applicable sanctions should disproportionate force be found to have been used [SPT 2021; CPT 2019]



Assessment: We found no evidence of specific efforts to ensure the training curriculum includes the UN Convention Against Torture, Nelson Mandela Rules or Istanbul Protocol.

Commitment: There is no commitment to include these standards in training.

Efforts: No evidence of effort.

Results: There are no direct results to report but His Majesty's Inspectorate of Prisons for Scotland (HMIPS) reports that most prisons do not have an embedded human rights culture.

Recommendation 12

Develop a methodology for assessing the effectiveness of training programmes in reducing the number of cases of torture and ill-treatment and in ensuring the identification, documentation and investigation of these acts, as well as the prosecution of those responsible [CPT 2019]



Assessment: There is a lack of evident activity around this action. While there are examples of duty bearers measuring aspects of training, such as training completion rates, there is little evidence of the State, SPS or NHS working to assess effectiveness of their training programmes in terms of outcomes in reducing ill-treatment, let alone creating a specific methodology to do so.

Commitment: None.

Efforts: SPS is introducing non-pain inducing restraint which relates to aspects of ill-treatment and assessment of its effectiveness is in progress.

Results: None.



Where somebody is detained in a prison or mental health setting, agency and autonomy are removed. They rely on the State to meet all their basic needs. And they are often some of the most vulnerable people in society.





2.4. Use of force and restraint

Force and restraint must only be used if absolutely necessary, and only where all other means to contain a situation have failed. Force and restraint must not be used with the intention to cause pain or as punishment. It must be the minimum amount of force necessary and used for the shortest necessary time. Detailed procedures must exist to regulate the use of force. These requirements are particularly strong regarding the use of force and restraint on children.

The **CRC** and **CAT** have raised serious concerns about the large number of children who continue to experience pain-inducing techniques and seclusion. Concerns have also been raised about the increasing use of force and restraint in prisons, aggravated by low staffing levels, inexperienced staff, the use of illicit substances, mental health issues, poor prison conditions and not enough time outside of the cells.

UN Committees have repeatedly called for efforts to reduce use of force in places of detention, including by taking legislative and statutory measures, as well as by improving oversight of the use of force. Recommendations have also been made to consistently investigate the use of force, and to regularly collect and publish data on the use of force. They highlighted specific concerns about issues relating to children, women, ethnic minorities and people with disabilities, with greatest concern for individuals holding two or more of these characteristics (e.g. children who are ethnic minorities and have a disability).

Recommendations are summarised and assessed as follows:

2.4.1. Children

Recommendation 13

Take legislative measures to explicitly prohibit, without exception, the use of harmful devices including spit hoods on children. Abolish all methods of restraint against children for disciplinary purposes in all institutional settings, both residential and non-residential, and ban the use of any technique designed to inflict pain on children [CRC 2023, 2016; CAT 2013]



Assessment: The Scottish Government does not accept the need for legislative measures and, accordingly, no action has been taken to implement this recommendation.

Commitment: There are no legislative measures to address this recommendation and the Scottish Government does not consider them necessary.

Efforts: The SPS is piloting non-pain inducing restraint at HMPYOI Polmont and HMPYOI Stirling.

Results: There are no clear outcomes for rights holders as there is no evidence of concerted efforts to implement this action. The Children's Commissioner, Scottish Human Rights Commission, Equality and Human Rights Commission, Mental Welfare Commission and The Promise Scotland continue to call for legislative measures to address restraint and seclusion for children in settings including prisons.

Recommendation 14

Develop statutory guidance on the use of restraint on children to ensure that it is used only as a measure of last resort and exclusively to prevent harm to the child or others and monitor its implementation [CAT 2013, 2019; CRC 2016]



Assessment: No statutory guidance on the use of restraint specifically tailored to children exists in any setting, including prisons. Non-pain inducing control and restraint techniques are being piloted at HMPYOI Stirling and HMPYOI Polmont.

Commitment: Rule 91, which deals with the use of force, has no specific provision for children. No other statutory guidance exists.

Efforts: The SPS is piloting non-pain inducing restraint at HMPYOI Polmont and HMPYOI Stirling.

Results: There are no clear outcomes for rights holders as there is no evidence of concerted efforts to implement this action. The Children's Commissioner, Scottish Human Rights Commission, Equality and Human Rights Commission, Mental Welfare Commission and The Promise Scotland continue to call for specific practice guidance to address restraint and seclusion for children in settings including prisons.

Recommendation 15

Regularly collect, analyse and publish disaggregated data on the use of restraint on children [CRC 2016]



Assessment: There is no evidence of specific action to address this recommendation.

Commitment: We have not been able to identify any published data on restraint on children in the prison estate nor any commitment to do so.

Efforts: None.

Results: None.

2.4.2. Ethnic Minorities**Recommendation 16**

Take urgent measures to ensure the protection of minority ethnic groups from torture and ill-treatment and disproportionate use of restraint [SPT 2021]



Assessment: There is no evidence of specific action to address this recommendation.

Commitment: Equality and Diversity teams are established at many prisons; however, we do not have evidence of specific commitments to address this recommendation.

Efforts: The only evidence is effort at some prisons to identify prisoners with protected characteristics who might need additional support, however, this is not specifically focused on instances of ill-treatment and restraint.

Results: Local Equality and Diversity teams within prisons do not proactively carry out this work, are not sufficiently trained to do so, and do not have the skills, time or availability of data.

2.4.3 Addressing Mental Health and Other Underlying Causes of Violence

Recommendation 17

Review behaviour management policies across prisons with the aim of identifying and reducing the underlying causes of violence and use of force [SPT 2021]



Assessment: The piloting of non-pain inducing restraint demonstrates efforts to improve practice on the use of force and restraint, however it is at the early stage of rollout and results are not yet available.

Commitment: SPS states its commitment to restraint and seclusion being used as a last resort.

Efforts: Non-pain inducing restraint is being piloted in three prisons and two Community Custody Units.

Results: The impact of the pilot on rights-holders' protection from ill-treatment are not yet available, however the pilot is being extended to further establishments.

2.4.4. Body Cameras

Recommendation 18

Consider taking measures to ensure that body-cameras are worn by front-line prison staff and turned on for all control and restraint operations [CPT 2019]



Assessment: Some efforts have been made to explore the above recommendation regarding body worn video cameras. Cameras are used in one prison and are being piloted in three further prisons. Their effectiveness, use, and the extent to which they are turned on for all control and restraint operations is yet to be determined.

Commitment: There is a commitment to consider piloting body worn video cameras.

Efforts: A pilot in HMP Addiewell reported to Scottish Government. While there has been no commitment to implement cameras across the estate, a six-month pilot has commenced in three further prisons.

Results: None.

“We underscore the urgent need for meaningful action to address systemic failures and ensure that every individual in Scotland is treated with the dignity and respect to which they have a right.”



2.5. Use of solitary confinement, seclusion and isolation

Solitary confinement should be used only in exceptional cases, as a last resort and for the shortest time possible. It should not be used for the management of people with mental disorder where it would make their illness worse. Prolonged solitary confinement, of more than 15 days with more than 22 hours without meaningful human contact, is prohibited. For everyone in solitary confinement, access to as many aspects of the regime must be maintained including meaningful human contact and, at an absolute minimum, access to one hour of exercise daily.

A wide range of criticism has been made about the manner in which solitary confinement and seclusion is used to manage people in detention in Scotland, in particular, vulnerable detainees such as people with severe mental ill-health, children and young people and women requiring psychiatric care.

The **SPT** and **CPT** have criticised the placement of people with severe mental ill-health in segregation units, rather than closed hospital conditions and the risk this poses to self-harm and suicide. They note an absence of high secure psychiatric facilities for women in Scotland and a lack of care options for women with personality disorders who cannot be treated under the Mental Health

Act. The **CRC** and **CAT** also raise concerns regarding the use of solitary confinement, segregation and isolation on children and young people.

The **CPT** has repeatedly criticised the use of long-term segregation of prisoners and the practice of moving them around the Segregation and Reintegration Units (SRUs) in Scottish prisons for years on end.

For those in solitary confinement, concerns arise around a lack of access to meaningful human contact and purposeful activity and the use of disciplinary sanctions on people in segregation that could deprive them of stimuli.

The **CPT** has identified practices which may, in effect, also amount to solitary confinement, where prisoners under protection measures outside SRUs are locked in their cells for 23 or 24 hours a day in conditions akin to solitary confinement. The NPM and HMIPS continue to raise concerns about regimes that result in prisoners spending 22 hours or more isolated in a cell.⁶

In March 2024, the **CCPR** expressed its concerns about the use of segregation and solitary confinement in Scotland.

Recommendations are summarised and assessed as follows:

Recommendation 19

Ensure individuals with severe mental ill-health are held in facilities suited to their needs; prioritise hospital settings and stop using segregation on health grounds. Develop appropriate facilities for the needs of the population [SPT 2021; CPT 2019]



Assessment: Full assessments are provided under Mental Healthcare (Recommendation 25) and Women Prisoners (Recommendation 27). Overall, the recommendation is making no meaningful progress.

Recommendation 20

Ensure appropriate use of segregation, adequate regimes and reintegration. Regimes must allow for regular fresh air, meaningful contact of at least two hours, and access to varied purposeful activity. Invest in alternatives to SRU and step-down facilities to enable gradual reintegration [CPT 2019; CCPR 2024]



Assessment: Serious concerns remain regarding the use of segregation and the adequacy of regimes. There is no specific action to address these concerns.

Commitment: We have been unable to identify any specific initiatives designed to address recommendation.

Efforts: We have been unable to identify any specific processes aimed at the specific goals recommended by human rights bodies.

Results: Reports continue to show prolonged usage of segregation, a consistent failure to meet the minimum requirement of two hours of meaningful contact per day, and too little engagement in reintegration planning from mainstream hall staff.



2.6. Healthcare services

The prohibition on ill-treatment requires that medical treatment provided within prison facilities must be appropriate and adequate including comprehensive record-keeping of a detainee's state of health and treatment, prompt and accurate diagnosis and care, and a comprehensive therapeutic strategy to treat medical conditions where necessary. This must all be comparable to healthcare available in the community. Prisons must also have sufficient qualified staff of various disciplines.

Responsibility for healthcare in prisons transferred from the SPS to the NHS in 2011 and nine health boards are now responsible for delivering healthcare in prisons situated within their boundaries.⁷

In addition to the significant issues found in relation to mental healthcare (addressed under that theme), the **CPT** addressed the provision of healthcare services in prisons more broadly in its report following the 2018 visit. It highlighted a lack of action to respond to the Scottish Parliament Inquiry in 2017 on healthcare in prisons highlighting inadequacies of prison healthcare. The Inquiry concluded that

“The overriding impression we have received from our evidence is of a population which has been very much underserved by the change in responsibilities. The promised improvements have not materialised and we do not accept the suggestion or expectation that progress and change within the health service takes a long period of time. It does not need to if the will is there and sadly within prison healthcare this has been conspicuous by its absence at senior management levels.”⁸

Recommendations are summarised and assessed as follows:

Recommendation 21

Noting an inadequacy in healthcare staffing across prisons, to increase the number of GPs across prisons and make efforts to fill addiction nurse staff posts and ensure first aid provision be available overnight [CPT 2019]



Assessment: Despite some significant efforts to address the longstanding issues of recruitment and retention of prison healthcare staff in some regions, gaps in staffing continue to be felt across the estate by staff and prisoners alike.

Commitment: There are some significant commitments to addressing staffing issues at local level, however, there appears to be no national joined-up approach. Explicit aims to address recruitment and retention of prison healthcare staff are missing from a number of national policies which focus on the healthcare workforce.

Efforts: Some additional funding has been provided to address staffing issues and some health boards have detailed plans to address staffing issues. However, there is no clear national picture.

Results: Adequate staffing to meet the needs of the population continues to be a common theme in monitoring and research, leading to issues with long waiting times for GP appointments, addiction support and mental health assessments.

Recommendation 22

Improve the system of sharing medical records amongst relevant medical services by merging all records into one electronic system [CPT 2019]



Assessment: Despite ongoing work to improve systems for prison healthcare records, recommendations around this have not yet been implemented and there are still difficulties in transferring health records between prison-based health teams and community-based GPs.

Commitment: Actions to develop a Digital Healthcare System have been identified as a priority.

Efforts: Efforts appear to be underway but are not due to be implemented in full until 2028.

Results: There is no central collection point for the health needs of the prison population. There continue to be issues with accessing and transferring records, which can result in delays and variable prescribing practices.

66 Gaps in staffing continue to be felt across the estate by staff and prisoners alike



Recommendation 23

Tackle substance use including NPS within a wider drug policy, including developing a peer-led programme of drug education, and review the way in which prescription drugs are distributed and their intake supervised [CPT 2019]



Assessment: There have been substantial and continuing commitments and efforts to address substance use, including the use of NPS, peer-peer programmes and efforts aimed at tackling prescribing practices. Strategies and approaches evidence efforts to adapt to the changing picture of substance flow and use, however drug use and drug deaths remain high.

Commitment: National drug strategies contain specific actions aimed at addressing substance use in prisons. SPS also has strategies aimed at addressing the problem.

Efforts: Demonstrate a range of approaches aimed at tackling substance use however, more research is needed on the availability and effectiveness of psychological interventions.

Results: Substance use and deaths remain high. The drivers of substance use in the general regime are identified as remaining issues, as well as variable prescribing practices between prisons and waiting times for addiction services.



2.7. Mental health

Human rights standards require adequate medical care and proper treatment and supervision for prisoners with mental healthcare needs. Care should be comparable to that available in the community. To avoid ill-treatment, diagnosis and care must be prompt and accurate and a comprehensive therapeutic strategy should be in place for those who require it. People must be detained in settings appropriate to their needs and there should be no significant delays in admission to hospital where required. Solitary confinement should be prohibited for patients with mental disorders where it may exacerbate their condition. Human rights bodies have raised concern about the poor mental health of people in detention and lack of access to treatment or services.

In 2016, the **CRC** noted concerns about lack of access to health services, including mental health services for children in custody. The **CAT** commented in the same year that there was a lack of mental healthcare provided to persons in detention.

The **Committee on the Elimination of Discrimination Against Women (CEDAW)** raised concerns in 2013 and again in 2019, about women's limited access to mental health care in prisons and recommended that provision be improved.

The **SPT** noted the high rates of chronic and acute mental disorders in detention and the high prevalence of self-harm and self-inflicted deaths. It raised concerns that prisons are used as a 'safe environment' for preventing harm while awaiting placement in a specialised facility, however prison officers are not adequately trained to deal with this, and transfer delays could be months. The Committee also raised alarm at the placement of prisoners with acute mental health issues in segregation units, which it deemed unacceptable. This echoed the

recommendation of the **CPT** that prisoners with severe mental health problems should not be placed in segregation units, but instead should be treated in a closed hospital environment.

In 2018 and 2019, the **CPT** raised several very serious concerns about the treatment of women prisoners with acute mental health needs, their accommodation in segregation units and lack of high-secure hospital beds in Scotland to refer them to.

Domestic inspection bodies have identified the same issues. The Mental Welfare Commission (MWC) have identified persistent inadequacies in the provision of mental healthcare in prisons noting that little has changed in the decade between 2011 and 2021. Both the MWC and HMIPS have identified that people who are seriously and acutely mentally ill are still not being transferred to hospital care without delay.

In 2023, HMIPS summarised the situation as follows:

“Firstly, a substantial proportion of SRU prisoners appear to have mental health difficulties. While often these could be managed in a prison setting, serious concerns remain regarding how well supported and trained staff are to manage and alleviate these. Given the stretched resources and regimes of SRUs, very little work was taking place to provide mental health and psychological interventions to provide support for these prisoners to assist them to settle in a mainstream prison environment. Indeed, many staff and prisoners reported mental health declining as prisoners stayed longer in SRUs.

Secondly...SRUs have increasingly come to be used as places of safety for those who are extremely mentally unwell, despite being wholly inadequate

environments – both in terms of facilities and staff expertise – to manage such individuals.”⁹

Recommendations are summarised and assessed as follows:

Recommendation 24

Ensure accessibility, availability and quality of mental healthcare in detention, including increasing presence of clinical psychologists where required and improve mental health care in all prisons [CEDAW 2013, 2019; CRC 2016; CAT 2016; SPT 2021; CPT 2019]



Assessment: Despite recognition of the level of need and repeated recommendations to improve mental healthcare in prisons, there has been no evident progress in improving outcomes for prisoners.

Commitment: There are some commitments in mental health and justice strategies to work to improve mental health in prisons, but little specific action identified.

Efforts: Prison healthcare staffing has received 6% of the funding made available, which does not match up to level of under-resourcing identified by the MWC and the Scottish Government’s own Needs Assessment. While there are some general commitments to working to improve outcomes, action to deliver these commitments has not yet been demonstrated. There are no standards underpinning prison mental healthcare specifically.

Results: Outcomes in relation to the accessibility, availability and quality of mental healthcare have not improved in more than ten years and remain inadequate to address the high levels of need in this population.

Recommendation 25

Transfer of prisoners with acute mental health problems to appropriate psychiatric facilities and increase number of psychiatric beds [CEDAW 2013, 2019; SPT 2021; CPT 2019]



Assessment: Despite recommendations aimed at addressing the gaps in provision, there has been no meaningful action to remedy this issue and serious delays continue to emerge. The outcomes of the new HMPYOI Stirling in addressing the needs of women with severe mental ill-health are yet to be seen, however, there remains a lack of provision of secure mental health services for women. Overall, delays in transfers, and the findings of recent reviews demonstrate continued usage of segregation for those with mental health needs.

“We have found that there are recommendations on specific matters such as providing high-secure care for women experiencing mental disorder, which are recognised as urgent human rights issues and yet we can find no evidence of any meaningful progress.”



Commitment: An Independent Review on forensic mental healthcare commissioned by the Scottish Government has made recommendations to address the gaps in provision. HMPYOI Stirling is designed to create suitable accommodation for women with the most acute need.

Efforts: There has been no meaningful action to implement the recommendations of the Independent Forensic Mental Health Review.

Results: Delays in transfers persist. The ability of HMPYOI Stirling to address the needs of acutely unwell women is yet to be demonstrated.

Recommendation 26

Training for prison personnel on recognising symptoms of mental health problems and appropriate referral [SPT 2021]



Assessment: There is no mandatory training for prison staff and, while NHS staff can access mental health training, there is no consistent approach to providing training across the estate and no clear plan to do so.

Commitment: There is no evident commitment to training for prison personnel on recognising symptoms of mental health problems and appropriate referral.

Efforts: There is no evident plan to address training needs.

Results: Prisoners express reluctance to speak to prison staff due to a perceived lack of training.



2.8. Women prisoners

Human rights standards outline particular measures to be taken in relation to women prisoners including:

- Particular attention to the needs of prisoners who have experienced physical, mental or sexual abuse;
- Special accommodation for prenatal and postnatal care;
- Individualised, gender-sensitive, trauma-informed and comprehensive mental health care and rehabilitation for women prisoners with mental health care needs;
- Allocation, to the extent possible, to prisons close to their home or place of social rehabilitation.

During the last periodic review of the UK in 2019, the **CEDAW** raised concerns over the increase of women prisoners in Scotland. The Committee recommended the development of alternative sentencing and custodial strategies, including community interventions and services, for women convicted of minor offences.

In 2013, the **CAT** had already taken account of an unprecedented increase in the female prison population, noting that roughly half of these women were thought to have severe and enduring mental illness. The Committee recommended the Scottish Government to implement domestic recommendations made by the Commission on Women Offenders.

The **CEDAW** criticised the inadequacy of mental health-care services in prisons for women in 2013 and 2019, urging further measures to be taken to improve the provision of mental health care for women prisoners.

The **CPT**, following its visit to Scotland in 2018, echoed concerns over the lack of appropriate

access to mental health treatment for women prisoners experiencing mental ill-health. The Committee recommended that the Scottish authorities take steps towards addressing the specific needs of female prisoners with personality/behavioural disorders through introducing therapeutic tailor-made programmes. If necessary, the number of clinical psychologists should be increased at prisons accommodating women prisoners. The Committee further recommended to Scottish authorities, including the SPS, NHS, judiciary, and social services, to work together to provide better protection for women who cannot be treated under the Mental Health Act, involving a more multi-disciplinary approach with psychology taking a lead in the management of these units. In this context, the CPT recommended that urgent consideration must be given to developing a specialised high-secure psychiatric unit for women in Scotland, to ensure that access to mental health treatment is provided on the same basis as for male prisoners.

The **CPT** also recommended that admission screenings should include a history of sexual abuse or other gender-based violence in order to inform care plans for women in custody. This is to ensure compliance with Rules 2(1) and 6(e) United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, which require a consideration of particular vulnerabilities at the time of admission.

Domestically, in 2019, the Minister for Mental Health commissioned the Independent Review of Forensic Mental Health Services in Scotland (the Barron Review). The final report, published in February 2021, noted that the lack of high secure care for women in Scotland raises serious human rights concerns on the grounds of gender discrimination.

Recommendations are summarised and assessed as follows:

- develop alternatives to imprisonment to reduce the rate of imprisonment of women in Scotland (This is addressed at **Recommendation 5 on conditions of detention**);
- improve the provision of mental health care for women prisoners (This is addressed at **Recommendation 24** on mental healthcare);

Recommendation 27

Establish a specialised high-secure psychiatric unit for women in Scotland [CPT 2019]



Assessment: Two years after the Scottish Government's commitment to provide high-secure provision for women prisoners in need of mental health care, none has been established and there is no evident progress towards doing so.

Commitment: A commitment was made to establish an interim high-secure facility for women at the State Hospital with a view to providing this service from 2022 onwards.

Efforts: Some working group activity has considered options, but no formal plans have been made to implement the commitment.

Results: No high secure provision for women exists.

Recommendation 28

Ensure admission screenings include a history of sexual abuse or other gender-based violence in order to inform any care plan established for women in custody [CPT 2019]



Assessment: A lack of information on the content of assessments screenings in Scotland makes it difficult to determine whether changes have been instituted. However, the Scottish Government did not accept that changes were necessary and there is no evidence that any changes have been made across the estate.

Commitment: There is no evident commitment to improving admission screenings and the Scottish Government did not accept that improvement was needed.

Efforts: There are no identifiable efforts to improve admission screening across the estate.

Results: A lack of information on the content of assessments screenings in Scotland makes it difficult to determine whether changes have been instituted.

Recommendation 29

Implement domestic recommendations to upgrade the female prison estate, using the opportunity to undertake deep structural and conceptual changes [CAT 2013; CPT 2019]



Assessment: There has been significant improvement to the female prison estate and new approaches to custody have been adopted. It is too early to assess whether these new facilities and approaches will lead to deep structural and conceptual changes as recommended by the CPT. However, the vast majority of women prisoners remain in parts of the prison estate that have not been reformed.

Commitment: The Scottish Government committed to replace HMP Cornton Vale.

Efforts: Building has been completed in line with the commitments.

Results: A new national unit at HMP Stirling has been opened, along with two Community Custody Units. However, the vast majority of women prisoners are held in the old estate at HMP Greenock, HMP Grampian and HMPYOI Polmont.

“We observe a glacial pace of action. We evidence that recommendations are made repeatedly – we have been able to track some recommendations to 1994 – without remedy at a sufficient pace.”

Conclusion

For many people, places of detention are where they are spending significant periods of their lives. For many more, it will be a place they return to more than once. Safeguards, dignity and human rights must be in place for all.

It is worth stopping to think about the situation of a person at the receiving end of one of these systemic failings. Someone, for example, experiencing serious mental illness and distress, housed in solitary confinement, for weeks on end while the system tries to work out whether they can be moved to hospital. We cannot expect that they will follow complaints processes and legal challenges to remedy their situation, nor should they have to do so. The onus is on the State to ensure these situations do not happen, and, when they do, to take urgent action to remedy them.

Our report does not present anything unknown. It is based on publicly available information and covers issues discussed regularly in Government, Parliament and the media. For the most part, the facts are known. The question, which our research cannot answer, is why the issues have yet to be remedied.

Our research demonstrates a heavy emphasis on process, where, in some areas, working groups have replaced action. As one example, we see clear proposals to address the gaps in provision in the forensic estate made, after a lengthy Independent Review commissioned by Scottish Government, only for its recommendations to pass back to a working group to consider again. After all this process, no concrete conclusion has been reached. Years later, we see no clear plan of action or new services developed.

This level of inaction on fundamental human rights issues is of real concern. There is a clear accountability gap. We must ask ourselves, who is checking what gets done? Who could do more to hold public bodies to account? While we will measure this situation again, we cannot be in the same situation in four years' time. Continuous reporting on lack of progress is not acceptable. It is a long way from delivering better experiences for some of the most disempowered members of our society, or for their families who are often left with the burden of advocating on their behalf.

Annex 1: Tables of evidence by theme

The following tables provide a summary of key findings according to structure, process and outcome in relation to each recommendation.



Investigating deaths in custody

Recommendation 1: Ensure an independent, prompt and impartial review of all deaths in custody



Structure

In 2019 the Scottish Government commissioned an Independent Review into the Response to Deaths in Prison Custody, which was published in 2021.¹⁰ The process for any potential criminal investigation or the investigation of deaths by the Crown Office Procurator Fiscal Service (COPFS), including Fatal Accident Inquiries, were expressly outwith the remit of the Review.¹¹

The key recommendation of the Review was that a separate independent investigation should be undertaken into each death in prison custody, carried out by a body wholly independent of the Scottish Government, SPS, NHS and private prison operators.¹² An independent investigation would complement Fatal Accident Inquiries and other internal investigative processes, supporting compliance with the procedural requirements of Article 2 ECHR (European Convention on Human Rights).¹³

The Scottish Government accepted in principle all recommendations made by the Review, including the key recommendation.¹⁴



Process

To oversee implementation of the recommendations and advisory points, the Scottish Government established and chair a Working Group, to progress the key recommendation. They also appointed an External Chair who established a Deaths in Prison Custody Action Group, an Understanding and Preventing Deaths Working Group, as well as a Deaths in Custody Action Plan.¹⁵ The External Chair was appointed in April 2022, but her term ended in March 2024.¹⁶

The delivery of the key recommendation is reportedly in progress – a draft investigative process has been developed and is currently subject to a pilot evaluation exercise.¹⁷

The Scottish Government has advised that the timescale for delivery of the key recommendation depends on how many pilot exercises require to be undertaken, however the Chair of the Independent Review is sceptical about the key recommendation “being delivered any time soon or indeed at all”.¹⁸

As of February 2024, 12 of the Independent Review into the Response to Deaths in Prison Custody’s 27 recommendations have been implemented.¹⁹



Outcome

There is no evidence of changed outcomes for rights holders yet.

There were 40 deaths in prison in 2023 and 44 deaths in 2022.²⁰

Recommendation 1: Ensure an independent, prompt and impartial review of all deaths in custody (continued)



Structure

The Scottish Government carried out a review of the arrangements for investigating the deaths of patients being treated for mental disorder which concluded in 2018.²¹

The Review recommended the Mental Welfare Commission develop a system for investigating all deaths of patients who, at the time of death, were subject to compulsory measures under criminal or civil legislation.²²



Process

In March 2022, the Mental Welfare Commission proposed to the Scottish Government a new unified system for investigating deaths.²³ The Scottish Government has not formally responded to the proposals and no new system has commenced.



Outcome

As there is no unified system of investigation in place, there is no evidence of impact for rights holders.

Recommendation 2: Review the overall FAI system to find ways to speed up the process**Structure**

The Scottish Government did not accept this recommendation. It states that it is confident in the current FAI system, and notes that “Parliament considered and modernised the law on FAIs in 2016, and there are no plans to revisit the legislation”.²⁴

In response to a 2009 review of FAIs (the Cullen Review)²⁵ the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 was passed.²⁶ Key changes made by the 2016 Act include mandatory publication of all FAIs, and a requirement that any findings of a Sheriff relating to a public body must be responded to in writing, with the response made public.

COPFS has taken the following actions:

- COPFS’ Strategic Plan 2023-27 commits to improving investigations of deaths, including FAIs.²⁷
- In 2022 COPFS established a specialist Custody Deaths Investigation Unit.²⁸
- In 2023 COPFS published a ‘Guide to FAIs’ on their website which includes information about the potential stages of a death investigation including the report of a death, limited investigations, full investigations, FAI, and determination.²⁹
- COPFS’ Business Plan 2023-24 commits to establishing a Death Investigation Improvement Programme to reduce the journey time for concluding death investigations, including FAIs.³⁰

**Process**

The Inspectorate of Prosecution in Scotland (IPS) carried out a thematic review of the COPFS arrangements for FAIs in 2016, and a follow-up review in 2019. As of September 2023, the IPS considers that of the 15 recommendations relating to FAIs:

- 10 have been achieved;
- two have been superseded by Act of Sederunt (Fatal Accident Inquiry Rules 2017);
- three are still in progress, with substantial progress having been made in relation to one of them.³¹

However, the IPS expressed their continuing concern over the timeliness of death investigations and the quality of communication between COPFS and next of kin. It noted that COPFS has a key performance target of conducting the investigation and advising next of kin of the outcome within 12 weeks in at least 80% of cases, which in 2022-23 was achieved in 65% of cases – a rise from 50% the year before, but still below target.³²

The Scottish Government is providing £223 million in the Crown Office Budget for 2024-25, an increase from £198.7 million in 2023-24.³³

Recommendation 2: Review the overall FAI system to find ways to speed up the process



Outcome

A Freedom of Information request showed that as of January 2024:

- the longest FAI currently outstanding concerns a death from over eight years ago;
- The average outstanding FAI has been waiting over two years to commence;
- there were 3 FAIs into deaths in custody which had been outstanding since 2018/19, one relating to a child and another relating to a young person.³⁴

The Scottish Government stated that the average number of days taken to complete FAIs has been gradually decreasing, from 927 days in 2013-14 to 690 days in 2017-18.³⁵

The IPS Review in 2019 notes that “while COPFS continues to meet the published targets for deaths requiring investigation and routine deaths, there has been little progress in shortening the timeline for mandatory FAIs with the first notice lodged within 12 months in only 37% of cases in our case review”.³⁶

The External Chair of the Deaths in Prison Custody Action Group has found that the “problem itself” is the FAI system where “Families feel the length of time between the death of their loved one and finding any answers at the FAI is far too long and that the communication from COPFS is inadequate and lacks empathy.”³⁷ This echoes the findings of the original Independent Review into the Response to Deaths in Prison Custody where “[v]ery few families spoke positively about the experience of an FAI. While the issue of long delays before the FAI took place were raised again, the main issues related to feeling heard and feeling they were being taken seriously.”³⁸

A review of over 200 FAIs which took place between 2005 and 2022 identified several problems with the current FAI system:

- FAIs consider each case solely in isolation and where findings are made, they often narrowly address an individual circumstance, leaving wider structures and processes unchallenged;
- Where a Sheriff identifies significant issues contributing to a death, there is no enforcement mechanism for the implementation of recommendations;
- Families are rarely involved in FAIs, whether that be through attending the inquiry, giving evidence to the inquiry, or having legal representation at the inquiry;
- In respect of family participation, the 2009 Cullen Review recommended that the limit for Legal Aid should be increased in FAIs, however this was not taken forward by Scottish Government and existing rules on Legal Aid result in many families having no access to legal representation in FAIs.
- there is a lack of transparency around information regarding outstanding FAIs as this information is not publicly available, in contrast to e.g. statistics regarding the number of outstanding criminal trials;
- FAIs are taking an unduly long time to complete – on average FAIs published in 2022/23 took more than three years to complete.³⁹

In conclusion, the researchers found that “[...] there are questions to be asked about the independence and effectiveness of this system, when it takes so long to find so little”.⁴⁰



Suicides

Recommendation 3: Reduce the number of deaths by suicide



Structure

In 2022 the Scottish Government, together with COSLA, launched the latest Suicide Prevention Strategy 2022-32 to reduce the rate of suicide in Scotland.⁴¹

In 2015 SPS introduced the suicide prevention strategy 2016-21 (Talk to Me) to reduce the rate of suicide in prisons.⁴²



Process

The Year 1 Delivery Plan for the Scottish Government Suicide Prevention Strategy includes an action to work with the prison health service to build effective and compassionate suicide prevention plans in high-risk settings, such as prisons.⁴³

The 2024-2025 Scottish Budget has allocated £18m for public health measures, including suicide prevention.⁴⁴ The Scottish Government stated it is on track to provide a budget of £2.8 million for suicide prevention by 2026.⁴⁵

HMIPS have made recommendations for the improvement of the Talk to Me strategy including that it be developed to be more specific to the needs of adolescents.⁴⁶

The Mental Welfare Commission recommended SPS review the Talk to Me strategy, taking account of all available feedback, particularly in relation to learning from its operation in practice over the past years.⁴⁷ Although reported as a priority action item for 2022/2023, a timescale for delivery of the review has yet to be advised.⁴⁸

Although noted as an action item for 2023/24, there is no timescale for completion of a review of Talk to Me or delivery of a new SPS suicide prevention policy.⁴⁹



Outcome

The number of suicides in prisons increased by 42% during the course of the 2016-21 strategy. Since the introduction of Talk to Me, in December 2016, there have been 64 suicides in prison (January 2017- September 2022). In the six-year period before this policy was in place (2011-2016), there were 45 suicides.⁵⁰ The number of suicides in prisons has fluctuated between 4 and 14 per year between 2012 and 2022 but has consistently remained at more than 10 per year since 2021.⁵¹

The Mental Welfare Commission found that the prison workforce reported feeling confident and competent in suicide prevention through Talk to Me, however prisoners indicated that Talk to Me's operation in practice is not satisfactory.⁵²

Recommendation 3: Reduce the number of deaths by suicide (continued)**Structure**

We have not identified any specific commitments to address suicides in the mental health estate.

**Process**

There is no accompanying process to assess.

**Outcome**

There is insufficient data available to establish the number of suicides in the forensic estate over time.

Recommendation 4: Compile data to assess effectiveness of suicide prevention strategies**Structure**

SPS is under a statutory obligation to adopt and maintain a publication scheme. Information currently available under the scheme includes information on all deaths in custody in calendar years (including cause of death based on the medical certificate of cause of death, institution and gender).⁵³

**Process**

The SPS records how many prisoners have died in custody while on the Talk to Me programme, however, this information is not publicly available. It is not clear how this data contributes to assessing the effectiveness of the strategy.

**Outcome**

There is no data publicly available to assess the effectiveness of the SPS Talk to Me strategy.

Recommendation 4: Compile data to assess effectiveness of suicide prevention strategies (continued)**Structure**

All deaths in mental health detention are reported to the Mental Welfare Commission but there is no regular reporting of suicides in the forensic estate.⁵⁴

**Process**

There is no specific strategy regarding suicides in mental health detention for which data could be collected.

**Outcome**

In forensic mental health, there is no publicly available data on rates of suicide or measures to address them.



Conditions of detention and overcrowding in prisons

Recommendation 5: Tackle overcrowding and reduce remand population



Structure

The Scottish Government has stated that it is committed to reducing the prison population and finding alternatives to custody.⁵⁵ It has introduced various laws, policies and strategies in the past 10 years in an attempt to move towards this intention, including specific strategies that focus on women and children.⁵⁶

Community disposals now available include:

- Community Payback Orders
- Electronic Monitoring Technologies
- Home Detention Curfews
- Drug Treatment and Testing Orders
- Multi-Agency Public Protection Arrangements
- Structured Deferred Sentences

The Scottish Government has committed to investing in substantial expansion of community justice services.⁵⁷

On 27 February 2024, the Cabinet Secretary for Justice and Home Affairs announced the Scottish Government's intention to commence an externally led review of sentencing and penal policy.⁵⁸



Process

Several parties have raised concerns that funding allocation does not match the policy intention of substantial expansion of community justice services – particularly in relation to justice social work and the third sector.⁵⁹

The ring-fenced funding allocated by Scottish Government to local areas for justice social work has remained static at £86.5m since 2017, though significant additional monies are made available to add to this core and in association with particular activities to be delivered.⁶⁰ At the same time it is required to take on an increased role in delivery of services, e.g. via the provisions in the Bail and Release from Custody (Scotland) Act. Concerns have been raised about the sustainability of the social work workforce owing to growing pressures on workloads and its capacity to deliver plans without increased investment.⁶¹

Community Justice Scotland have said “The result is that preventative work in public sector and third sector provision has been under-emphasised in funding decisions. This does not serve the preventative aspirations of The Vision for Justice in Scotland or the new National Strategy for Community Justice, and will not achieve the ultimate goal of shifting the balance between custody and community sentences.”⁶²

A Diversion from Prosecution Working Group, comprising of diversion partner agencies, has been established by the Scottish Government, and its work is ongoing. Its function is to coordinate implementation of the recommendations in the joint review of diversion from prosecution, including in relation to communication, processes and consistency of practice.⁶³

Recommendation 5: Tackle overcrowding and reduce remand population



Outcome

Scotland's incarceration rate is rated "very high" by the Council of Europe. It has a prison population rate of 136 per 100,000 of population compared to a European average of 104 per 100,000 of population.⁶⁴

While a slight reduction in the prison population occurred during 2020 due to an early release policy for some categories of prisoner in response to Covid-19, the population has since risen again, sitting, at the time of reporting, around 8300⁶⁵, with further increases projected.⁶⁶

As of November 2023, the extended operating capacity that the prison estate can accommodate is 8,475. This is the level at which prisons go above their target operating capacity but can still provide a 'restricted regime'. The target operating capacity is 8,007. As of 2 November 2023, five prisons were operating above their target operating capacity.⁶⁷ The Chief Executive of SPS has warned that numbers exceed 8,500 then the Scottish Government would have to consider emergency measures.⁶⁸

The number of people held in prison on remand has also increased significantly in recent years with remand prisoners representing about 25-30% of the prison population at any one time⁶⁹, as has the length of time people spend on remand.⁷⁰

Community sentencing has increased significantly over a 10-year period. In 2021-22 (the most recent year that criminal proceedings official statistics are available), 14,160 people (24% of all people convicted) were given a community sentence, an increase of 45% on the previous year.⁷¹

Community sentencing represents a higher proportion of sentences overall than custodial sentencing, but the number of custodial sentences has also increased, as has the length of sentences.⁷²

A review of diversion from prosecution carried out in February 2023 found that diversion was on the whole working well, however there was a need to improve awareness of diversion as a response to offending behaviour and improve consistency of practice across Scotland.⁷³

Recommendation 5: Tackle overcrowding and reduce remand population (continued)	
 Structure	
	Mitigating measures to address court backlogs have been put in place since 2020 via the ‘Recover, Renew and Transform’ programme and the Courts Recovery Programme which piloted new ways of working included the introduction of virtual processes and increased use of technology. The Scottish Government is currently consulting on whether to make some of these measures permanent.
 Process	
	Audit Scotland assessed that the Scottish Government and Scottish Courts and Tribunal Services (SCTS) responded quickly to the pandemic and used effective scenario-based modelling to assess the impact of different options. The Scottish Government invested over £100m to support the Recover, Renew, Transform programme to fund the establishment of remote jury centres and support the court reform programme. ⁷⁴
	SCTS will receive increased funding in the 2024-25 budget to £164.9m; this is a 9% increase from the previous year. ⁷⁵ However, it was reported that the budget for 2023-24 was insufficient to meet the core costs of running the courts, requiring additional investment from the Scottish Government. ⁷⁶
 Outcome	
	Audit Scotland has found that although the criminal trial backlog has reduced since the pandemic, the waiting times for the most serious cases has more than doubled since 2020. ⁷⁷

Recommendation 6: Improve prison conditions – “dog boxes”, cell sizes, access to purposeful activity	
 Structure	
	No relevant evidence to report.
 Process	
	Some refurbishments have happened at HMP Barlinnie, including to the reception area and healthcare centre. This was completed and became operational in April 2023 at a cost of £9m. ⁷⁸
 Outcome	
	The “dog boxes” at Barlinnie have been removed.

Recommendation 6: Improve prison conditions – “dog boxes”, cell sizes, access to purposeful activity (continued)



Structure

There does not appear to be a national strategy specifically focused on enhancing access to purposeful activities in prison.

The Strategy for Women in Custody 2021-2025⁷⁹ and the Vision for Young People in Custody 2021⁸⁰ contains commitments to develop individualised plans for time in custody and to encourage participation in activities that promote health and wellbeing, and progress skills.



Process

Some individual prisons have introduced more activity:

- Efforts to ensure that both convicted and remand prisoners had access to reasonable regime or at least access to work were noted in Independent Prison Monitors (IPM) reports for HMPs Inverness, Dumfries, Kilmarnock and Perth.
- Some positives in relation to general access to activities (e.g. work, education, gym) were referenced in IPM reports for HMPs Inverness, Kilmarnock, Perth and Polmont (although there were some concerns about the amount of time spent in cell for some prisoners in Polmont)
- Reintroduction of evening activities were noted in HMP Glenochil and HMP Perth.⁸¹

There is little concrete activity outlined to progress the commitments for women and young people. Activity to put the commitments across the women's estate into action between 2021-2025 is limited to “agree[ing] a set of regime principles which embrace the gender specific and trauma informed approach at all levels”.⁸² For young people, the action is to assess the impact of Covid-19 and identify supporting actions.⁸³



Outcome

IPM and HMIPS report a common theme of issues regarding access to a comprehensive regime and excessive time spent in cells. This was often attributed to staff shortages but was also impacted by the complex task of managing different categories of prisoners safely. A restricted regime created perceived and real impact on progression of prisoners⁸⁴. Lack of work (e.g. closure of work sheds) and education opportunities and lack of evening activities were noted in some prisons⁸⁵, as were lack of training and accredited programmes⁸⁶.

Those untried are currently likely to be experiencing a more restrictive regime, have less access to education, work and rehabilitative activities and spend more time in their cells.⁸⁷

Recent HMIPS inspection reports on the Standard relating to purposeful activity rated 2 prisons as satisfactory and 7 as generally acceptable.⁸⁸

Recommendation 6: Improve prison conditions – “dog boxes”, cell sizes, access to purposeful activity (continued)



Structure

A review of the Scottish Prison Estate was carried out by the Scottish Government in 2002, which initiated a 20-year development programme to ensure that prisons were fit for purpose. This required replacing some prisons altogether and upgrading others. The project did not include any plans to increase the capacity of the prison estate.⁸⁹

The Scottish Government committed to have replaced HMP Barlinnie by the end of parliamentary term 2026.⁹⁰



Process

Completed work up to 2019 included:

- Construction of 2 new publicly managed prisons (HMP Low Moss and HMP/YOI Grampian).
- Remedial work on 5 prisons (HMP Edinburgh, Glenochil, Perth, Polmont and Shotts)
- Development of two privately managed prisons (HMP Kilmarnock and Addiewell)
- Construction of the Women’s National Facility (to replace HMP Cornton Vale) and two community custody units for women, Lillas and Bella.⁹¹

None of the next phase of developments, which were due to be completed by 2025, has been commenced. This includes:

- Construction of HMP Highland (to replace HMP Inverness)
- Construction of HMP Glasgow (to replace HMP Barlinnie)
- Construction of HMP Inverclyde (to replace HMP Greenock).⁹²

HMP Highland, which was due to be operational by July 2024, is now not expected to open until 2026.⁹³ The opening of HMP Glasgow, which is due to replace HMP Barlinnie, is now not expected until 2027.⁹⁴ There is no imminent plan to replace HMP Greenock.⁹⁵

The 2024-25 Scottish budget sees a 17% uplift for prisons from previous year, which includes a 42% increase in the capital budget.

Recommendation 6: Improve prison conditions – “dog boxes”, cell sizes, access to purposeful activity (continued)



Outcome

Delays to planned refurbishment and development work mean those being accommodated in crowded and poor material conditions will remain so for longer.

In October 2023, 2,230 prisoners were living in shared cells (1,115 cells in double occupancy) with a living space of less than 8m², breaching the minimum CPT requirement.⁹⁶ In eight out of 15 SPS prisons, a majority of multiple-occupancy cells fall below the 8m² standard.⁹⁷

HMIPS notes that there remains a lack of strategy for tackling numbers beyond capacity and therefore humane containment rather than rehabilitation will become the focus, which does not meet the requirements set out in Scottish Government and SPS strategies.⁹⁸

As of 2 November 2023, five prisons were operating above their target operating capacity.⁹⁹

As of Aug 2023, HMP Barlinnie was running at 140% capacity with just under 1,400 prisoners in a space designed for 987.¹⁰⁰

Of the full prison inspection reports conducted since 2020, the following ratings were given:

Standard 2 – Decency: 3 prisons were rated satisfactory, 5 prisons generally acceptable and one prison poor.

Standard 3 – Personal safety: 7 prisons were rated satisfactory, 1 generally acceptable and 1 poor.

IPM annual monitoring reports document a number of examples of good practice within prisons, as well as evidence of effective management and innovation within difficult operating environments.¹⁰¹

Overcrowding, poor material conditions, access to a comprehensive regime and time spent in cell, access to fresh air, substance misuse and violence, long waiting times for healthcare, dental and mental health appointments, prolonged segregation were all noted in prison monitoring and inspection reports from IPM and HMIPS.¹⁰²

Statistics on prison complaints indicate key concerns for prisoners. From data provided by SPS for a three-year period from 2021- 2024, the prison environment and prison regime came out in the top five complaint issues. For the years in question, the most complained about prisons were HMP Addiewell, HMP Kilmarnock and HMP Edinburgh.¹⁰³



Investigating allegations of ill-treatment

Recommendation 7: Ensure prompt and systematic investigation of all injuries and allegations



Structure

We found no evidence of State action to address the specific gaps identified by human rights bodies. Prisons use VIRS (violent incident review) forms to document incidents of violence, as well as the prisoner records system to keep records.¹⁰⁴ This reporting process does not, however, relate specifically to ill-treatment by duty bearers towards rights holders.



Process

We did not identify any specific efforts to address this recommendation.



Outcome

Some prisons have been praised for diligent documentation and process (e.g. HMP Polmont 2023 inspection), whereas others have been challenged on their performance in terms of following the process for violent incidents (e.g. HMP Shotts 2022 inspection). With regards to investigation following the reporting process, there are also clear issues with regards to investigating violence. For example, in the 2022 HMP Inverness inspection report, HMIPS said “We would also like to see violent incidents reviewed more systematically; in too many cases no review had taken place.”¹⁰⁵

Recommendation 8: Collect, analyse and publish data on complaints of torture or ill-treatment



Structure

The Scottish Government and SPS recognise the importance of collecting data in general.¹⁰⁶ There is no specific mention of the collection or publication of data on complaints of torture or ill-treatment, and we could not identify such data in the public domain.



Process

We did not identify any specific efforts to address this recommendation.



Outcome

At several prisons, inspection reports found considerable evidence of non-compliance with the complaints process, issues of staff attempting to resolve complaints informally rather than documenting the complaint correctly, and serious flaws in handling of equality and diversity complaints, among other concerns.¹⁰⁷

In the last ten prison inspections in Scotland, only 3 prisons (Greenock, Castle Huntly, and Kilmarnock) had a majority of respondents recording confidence in the complaints process. In five of these inspections, more than 70% of respondents said the complaints process worked badly or very badly. In three of these, more than 80% of respondents had this concern (Edinburgh 84%, Perth 86%, Addiewell 84%).¹⁰⁸

Recommendation 9: Establish accessible complaints mechanisms	
 Structure	
	We found no evidence of State action to address the specific gaps identified by human rights bodies.
 Process	
	We did not identify any specific efforts to address this recommendation.
 Outcome	
	Serious concerns persist with regards to complaints processes. Recent inspection reports highlight barriers for those with literacy issues or who do not speak English, as well as issues with compliance regarding the equality and diversity complaints process. ¹⁰⁹ Some recommendations from HMIPS regarding complaints processes have been outstanding since at least 2018. ¹¹⁰



Training for prison staff

Recommendation 10: Ensure ongoing, up-to-date training



Structure

SPS appear to have moved to a staff-driven approach to training, in which the onus is placed on staff to complete training and ensure they remain in competency.¹¹¹

SPS stated in their 2023-2028 Corporate Plan their goals to “[e]mbed a culture of continuous improvement through effective training...”, to become a trauma-informed organisation by 2028, and a commitment to activities around “[i]mproving staff learning, development and support.”¹¹²

The SPS Women’s Estate and Young Person’s Estate Learning and Development Strategy were introduced in late 2020 with the intention to have all staff trained to a consistent skill-set who work in prisons with either women or young persons, including a new trauma-aware course now completed by all new recruits in the SPS and those who work in residential care with woman or young persons.¹¹³



Process

Inspection reports show that prisons in Scotland employ Learning and Development Managers who are making efforts to improve compliance with training.¹¹⁴

SPS began a training programme to improve understanding of trauma-informed practices. In 2023-24 SPS has committed to “[c]ontinue to roll out a programme of senior leader trauma-awareness training”.¹¹⁵

During 2023/24, two cohorts of SPS senior leaders completed NHS Education for Scotland’s two-day ‘Scottish Trauma Informed Leaders Training’ (STILT) (50 attendees in total). Cohort three is scheduled to take place in Q1 of the 2023-2024, period which will see the remainder of the senior leaders in the organisation attend. Discussions are underway to agree a roll out of the training to Establishment and Directorate Senior Management teams during the 2023-2024 reporting period.¹¹⁶

Some training on the use of force is provided by the pilots of non-pain inducing restraint (detailed at Recommendation 17).

Recommendation 10: Ensure ongoing, up-to-date training**Outcome**

Prison inspection reports from the past several years show an ongoing prevalence of staff being out of competency on core training courses, including First Aid, Emergency Response, Personal Protection Training, Control and Restraint, Talk To Me suicide prevention, Mandatory Drug Testing and more. Since 2019, only three prisons have received ratings of “good” or “satisfactory” on HMIPS’ prison staff training standard (8.4), while the remaining 11 prisons that were inspected received ratings of “generally acceptable,” just one step above “poor”.¹¹⁷

In many inspection reports, the COVID-19 pandemic was cited as the cause of lower training compliance, particularly in training that needed to take place in person, such as Control and Restraint. However, in comparing pre-pandemic and post-pandemic inspection ratings on Standard 8.4 training compliance was not better before the pandemic.

While healthcare staff in prisons demonstrated higher training compliance than prison staff in many of the core training modules such as health assessment, emergency response and Talk to Me, concerningly there was lower compliance in mandatory training modules on equality, diversity, and human rights.¹¹⁸

People with lived experience of having mental health needs while in prison have expressed a reluctance to share their mental health concerns with prison officers due, in part, to a perceived lack of training to provide sought after support.¹¹⁹

Recommendation 10: Ensure ongoing, up-to-date training (continued)**Structure**

Two new resources have been developed in relation to Deaths in Custody:

- A training video produced by SPS College with regards to responding to a death in custody.
- A Death in Prison Custody NHS Support Toolkit

**Process**

There has been a high uptake of the training video, however this is contingent on staff taking the initiative to view the video.¹²⁰

Training on the toolkit has an average national uptake of 80%.¹²¹ Healthcare Improvement Scotland are also monitoring the usage of the NHS Death in Prison Custody Support Toolkit as part of their inspections process to ensure compliance.¹²²

**Outcome**

There is no available evidence of outcomes yet.

Recommendation 11: Ensure human rights standards are included in training**Structure**

Human rights training does not, according to current public information, contain the specific standards recommended by human rights bodies.¹²³

Human rights training is only required to be taken every ten years, a frequency that HMIPS suggested is too low and could be reconsidered.¹²⁴

There is no evidence that medical personnel working with detained people are trained in the Istanbul Protocol.¹²⁵

**Process**

No relevant process to assess.

**Outcome**

HMIPS have repeatedly found that many prisons do not have embedded human rights cultures.¹²⁶

Recommendation 11: Ensure human rights standards are included in training (continued)**Structure**

The Scottish Government cites control and restraint training as ensuring that no more force than is strictly necessary should be used to control prisoners.¹²⁷ There is no evidence that the training includes sanctions should disproportionate force be found to have been used.

**Process**

Many prison officers are out of compliance with this training requirement, according to recent inspection reports.¹²⁸

**Outcome**

No relevant evidence to report.

Recommendation 12: Develop a methodology to assess the effectiveness of training**Structure**

There is no evidence of a commitment to assess the effectiveness of training in reducing cases of torture and ill-treatment or in ensuring appropriate follow-up of cases of ill-treatment.

**Process**

A review of the effectiveness of introducing non-pain inducing techniques, related to aspects of ill-treatment, at HMP YOI Polmont and the two Community Custody Units has been commissioned.

**Outcome**

No clear outcomes for rights holders as there is no evidence of concerted efforts to implement this action.



Use of force and restraint

Recommendation 13: Explicitly prohibit the use of harmful devices, disciplinary restraint and any technique designed to inflict pain on children



Structure

Rule 91 describes when force can be used against a person in SPS care, including children. However, there are no explicit legislative measures to prohibit the use of harmful devices on children, abolish methods of restraint against children for disciplinary purposes, or ban the use of any technique to inflict pain on children. The Scottish Government has stated that it does not consider legislation to be necessary.¹²⁹

While SPS asserts that staff are not trained in the use of spit hoods and they are not used, the Scottish Prison Rules make no reference to spit hoods, and state that restraints mean “body belts,” with no mention, or prohibition, of any other devices.¹³⁰

In response to a Parliamentary Question in 2016 regarding the use of spit hoods, MSP and then-Cabinet Secretary for Justice Michael Matheson deferred all authority to Police Scotland, stating “Operational policing is a matter for the Chief Constable of Police Scotland, under the oversight of the Scottish Police Authority.”¹³¹



Process

The Scottish Government states it is “working with the Scottish physical restraint action group to explore definitions of restraint along with the availability of data, training and support.”¹³²

HMP & YOI Polmont and HMPYOI Stirling are piloting non-pain inducing restraint.¹³³ The 12-month pilot phase became operational in HMPYOI Polmont, Bella and Lillas CCUs in 2022-23.¹³⁴ HMP Low Moss commenced non-pain inducing techniques in April 2024.¹³⁵ An evaluation of its effectiveness has been commissioned.¹³⁶



Outcome

No clear outcomes for rights holders yet.

The Children’s Commissioner, Scottish Human Rights Commission, Equality and Human Rights Commission, Mental Welfare Commission and The Promise Scotland have jointly called for a coherent statutory framework on restraint and seclusion across all settings in which children are under the care and/or supervision of the State, including prisons. They state that this should be implemented by setting-specific practice guidance and provision of appropriate levels of staff support.¹³⁷ The Scottish Government has not agreed to these actions¹³⁸.

Recommendation 14: Develop statutory guidance on the use of restraint on children**Structure**

There is no statutory guidance on the use of restraint specifically on children in any setting, including prisons.

Rule 91 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011, describes when force can be used against a person in SPS care. This rule covers, but is not tailored to, children.¹³⁹

**Process**

See table above regarding pilots of non-pain inducing restraint.

**Outcome**

See table above.

Recommendation 15: Collect, analyse and publish data on restraint on children**Structure**

We have not been able to identify any published data on restraint on children in the prison estate nor any commitment to do so.¹⁴⁰

**Process**

No relevant evidence to report.

**Outcome**

No relevant evidence to report.

Recommendation 16: Take urgent measures to protect minority ethnic groups from ill-treatment and disproportionate restraint**Structure**

Equality and Diversity (E&D) teams are established at many prisons; however, we do not have evidence of specific commitments to address this recommendation.

**Process**

At some prisons, e.g. HMP Inverness, weekly reviews took place to identify prisoners with protected characteristics who might need additional support, and competency levels around training on E&D were above target levels, according to recent inspection reporting.¹⁴¹

**Outcome**

No clear outcomes for rights holders reported.

E&D concerns have been raised in several recent inspection reports with regards to staff compliance with E&D training, skill levels of E&D team staff, E&D complaints processes.¹⁴²

There is no consistent proactive monitoring of disproportionate restraint carried out by local E&D teams.¹⁴³

Recommendation 17: Review behaviour management policies



Structure

The SPS has stated its commitment “to the principle of restraint and seclusion being a last resort, utilised when there is a significant risk to the person or others and all alternative strategies have been unsuccessful.”¹⁴⁴



Process

HMP & YOI Polmont and HMPYOI Stirling are piloting non-pain inducing restraint.¹⁴⁵ The 12-month pilot phase became operational in HMPYOI Polmont, Bella and Lillas CCUs in 2022-23.¹⁴⁶ HMP Low Moss commenced non-pain inducing techniques in April 2024.¹⁴⁷ An evaluation of its effectiveness has been commissioned.¹⁴⁸



Outcome

No clear outcomes for rights holders reported yet.

Recommendation 18: Consider measures to ensure body cameras for all control and restraint operations



Structure

According to a September 2023 question and response in Parliament, “The feasibility of a pilot to test the introduction of BWVCs [body cameras] across the SPS estate is...being considered in partnership with Trade Union Partners.”¹⁴⁹



Process

In 2019, HMP Addiewell piloted 50 body cameras and provided a report to the Scottish Government to “help inform corporate decisions” and “inform any proposed roll out.”¹⁵⁰

In October 2023 there were 84 body worn video cameras available across the Scottish prison estate, in HMP Kilmarnock and HMP Addiewell.¹⁵¹ HMP Kilmarnock has since transferred into SPS ownership and body cameras were not retained.¹⁵²

A pilot commenced on 1 April 2024 in HMP Low Moss, HMP Barlinnie and HMP Perth with each establishment having 25 Body Worn Cameras. This Pilot will run for a six-month period and an evaluation of their use and effectiveness is currently underway.¹⁵³



Outcome

No clear outcomes for rights holders reported.



Use of solitary confinement, seclusion, isolation

Recommendation 19: Stop using segregation for those with mental health needs



Structure

The Scottish Government Women's Strategy was designed to create suitable accommodation for women with the most acute need.¹⁵⁴ In 2023 a new HMPYOI Stirling was opened in response to concerns around women with severe mental ill-health being held for prolonged periods of time in segregation.



Process

No relevant evidence to report.



Outcome

The first full inspection of the new HMPYOI Stirling is yet to be published, and so a judgement on its effectiveness to meaningfully address concerns raised would be premature. That said, the capacity for acutely unwell women is limited – on 11 Feb 90 women were held in HMPYOI Stirling and 214 held in the rest of the estate.¹⁵⁵ This limits the ability for a new facility to positively affect women held.

Recommendation 20: Ensure appropriate use of segregation, adequate regimes and reintegration



Structure

SPS have in place a Prisoner Management Assurance Group (PMAG) to regularly review SRU stays exceeding three months and tackle complex cases.



Process

It has not been possible to identify any process or legislation which has the goal of a reduction in long-term SRU stays.

HMIPS have recommended that PMAG be replaced as both SRU staff and Senior Managers are critical of whether it is useful as it has no power to dictate transfers.¹⁵⁶



Outcome

A 2023 HMIPS review into segregation found that, between April 21 – March 22, 138 prisoners were referred to PMAG after spending over three months in SRU¹⁵⁷. The report also captured data of long stays in Sept 2022. The longest continuous SRU stay was 1,017 days – almost three years. Eight individuals had been held continuously in SRUs for over a year, including seven who had been in an SRU for over 600 days, and four who had been in an SRU for over two years.

The 2023 HMIPS review found there were numerous gaps and limitations, including: too little focus on providing SRU prisoners with the support they need to deal with underlying issues that lead to SRU stays; no options in the male estate for providing a gradual transition via a step-down facility; too little engagement in reintegration planning from mainstream hall staff.¹⁵⁸

Recommendation 20: Ensure appropriate use of segregation, adequate regimes and reintegration (continued)	
 Structure	
	There have been no amendments to the Prison Rules (The Prisons and Young Offenders Institutions (Scotland) Rules 2011) requiring the basic human rights standards to be met. There is no absolute prohibition on prolonged solitary confinement. There is no requirement for prisons to facilitate two hours of meaningful human contact.
 Process	
	No relevant evidence to report.
 Outcome	
	Continued monitoring and inspection have found that as a matter of routine, almost all prisoners in a segregation unit are confined to their cells except when exercising alone or showering. Two hours meaningful human contact was rarely met, and regimes were limited. ¹⁵⁹



Recommendation 21: Address staffing issues



Structure

Explicit aims to address recruitment and retention of prison healthcare staff are missing from a number of national policies which focus on the healthcare workforce.¹⁶⁰

Some of the workforce plans at regional NHS health board level address prison healthcare shortages, with detailed local plans to attempt to remedy this.¹⁶¹ Some have no mention of prisons at all.¹⁶² There appears to be a lack of a national joined-up approach.



Process

The Scottish Government announced a £100,000 fund in 2018 for projects which promoted partnership between SPS and NHS healthcare services.¹⁶³

Funding for NHS health boards with prisons within their boundaries have increased over past three years.¹⁶⁴ There has been increased recruitment activity for prison healthcare within some of these areas.¹⁶⁵



Outcome

Adequate staffing to meet the needs of the population was a common theme across IPM monitoring reports for 2022/23. Long waiting times for GP appointments, addiction support and mental health assessment and treatment were noted.¹⁶⁶

The Scottish Government's Needs Assessment identified ongoing staffing issues and a high number of vacant primary care nursing positions across the estate. Covid-19 exacerbated the issues.¹⁶⁷

NHS Glasgow and Greater Clyde has indicated that registered nurses are at only 83% of required capacity (72 out of the 87 required)¹⁶⁸, while NHS Lanarkshire notes that sickness absence within prison healthcare can be up to 30% at any one time, sometime due to work-related stress.¹⁶⁹

Some positive developments have been cited, for example the enhanced multi-disciplinary mental health services now working within prisons and improved working relationships between different agencies.¹⁷⁰

Staff continue to feel under-resourced and overworked.¹⁷¹ These issues appear to affect health staff at all grading levels- from newly qualified nurses to experienced GPs.

Availability of nursing staff impacts on the timing of prescription medication, with the last medication being administered late the afternoon in some prisons.¹⁷²

Recommendation 22: Improve record sharing



Structure

Development of a suitable clinical IT solution for prisons is an action included under the National Strategy for Community Justice Delivery Plan. The Plan also includes an action to develop and implement a revised Information Sharing Agreement between SPS and NHS Boards.¹⁷³

The new IT system is part of a wider Prisons Digital Health Care System provisioning programme.¹⁷⁴

Improving health and care data is also a key action under SPS' current corporate plan.¹⁷⁵



Process

Work is underway to implement an updated patient management system which brings prisons on a par with GP practices across Scotland. Additional functionality is being developed within that solution to support prescribing and medicines administration within the prison setting.^{176 177}

Regional prisons facilitators have been in post since April 2024.

The main changes of the Provisioning Programme are due to be implemented by 2025, with full implementation by 2028.

The Memorandum of Understanding between the NHS and SPS is currently being revised by the National Prison Care Network.¹⁷⁸



Outcome

The Scottish Government's Needs Assessment highlighted that there is no central collection point for the health needs of the prison population, with limited information sharing taking place between justice, health, social work and the third sector.¹⁷⁹

There continue to be issues with accessing and transferring records, which can result in delays and variable prescribing practices.¹⁸⁰

The use of different information systems by different agencies can lead to siloed working, with inadequate access to records.

Recommendation 23: Address substance use



Structure

The need to address substance use in Scotland's prisons has been recognised for many years and forms part of the National Mission to address drug use and drug-related deaths in Scotland.¹⁸¹

Consecutive national strategies introduced since 2008 highlight key issues which are still relevant in 2024, including the need to tackle the flow and supply of drugs into prison, improving care and addiction support in prison and improving continuity of care between prison and the community.¹⁸² The approach has moved away from a punitive one to a focus on recovery.

The action plan of the National Mission on Drugs, introduced in 2021, covers prisons.¹⁸³

Increased access to treatment and recovery services in prison via the Digital Lifelines Scotland initiative is a key priority.¹⁸⁴

A National Naloxone programme has existed since 2011 and provides those leaving prison with Naloxone subscription in an attempt to prevent opioid overdoses.¹⁸⁵ Increasing peer-to-peer distribution of Naloxone is part of the National Mission's goals.¹⁸⁶

SPS has had a policy on the Management of Offenders at Risk due to any Substance (MORS) since 2014 and it is currently being revised.¹⁸⁷ Individual prisons also have their own strategies.



Process

Opioid Replacement Therapy (OST) is widely used in prisons as a form of treatment, as well as a harm reduction strategy, but prescribing practices vary significantly between prisons.¹⁸⁸

The Scottish Government allocated £1.9m during the pandemic to support prisoners to switch to Buvidal – a longer lasting form of OST which can be taken weekly or monthly as opposed to daily. Benefits of this appear to be that in the long-term it will free up nursing staff time which would allow them to run other clinics, while also reducing concerns around drug misuse and diversion.¹⁸⁹ However further research is required to assess benefits and risks.¹⁹⁰

Some psychological interventions are also available in prisons, but there has been limited research on the practices or outcomes of these.¹⁹¹ Peer-to-peer support is being delivered across most prisons, often via recovery cafes, with good feedback, but uptake of this provision is only 'adequate'.¹⁹²

As part of the Scottish Government's National Mission to reduce drug-related deaths and harms, £50m of funding was pledged per year over a five-year period, including The Prison To Rehab programme.¹⁹³

Recommendation 23: Address substance use**Outcome**

Around 25% of people were receiving OST in 2021. This raises the question of whether predominance of OST restricts rather than increases treatment choices. Variable prescribing practices between prisons and problems with information systems can create issues for prisoners moving between different prisons and the community.¹⁹⁴

IPM reports reveal concern around lack of access to and long waiting times for addiction services.¹⁹⁵

Drug-related deaths continue to be a problem in prisons. Between September 2020 and 2022, drug related deaths accounted for 25 of the 121 deaths in Scottish prisons (note including those still awaiting classification).¹⁹⁶

It is acknowledged that drug use is linked to critical unmet need, as well as being used to cope with life in prison – boredom, limited regime, isolation etc.:

“There was a palpable sense in discussions of how impossible it would feel to sustain abstinence in the current prison culture and environment”.¹⁹⁷

People on remand, women, young people and people with diagnosable mental health conditions are key groups of concern.¹⁹⁸

Recommendation 23: Address substance use (continued)**Structure**

The Scottish Government amended the Prison and Young Offenders Institutions (Scotland) Rules¹⁹⁹ which allowed for routine photocopying of prisoner mail, to tackle the flow of Novel Psychoactive Substances, which are now more common than opioids. Substances enter prison soaked in mail or clothing and are not always easy to detect.

**Process**

No relevant evidence to report.

**Outcome**

The introduction of routine photocopying of mail has reduced the amount of substances entering via the mail, although there are concerns that closing down one drug route fails to address the underlying demand issue.²⁰⁰

Influxes of drugs into prison can also be linked to increased incidents of violence. Prison staff and governors are concerned about Novel Psychoactive Substance use – both the unpredictability of behaviour and the potential for overdoses.²⁰¹

Illicit substances continued to be ‘readily available’ in prisons, with the market being dominated by availability rather than choice.²⁰²



Mental healthcare

Recommendation 24: Improve mental healthcare in all prisons



Structure

Responsibility for the care and treatment of prisoners with mental ill health transferred from the Scottish Prison Service to the NHS in 2011.

The Justice Strategy sets out a priority to design and implement the Health and Wellbeing Strategy, including drugs, mental health and deaths in custody.²⁰³

The Delivery Plan for Scotland's Mental Health and Wellbeing Strategy 2023-2025 commits to work with NHS partners, the Scottish Prison Service and the National Prisoner Care Network to improve access to, and the consistency and profile of, mental healthcare in prisons, and improve governance and oversight of the delivery of healthcare in custody settings, including mental healthcare in prisons.²⁰⁴

The SPS Strategy for Women in Custody for Women 2021-2025 seeks to promote women's health and wellbeing in several ways, including through collaboration with the NHS to ensure that a therapeutic regime is developed and that forensic mental health issues are identified and responded to effectively. Where relevant this may involve transfer to a facility to receive appropriate treatment in response to mental ill health.²⁰⁵



Process

A national Needs Assessment of mental health in the prison population was completed in September 2022. While this is intended to support the Mental Health and Wellbeing Strategy, no action plan has yet been implemented.²⁰⁶

An action to finalise the SPS Mental Health Strategy is due in Q4 23/24.²⁰⁷



Outcome

The Mental Welfare Commission found that, while structures and processes are different, little had changed in relation to the outcome for prisoners' mental health, between 2011 and 2021.²⁰⁸

The Mental Welfare Commission found that access to, and delivery of, mental health support is underserved and under resourced.²⁰⁹

The Needs Assessment concludes that mental health services in prison are not equivalent to care available to people in the community, and do not adequately address the high levels of need in this population.²¹⁰

Both the Needs Assessment and the Mental Welfare Commission have found that despite repeated concerns and scrutiny of the same issues, most recommendations have not been fully implemented.²¹¹

Recommendation 24: Improve mental healthcare in all prisons (continued)	
 Structure	
	The Mental Health Strategy 2017-2027 committed to increase the workforce by 800 posts to give access to dedicated mental health professionals to a range of settings including prisons. ²¹²
 Process	
	At the final reporting date in April 2022, an additional 958.9 WTE mental health posts across Scotland were recruited to, but only 6% of those were in prisons. ²¹³
 Outcome	
	Psychiatry provision across the prison estate totals to 39 sessions, equivalent to just under four full-time psychiatrists. This equates to an average of 210 residents per one half-day psychiatry session. Provision was found to be relatively arbitrary in relation to prison size, with too few sessions at the largest prisons including HMPs Edinburgh, Barlinnie and Addiewell.²¹⁴ Clinical psychology sessions amount to an average of 50 residents per one half-day session, however this is very unevenly spread, with some prisons having substantial input and some none at all.²¹⁵

Recommendation 24: Improve mental healthcare in all prisons (continued)	
 Structure	
	Core Mental Health Quality Standards apply across all mental health services but make no specific mention of prisons. ²¹⁶
 Process	
	The Scottish Government's Needs Assessment calls for the adoption of prison mental healthcare standards to be adopted to ensure consistency in the care available across the prison estate. ²¹⁷
 Outcome	
	No relevant evidence to report.

Recommendation 25: Transfer prisoners with acute mental health problems to appropriate psychiatric facilities



Structure

The Independent Forensic Mental Health Review (the Barron Review) recommended that a new NHS Board should be created for forensic mental health services in Scotland.²¹⁸

There is no standard set for the maximum amount of time to transfer a patient from prison to hospital.²¹⁹



Process

A Short Life Working Group to consider the recommendation reached no concrete conclusion.²²⁰ The Group carried out an Options Appraisal²²¹ and concluded “that there was no clear preference for a board or a structured partnership approach but there was a desire for change.”²²²

There is no published action plan to implement the Barron Review, although Scottish Government advise that a progress report is due to be published.²²³



Outcome

The Mental Welfare Commission and HMIPS have identified that people who are seriously and acutely mentally ill are still not being transferred to hospital care without delay.²²⁴

The average number of days between date of referral and date of transfer ranged from 14.6 to 25.6 calendar days.²²⁵ The average length of time for women’s transfers was 43.2 days.²²⁶ The Barron Review had concerns that the figures are underestimates which do not capture the period before a formal referral. The Mental Welfare Commission found delays of over three months before referral and over 45 weeks in SRU.²²⁷

Recommendation 25: Transfer prisoners with acute mental health problems to appropriate psychiatric facilities (continued)



Structure

The Barron Review recommended that a high secure service for women should be opened in the State Hospital by November 2021.²²⁸



Process

There is no published action plan to implement the Barron Review and it has not been possible to identify any budget allocation to fulfil this recommendation.



Outcome

There have been no high secure female beds in Scotland for either mental illness or intellectual disabilities since 2012 and no new admissions since 2008.²²⁹

Women requiring high secure forensic provision in severe mental distress continue to either be held in a prison environment ill-suited for their needs or are transferred many hundreds of miles to a high secure facility in England. It is nearly a five-hour drive between HMP Stirling and Rampton Secure Hospital.

Recommendation 25: Transfer prisoners with acute mental health problems to appropriate psychiatric facilities (continued)



Structure

The Scottish Government Women's Strategy was designed to create suitable accommodation for women with the most acute need.²³⁰ In 2023 a new HMPYOI Stirling was opened in response to concerns around women with severe mental ill-health being held for prolonged periods of time in segregation.



Process

No relevant evidence to report.



Outcome

The new HMPYOI Stirling is yet to receive a full inspection since opening, and so a judgement on its effectiveness to meaningfully address concerns raised would be premature. That said, the capacity for acutely unwell women is limited – on 3 March 2024 89 women were held in HMPYOI Stirling and while 100 were held in HMPYOI Polmont, 46 in HMP Greenock, 37 in HMPYOI Grampian.²³¹ This limits the ability for a new facility to positively affect women held.

Recommendation 26: Training for prison personnel on recognising symptoms of mental health problems and appropriate referral



Structure

There is no mandatory training relating to mental health for prison staff (apart from training on the Talk to Me programme), despite the recognised high prevalence of mental health needs among people in prison.²³²

There is good availability of mental health training for NHS staff.²³³



Process

A training needs analysis for SPS and NHS staff has taken place in parts of the prison estate but there is no consistent approach to mental health training across the estate and no training implementation plan.²³⁴



Outcome

People with lived experience of having mental health needs while in prison have expressed a reluctance to share their mental health concerns with prison officers due to a general lack of dignity and respect from officers, or perceived lack of training to provide sought after support.²³⁵



Women prisoners

Recommendation 27: Establish a high-secure psychiatric unit for women



Structure

The Barron Review recommended that a high secure service for women should be opened in the State Hospital by November 2021.²³⁶

The Scottish Government committed to take forward arrangements for an interim high secure facility for women to be opened at the State Hospital site at Carstairs, with a view to providing this service in Scotland from 2022 onwards.²³⁷



Process

The Forensic Network short life working group for Women's Service and Pathways across the forensic mental health estate reconvened in 2021.²³⁸ The Group prepared a Clinical Infrastructure Assessment for The State Hospital.²³⁹

According to the Forensic Network's Annual Plan, the implementation of recommendations on female pathways in forensic mental health in Scotland through the Women's Forensic Services Planning Group is a key objective for 2023/24.²⁴⁰

The Scottish Government Mental Health and Wellbeing Delivery Plan 2023-2025 notes as a strategic action to support and progress positive change in forensic mental health services. During the lifespan of the Delivery Plan 2023-25, Scottish Government, together with SPS and NHS Boards, they intend to develop a plan with stakeholders to deliver services in Scotland for women who need high secure care and treatment in the short and long-term.²⁴¹



Outcome

Neither the NHS State Hospital Board for Scotland's Annual Operating Plan 2022/23²⁴² nor the NHS Scotland Delivery Planning Guidance 2024/25²⁴³ contain any plans for opening a high-secure service for women at the State hospital.

As of February 2024, there is no high secure psychiatric unit available for women in Scotland, and no further information on progress made towards opening a high-secure service for women at the State hospital could be found.

Women who require high secure care continue to be considered for transfer to National Women's Service, Rampton Hospital in England.²⁴⁴

Recommendation 28: Improve admission screenings for women



Structure

The Scottish Government did not accept this CPT recommendation, describing admission processes for women prisoners as “robust”, and “where signs of possible abuse are identified, NHS staff are advised and can direct the prisoner to appropriate care and support”.²⁴⁵

Standards and guidelines lay out what the health admission assessment should include but make no mention of sexual violence or gender-based violence.²⁴⁶ The health screening questionnaire asks about women’s physical and mental health history, previous contact with services, any medication prescribed, previous and/or current alcohol or drug use.²⁴⁷



Process

In contrast to other parts of the UK, no information on guidance and standards for health assessment screenings is publicly available for Scotland.



Outcome

A lack of data and information on the content of assessment screenings in Scotland makes it difficult to determine whether questionnaires include questions on sexual and gender-based violence.

Whilst a review of HMIPS inspection reports suggests that screening processes generally appear to be adequate in most prisons, there is little evidence to suggest that they include screening for sexual and gender-based violence, as recommended by the CPT.

Recommendation 29: Upgrade the female prison estate



Structure

In 2015, Scottish Ministers announced there would be a national prison for women created on the site of the previous HMP and YOI Cornton Vale in Stirling, and up to five community based custodial units for those requiring closer engagement.²⁴⁸

HMP Stirling is intended to “offer a bespoke facility with small distinct accommodation areas, with the flexibility to accommodate the needs of all adult and young women. The facility includes: an enhanced needs area to support those women requiring more intensive mental health support; a Separation and Reintegration Unit (SRU), Progression Unit, Mother and Baby Unit and an Assessment Centre to allow for a period of initial assessment.” HMP Grampian is intended to operate in a similar manner.²⁴⁹



Process

Work has been completed on two new women’s custody units and a national facility for women at HMP Stirling.



Outcome

The Community Custody Units for women, the Bella and Lillas Centres, opened in August and October 2022 respectively. Together they can accommodate 40 women. The SPS has indicated that research and evaluation of the two community custody units will be used to inform the future development of the women’s estate.²⁵⁰

HMP Stirling opened in June 2023 has capacity to hold a maximum of 117 individuals, along with a separate Mother and Baby Unit with 2 spaces. HMIPS inspected HMP Stirling and Bella and Lillas Centres in February 2024, but findings are not yet published.²⁵¹

Annex 2: List of Acronyms

CAT – UN Committee against Torture, which monitors implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment

CCPR – UN Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights

CEDAW – Committee on the Elimination of Discrimination against Women, which monitors implementation of the Convention on the Elimination of All Forms of Discrimination against Women

COPFS – The Crown Office and Procurator Fiscal Service

COSLA – The Convention of Scottish Local Authorities

CPT – European Committee on the Prevention of Torture, which visits places of detention and assesses how persons deprived of their liberty are treated in order to strengthen their protection from torture and inhuman or degrading treatment or punishment

CRC – UN Committee on the Rights of the Child, which monitors implementation of the Convention on the Rights of the Child

E&D – Equality and Diversity

FAI – Fatal Accident Inquiry

HMIPS – His Majesty's Inspectorate of Prisons for Scotland

HMP – His Majesty's Prison

IPM – Independent Prison Monitors

IPS – Inspectorate of Prosecution in Scotland

MWC – Mental Welfare Commission

NHS – National Health Service

NPM – National Preventive Mechanism

OPCAT – United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

OST – Opioid Replacement Therapy

PMAG – Prisoner Management Assurance Group

SCTS – Scottish Courts and Tribunal Services

SPS – Scottish Prison Service

SPT – UN Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, which visits places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

SRU – Segregation and Reintegration Unit

UN – United Nations

Annex 3: Reviews by Human Rights Bodies

UN Human Rights Committee (CCPR)

- Concluding observations on the eighth periodic report of United Kingdom of Great Britain and Northern Ireland (28 March 2024) CCPR/C/GBR/CO/8.
- Concluding Observations on the seventh periodic review of the United Kingdom of Great Britain and Northern Ireland (17 August 2015) CCPR/C/GBR/7.

UN Committee against Torture (CAT)

- Concluding Observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland (7 June 2019) CAT/C/GBR/CO/6.
- Concluding Observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland (24 June 2013) CAT/C/GBR/CO/5.

Subcommittee for the Prevention of Torture (SPT)

- Visit to the United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: recommendations and observations addressed to the State party (31 May 2021) CAT/OP/GBR/ROSP/1.

UN Committee on the Rights of the Child (CRC)

- Concluding Observations on the combined sixth and seventh periodic reports of the United Kingdom of Great Britain and Northern Ireland (22 June 2023) CRC/GBR/CO/6-7.
- Concluding Observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland (12 July 2016) CRC/C/GBR/CO/5.

UN Committee on the Elimination of Discrimination against Women (CEDAW)

- Concluding Observations on the eighth periodic report of the United Kingdom of Great Britain and Northern Ireland (14 March 2019) CEDAW/C/GBR/CO/8.
- Concluding Observations on the seventh periodic report of the United Kingdom of Great Britain and Northern Ireland (30 July 2013) CEDAW/C/GBR/CO/7.

European Committee for the Prevention of Torture (CPT)

- Report to the United Kingdom Government on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 14 to 18 October 2019 (8 October 2020) CPT/Inf (2020) 28
- Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 17 to 25 October 2018 (11 October 2019) CPT/Inf (2019) 29.

Endnotes

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- 2 UK NPM, [Scotland's progress in the prevention of ill-treatment in places of detention: An assessment of the implementation of recommendations made by the European Committee for the Prevention of Torture](#) (August 2021).
- 3 Forensic Network, [10 Years of the Forensic Network Census – 2013-2022](#)
- 4 Independent Forensic Mental Health Review : final report (www.gov.scot)
- 5 Scottish Legal News, [Thomas Ross KC: When did Scotland become a rogue nation?](#) (July 2023); Irish Legal News, [Germany refuses man's extradition to UK over jail concerns](#), (September 2023).
- 6 UK NPM, [Scotland's progress in the prevention of ill-treatment in places of detention: An assessment of the implementation of recommendations made by the European Committee for the Prevention of Torture](#) (August 2021).
- 7 The Scottish Public Health Observatory
- 8 Health and Sport Committee, [Healthcare in Prisons](#) (May 2017)
- 9 HMIPS, [A Thematic Review Of Segregation In Scottish Prisons](#) (2023).
- 10 HMIPS et al, 'Independent Review of the Response to Deaths in Prison Custody', (November 2021).
- 11 Letter from Cabinet Secretary to Convenor of Justice Committee, 7 November 2019
- 12 HMIPS et al, 'Independent Review of the Response to Deaths in Prison Custody', (November 2021).
- 13 HMIPS et al, 'Independent Review of the Response to Deaths in Prison Custody', (November 2021).
- 14 Scottish Government, 'News: Death in custody review' (November 2021)
- 15 Scottish Government, [Deaths in Prison Custody Action Group – gov.scot](#) (www.gov.scot)
- 16 Scottish Government, [Independent Review of the Response to Deaths in Prison Custody – Second progress report – gov.scot](#) (www.gov.scot) (12 February 2024).
- 17 Scottish Government, [Independent Review of the Response to Deaths in Prison Custody – Second progress report – gov.scot](#) (www.gov.scot) (12 February 2024).
- 18 Scottish Government, [Independent Review of the Response to Deaths in Prison Custody – Second progress report – gov.scot](#) (www.gov.scot) (12 February 2024).
- 19 Scottish Government, [Independent Review of the Response to Deaths in Prison Custody – Second progress report – gov.scot](#) (www.gov.scot) (12 February 2024). Additional information provided directly by Scottish Government

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- 23 Mental Welfare Commission for Scotland, [Investigating Deaths Occurring during Compulsory Care and Treatment under Mental Health Legislation in Scotland: Final report to the Scottish Government, March 2022](#) (March 2022).
- 24 See answer by Minister for Community Safety (Elena Whitham), 'Question Reference: S6O-01538' (10 November 2022).
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- 26 [Inquiries into Fatal Accidents and Sudden Deaths etc \(Scotland\) Act 2016](#)
- 27 Crown Office and Procurator Fiscal Service, 'Strategic Plan 2023-27'(19 April 2023).
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- 30 Crown Office and Procurator Fiscal Service, 'Business Plan 2023-24' (19 April 2023).
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- 36 Inspectorate of Prosecution in Scotland, 'Follow-up Review of Fatal Accident Inquiries' (August 2019) 49.
- 37 Scottish Government, [Independent Review of the Response to Deaths in Prison Custody – Second progress report – gov.scot \(www.gov.scot\)](#) (12 February 2024).
- 38 HMIPS et al, [Independent Review of the Response to Deaths in Prison Custody: Responses from Families](#) (November 2021).

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- 40 The Scottish Centre for Crime and Justice Research, '[Nothing to see here? Deaths in custody and FAIs in Scotland 2023](#)' (5 February 2024) 42.
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- 42 Scottish Prison Service, '[Talk to Me: Prevention of Suicide in Prison Strategy 2016-2021](#)' (November 2015) 4.
- 43 Scottish Government and COSLA, '[Creating Hope Together: Year 1 Delivery Plan 2023-24](#)' (December 2023) 10.
- 44 Scottish Government, '[Equality and Fairer Scotland Budget Statement 2024-25](#)' (19 December 2023) 21.
- 45 Scottish Government, '[Annex B: Equality and Fairer Scotland Budget Statement 2024-25](#)' (19 December 2024) 68.
- 46 HMIPS, '[Report on an Expert Review of the Provision of Mental Health Services, For Young People Entering and in Custody at HMPYOI Polmont](#)' (May 2019).
- 47 Mental Welfare Commission, '[Mental health in Scotland's prisons 2021: Under-served and under-resourced. Closure Report](#)' (April 2023) 10.
- 48 Mental Welfare Commission for Scotland, '[Visit report- Mental health support in Scotland's prisons 2021: under-served and under-resourced](#)' (April 2022) 10.
- 49 Scottish Prison Service, '[SPS Delivery Plan 2023-24](#)' (April 2023).
- 50 The Scottish Centre for Crime and Justice Research, '[Still nothing to see here? One year update on prison deaths and FAI outcomes in Scotland](#)' (November 2022) 21.
- 51 Scottish Government, '[Deaths in Prison Custody in Scotland 2012-2022](#)' (August 2023); Scottish Prison Service, '[Deaths in Custody](#)'.
- 52 Mental Welfare Commission for Scotland, '[Visit report- Mental health support in Scotland's prisons 2021: under-served and under-resourced](#)' (April 2022) 39.
- 53 Scottish Prison Service, '[Model Publication Scheme Guide to Information](#)' (February 2022).
- 54 Mental Welfare Commission, '[Mental Health Act monitoring report 2022-23](#)' (October 2023) 58.
- 55 Scottish Government, '[Policy: Reducing reoffending](#)' (April 2024).
- 56 Relevant Legislation that has been passed or introduced includes:
 - The [Community Justice \(Scotland\) Act](#), which came into force in 2016. The Act defines the meaning of community justice and gives effect to bail conditions, community disposals and post-release requirements. It established a public body 'Community Justice Scotland' (CJS), defining its functions and powers, and set a requirement for CJS to publish a national strategy and an outcomes improvement plan. It also denoted key statutory community justice partners and third sector involvement.

- The [Presumption Against Short Periods of Imprisonment \(Scotland\) Order](#) 2019 extended the presumption against short-term sentences from three months to twelve months for offences committed on or after 4th July. This is based on evidence that people who have completed short term sentences are more likely to reoffend.
- The [Management of Offenders \(Scotland\) Act](#) 2019 introduced some changes to the criminal justice system- mainly in relation to provision of electronic monitoring and other restrictive measures of offenders, reduced the periods for disclosure of convictions and allowed for longer term prison sentences to become 'spent'. It also made changes to the Parole Board for Scotland.
- The [Bail and Release from Custody \(Scotland\) Act](#) 2023 introduced a number of reforms seeking to refocus how imprisonment is used. It was intended to ensure that custody for remand is used as a last resort and give greater focus to rehabilitation and reintegration of individuals leaving custody. It made changes to the law in two main areas- in relation to decisions about granting bail to people accused of a crime and in relation to arrangements for the release of some prisoners and support that is provided to those who leave prison.

Relevant Policy/ Strategy:

- The Scottish Government's, [Vison for Justice](#), published in 2022 seeks to improve outcomes for individuals, focusing on prevention and early intervention and ensuring the right services are provided at the right time. It seeks to shift the balance from use of custody towards justice in the community, with a particular focus also on women and children in the justice system. It also prioritises victims' voices being heard.
- A [National Strategy for Community Justice](#) was also published in June 2022, setting out four national aims and 13 priority actions. The aims include optimising the use of **diversion and intervention** at earliest opportunity, ensuring consistency of interventions across Scotland, ensuring that services are accessible and strengthening leadership, engagement and partnership working of local and national community justice partners. A [Community Justice Delivery plan](#) was subsequently published in June 2023 which outlines how the aims of the strategy will be delivered, along with timescales for delivery.

A number of other strategies interact with the above, including but not exclusively:

- [Restorative justice: action plan – gov. scot \(www.gov.scot\)](#)
- [Violence prevention framework – gov. scot \(www.gov.scot\)](#)
- [Equally Safe strategy – Violence against women and girls \(VAWG\) – gov.scot \(www.gov.scot\)](#)

- 57 Scottish Government, [The Vision for Justice in Scotland](#) (8 February 2022).
- 58 Scottish Government, 'Scotland's prison population: Ministerial statement' (27 February 2024).
- 59 In their evidence to the Criminal Justice Committee in 2023 as part of pre-budget scrutiny, COSLA and Social Work Scotland highlighted that funding for justice social work has fallen short for a number of years while noting that there have been increases to all key parts of the criminal justice budget except justice social work. They consequently recommend that a thorough assessment is made of the resource requirements of the service to ensure it is properly funded going forward. [Response 316486734 to Criminal Justice Pre-Budget scrutiny: 2024-25 – Scottish Parliament – Citizen Space](#)
- 60 Community Justice Scotland, [Community Justice Outcome Activity Annual Report 2022-2023](#)
- 61 See [Social work Scotland response](#) to the public consultation on the Bail and Release from Custody (Scotland) Bill; See [COSLA response](#) the public consultation on the Bail and Release from Custody (Scotland) Bill.
- 62 Community Justice Scotland, [Community Justice Outcome Activity Annual Report 2022-2023](#)
- 63 Information provided directly by Scottish Government
- 64 Council of Europe and University of Lausanne, [Prisons and Prisoners in Europe 2022](#) (26 June 2023).
- 65 See latest stats at [SPS Prison Population](#)
- 66 Audit Scotland, [The 2022/23 audit of the Scottish Prison Service](#) (December 2023)
- 67 Audit Scotland, [The 2022/23 audit of the Scottish Prison Service](#) (December 2023)
- 68 BBC News, [‘Scottish prison boss says ‘we can’t take any more’](#) (5 February 2024).
- 69 See, [HMIPS response](#) to public consultation on the the Bail and Release from Custody (Scotland) Bill. See also: [Scottish Prison Population Statistics 2021-22 – gov.scot](#) (www.gov.scot)
- 70 [Fraser of Allander, Crime, Imprisonment, and its Cost in Scotland](#) (June 2023)
- 71 Scottish Government, 'Criminal Proceedings in Scotland 2021-22' (24 October 2023).
- 72 8,169 people received custodial sentences which was an increase of 13% from the previous year. Custodial sentences represented 14% of all sentences imposed for convictions in 2021-22, with the average length of sentencing being 376 days (14% longer than in 2020-21) [Criminal Proceedings in Scotland 2021-22 – gov.scot](#) (www.gov.scot)
- 73 IPS et al, [Diversion from prosecution: joint review](#) (21 February 2023).
- 74 Audit Scotland, [Criminal courts backlog | Audit Scotland](#) (25 May 2023).
- 75 Scottish Government, [Annex A.6 – Justice & Home Affairs – Scottish Budget: 2024 to 2025 – gov.scot](#) (www.gov.scot) (December 2023).
- 76 Scottish Parliament, 'Pre-budget Scrutiny 2024-25 Report (24 November 2023).

- 77 Audit Scotland, [Criminal courts backlog | Audit Scotland](#) (25 May 2023).
- 78 Scottish Government, '[Infrastructure Investment Plan 2021-22 to 2025-26: major capital projects progress update](#) (March 2023).
- 79 SPS, [Strategy for Women in Custody 2021-25](#)
- 80 SPS, [Vision for Young People in Custody 2021](#)
- 81 For example, see IPM monitoring reports for HMP Inverness, HMP Kilmarnock and HMP Perth, available at: [Publications | HMIPS](#) (prisonsinspectoratescotland.gov.uk)
- 82 SPS, [Strategy for Women in Custody 2021-25](#) (2021).
- 83 SPS, [Vision for Young People in Custody 2021](#) (2021).
- 84 For example see: HMIPS, [–Report on the full inspection of HMP Dumfries](#) (January 2020).
- 85 See HMIPS IPM Monitoring reports for HMP Greenock, HMP Barlinnie, HMP Inverness, HMP Glenochil, HMP Perth, HMP Edinburgh and HMP Shotts, available at: [Publications | HMIPS](#) . See also full inspection reports for HMP Shotts, available at: HMIPS – [HMP Shotts Full Inspection Report](#) (May 2022
- 86 For example see HMIPS, [HMP Perth – Full Inspection Report – May 2023](#); [HMP Greenock – Full Inspection Report – February 2023](#)
- 87 See, [HMIPS response](#) to public consultation on the Bail and Release from Custody (Scotland) Bill
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- 91 SPS, [Infrastructure Commission For Scotland Report](#) (May 2019)
- 92 SPS, [Infrastructure Commission For Scotland Report](#) (May 2019)
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- 94 BBC News, '[Barlinnie prison at risk of catastrophic failure, says governor](#)' (4 August 2023).
- 95 Scottish Parliament, [Official report, Meeting of the Parliament](#) (31 January 2024).
- 96 Scottish Parliament, [Question reference: S6W-22566](#)
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- 98 Scottish Parliament, [Official report, Meeting of the Parliament](#) (31 January 2024).
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101 Publications | HMIPS

102 Common themes that emerged in both the IPM monitoring reports and inspection reports include:

- **Overcrowding** where cells designed for one had been adapted for two people, resulting in cramped conditions and failure to meet requirement of 4m² for each prisoner as prescribed by CPT. In 2022/23, Barlinnie was exceeding operating capacity by 20.8%, while Inverness was operating at 10% above the design capacity at various points throughout the year. A high percentage of remand prisoners was recorded in HMP Inverness.
- **Poor Material Conditions** of some of the prison estate which impacted on decency. This was largely due to the age of some of the buildings and included examples of damp cells and cells with poor quality light and lack of access to green space. There were also issues of cleanliness recorded in one or two other prisons. One prison (HMP Addiewell) was noted to be 'chronically undersupplied' with bedding (sheets, duvet and towels) and kitchen crockery and cutlery which meant that prisoner regularly slept without appropriate bedding. Hygiene products were also not available on the halls. Some of the prisons noted a lack of privacy in relation to toilets and showers.
- **SPS staff shortages** were having detrimental impact on various aspects of prison life across a number of the prisons.
- **Access to a comprehensive regime and excessive time spent in cells-** This was often attributed to staff shortages, but was also impacted by the complex task of managing different categories of prisoners safely. A restricted regime created perceived and real impact on **progression of prisoners**. Lack of work (e.g. closure of work sheds) and education opportunities and lack of evening activities were noted in some prisons, as were lack of training and accredited programmes.
- Some prison inspection and IPM reports noted that not all prisoners were getting a full hour of exercise in the fresh air each day. This was due to a variety of factors including the timing of the session, clashes with other elements of the regime and lack of access to appropriate clothing or shelter. Some categories of prisoners were getting less fresh air than others in one or two prisons. Lack of access to appropriate clothing for outdoor exercise was raised in the inspection report for HMP Perth.
- **Substance misuse:** There were concerns about the influx of illicit substances or drugs into prison.
- **Violence:** although violence appeared to be mostly well managed with prisoners reporting feeling safe in the majority of the prisons, some prisons observed peaks in violence at particular times throughout the year-sometimes linked to substance use and there were a couple of prisons where violence was a significant concern, with staff and prisoners reporting feeling unsafe.

- **Healthcare Provision:** Healthcare staffing issues were noted, resulting in long delays. In particular there were long waiting times for GP appointments, addiction support and mental health assessments and treatment. There were also occasional issues with medication, with reports of the wrong medication having been administered in two prisons. Low staffing impacted on the timing of medication in some prisons, with evening medication often being administered in late afternoon which was not appropriate. In HMP Addiewell, there had been two cases where failure to provide medical treatment could have had serious consequences (one being a fracture which wasn't sent for x-ray for almost 2 weeks, the other a suspected case of sepsis not being seen for several hours). Both were due to a breakdown in communication between prison and NHS.
- **GEOAmey Failures:** GEOAmey failures were also creating impacts for prisons, with issues of missed medical appointments and court hearings being documented.
- **Use of Segregation:** While IMPs observed that SRUs were generally well run, they were concerned about their excessive and prolonged use. However, it was noted that Polmont had done 'amazing' work on reducing the population held in SRU.

103 This is based on data provided to SHRC by SPS. It covers the years 2021-22; 2022-23 and 2023-24

104 See for example [HMP Polmont 2023](#), [HMP Shotts 2022](#)

105 [HMP Inverness 2022](#)

106 The Scottish Government stated in their [response to the Independent Review into the Delivery of Forensic Mental Health Services](#) that it “recognises the importance of good quality data and information in managing services, transitions and in improving the quality and performance of services.” They highlighted that they would “work with Public Health Scotland, the Forensic Network and providers of forensic mental health services to assess what is needed in data management systems, in the context of work to improve the availability and quality of performance and outcomes data in all mental health services.” No evidence has been found of action taken on this.

SPS has included “**Data & Evidence**” as a key factor in their 2023-28 corporate plan, stating that:

*“To deliver, and improve Scotland’s prison system, we must start by understanding what works well, and what could be better. We need to understand how the system could be different and what we could learn from others, and use this to continually improve our service and organisation. **All of this is reliant on robust data and evidence** [emphasis added]. This evidence will come to us in a range of forms and from a variety of sources. We will build on our structured research programme and focus on how we best use our data to improve our services. Speaking and, more importantly, listening to people with lived experience, having spent time in our care or knowing somebody who has, is fundamental to effective public service design, delivery, and improvement, and something that we will further embed*

in our work. Good evidence is also generated through, and dependent on, solid assurance and audit processes. We will therefore be introducing an improved 'Planning, Assurance and Control' model within SPS to support this across the organisation." [SPS Corporate Plan 2023-28](#), p. 23

- 107 See for example [HMP Perth 2023](#), [HMP Polmont 2023](#), [HMP Addiewell 2023](#). According to HMIPS Inspection Report of HMP Perth in 2023, "While informal resolution should not be discouraged, the outcome of the discussion and the prisoner's views must be recorded. This will allow for a true reflection of issues to be identified and analysed by prison management, improving outcomes for prisoners and staff."
- 108 • [HMP Edinburgh – Pre-inspection Survey Results, September 2023](#) p.16
- [HMP YOI Polmont Inspection report 2023](#), p.24
- [Pre-Inspection Survey Full Report – Perth 2023](#) p.16
- [Pre-inspection survey – HMP Greenock 2023](#) p.16
- [Pre-inspection survey Addiewell 2022](#) p.15
- [HMP Castle Huntly Pre-Inspection Survey 2022](#), p.15
- [HMP Shotts Pre-Inspection survey findings, 2022](#) p.13
- [Report on HMP Low Moss Full Inspection 2022](#), p.10
- [Report on Full Inspection of HMP Kilmarnock 2021](#), p.82
- 109 For example, at the recent HMP YOI Polmont inspection, it was found that "[n]ot all halls with foreign nationals held complaints forms in the relevant languages" and that "[g]iven the high level of literacy deficits, using a complaints system that requires literacy could also be deemed inhibitory." [HMP YOI Polmont inspection 2023](#). At the 2023 HMP Perth inspection, HMIPS found issues with the equality and diversity complaints system, including concerns that "E&D champions were in need of further training and support [and] E&D complaints [were] not being recorded and monitored effectively." [HMP Perth Inspection Report 2023](#)
- 110 Open recommendations from 2018 (still not completed as of 2023 inspection) include:
- "HMP YOI Polmont should ensure that complaints paperwork is available in a range of formats with guidance available on how to access. [Polmont inspection 2023](#), p.63
- [2023 update] Complaints forms were available on all halls but not in a range of formats. Not all halls held them in the languages spoken in the halls"
- 111 According to their [2023-28 Corporate Plan](#), the SPS aim to "[encourage] staff to take ownership of their professional development and embrace learning opportunities" p. 23
- 112 [SPS Corporate Plan 2023-28](#)

- 113 The course content includes an introduction to trauma and its causes, the NES trauma framework, impact of trauma on prisoners and staff and how to support/work in a trauma informed manner. [Independent Review of the Response to Deaths in Prison Custody – Follow up on progress report](#), December 2022, p. 25
- 114 E.g. [HMIPS – HMP Shotts Full Inspection Report – May 22](#) (May 2022) 07.
- 115 SPS, [SPS Annual Delivery Plan 2023 – 24](#) (2023)
- 116 SPS, [SPS Annual Report and Accounts 2022/23](#) (2022) 37.
- 117 For example:
- The 2023 HMIPS inspection report on HMPYOI Polmont expressed concern about “the high number of staff who had fallen out of competency around both TTM training and Emergency Response.” The report argued that “HMP YOI Polmont must ensure that priority is given to mandatory core role training which is for the welfare of both prisoners and staff.” Further, due to the implementation of a pilot for a new Control and Restraint training (C&R Phase 2), many prison officers had fallen out of competency with C&R Phase 1, which was required for Mutual Aid. HMIPS highlighted that “the pool of staff available to become part of the Mutual Aid response was severely limited, and potentially most were officers within their first year of service having completed C&R Phase 1 as a mandatory part of the officer initial recruit training at SPS College.”
 - The 2023 HMP Perth inspection report highlighted “There was an established training programme...[h]owever, at the time of our inspection the prison was well behind where it would have wished to be in terms of core competency training.” Specifically, “C&R training compliance at the time of the inspection was 76% with PPT at 63%.”
 - At HMP Greenock, a prison which had not experienced the staffing issues common in other prisons, and had a full complement of staff at the time of the 2023 inspection, still had issues with full adherence to training, including First Aid, manual handling. According to the report, “levels of competencies ranged from Fire Awareness online training at 78% to C&R Supervising training sitting at 100%.” A new staff-driven training approach had seen challenges and the prison expects “it will take time for this approach to embed.”
 - The 2022 Inspection of privately-run HMP Addiewell found that “five out of the seven mandatory competencies were under the required levels. Although TTM and H&S were at 100% there were other challenges around PPT and Fire Response which were well below acceptable figures and needed addressing.”
 - At HMP Castle Huntly, HMIPS found in 2022 that “[the areas where the prison were significantly below 90% compliance levels related to C&R, PPT, H&S for Managers, Mentally Healthy Workplaces and E&D. The key priority was C&R, where the prison were inhibited from only having three C&R instructors, below the complement of six, and at the time of our visit were only at 47% compliance.”

- At HMP Shotts (2022), “The prison had an overall record of 78% compliance for core competency training, with significantly lower compliance rates around Personal Protection Training, C&R, Fire Response Procedures and Emergency Response.”
- 118 [HMP Perth Inspection Report 2023](#), p. 116
- 119 Scottish Government, [Understanding the Mental Health Needs of Scotland’s Prison Population](#)
- 120 Scottish Government, [Independent Review of the Response to Deaths in Prison Custody – Second progress report – gov.scot \(www.gov.scot\) \(12 February 2024\)](#). 20.
- 121 Information provided directly by Scottish Government
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- 123 According to the [UK response to the Committee Against Torture in 2023](#), “a foundational understanding of human rights and the Universal Declaration of Human Rights (“UDHR”) [are included] as part of the Scottish Prison Service’s equality and diversity training. In addition, all new Residential Officers are required to undertake further training on the UDHR, the ECHR, and the HRA, with a specific focus on how human rights apply to their professional role and individuals in custody.” p. 13
- 124 [HMP YOI Polmont Inspection report 2023](#), p. 69
- 125 In the [Scottish Government Position Paper on the UNCAT](#) (2019), the response to a specific question asking whether staff are trained in the Istanbul Protocol did not provide any evidence that medical personnel working with detained persons receive this training, and a review of the recently-released [National Trauma Training Framework](#) cited in the position paper does not contain any reference to the protocol.
- 126 Some examples include the [HMP Perth 2023 inspection report](#), in which HMIPS states that “Not uncommon to other establishments, HMP Perth did not have an embedded human rights culture or E&D processes.” (p. 9). Similar comments have been made in the previously cited Greenock inspection report (2022), and suggestions were made that human rights culture could be improved at HMP Inverness (2022) and Castle Huntly (2022). Very serious human rights concerns were raised in the 2023 Addiewell Inspection report.
- 127 [State response to CPT visit 2018](#), p. 25-26
- 128 Supra at note 117
- 129 In a 2023 Committee meeting regarding the Children (Care and Justice) (Scotland) Bill, Natalie Don, Minister for Children, Young People and Keeping the Promise, also stated that “the Scottish Government is content that additional legislative provision in relation to restraint is not necessary to ensure the safety of the child and others. That is because an overly prescriptive approach to minimising restraint practices could have adverse consequences in relation to escalation and criminalisation. Instead, ministers consider that a blended framework of regulation, guidance, practice support and precise reporting

is likely to serve Scotland's children best. Work is on-going with partners to reduce and, where possible, eliminate the use of restraint with children in care. That includes working with the Scottish physical restraint action group to explore definitions of restraint along with the availability of data, training and support.”
[Education, Children and Young People Committee Meeting](#), 3 May 2023

- 130 The Prisons and Young Offenders Institutions (Scotland) Rules 2011 SSI 2021/446.
- 131 [Parliamentary question on spit hoods \(2016\)](#)
- 132 [Education, Children and Young People Committee Meeting](#), 3 May 2023
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- 134 SPS, [SPS Annual Report and Accounts 2022/23](#) (2022)23
- 135 Information provided directly by Scottish Government
- 136 SPS, [SPS Annual Report and Accounts 2022/23](#) (2022) 23
- 137 [Letter from CYPSCS, SHRC, EHRC, The Promise and Mental Welfare Commission to Scottish Ministers](#) (November 2023)
- 138 [Letter from Scottish Government to CYPSCS, SHRC, EHRC, The Promise and Mental Welfare Commission](#) (January 2024)

139 Rule 91: Control of prisoners

—(1) In the control of prisoners, an officer must seek—

(a) to influence behaviour by example and leadership; and

(b) to enlist the willing co-operation of prisoners.

(2) An officer may only use force against a prisoner when it is necessary to do so taking into account all of the circumstances of the situation and the force used must be—

(a) proportionate to the risk posed by the prisoner in that situation; and

(b) no more than necessary for the purposes of that situation.

(3) Where an officer uses force against a prisoner that officer must keep a written record of that use of force.

(4) An officer must not deliberately provoke a prisoner.

140 NB: there are statutory reporting mechanisms in place for reporting incidents of restraint and seclusion in residential and secure care [Letter from Scottish Government to CYPSCS, SHRC, EHRC, The Promise and Mental Welfare Commission](#) (January 2024)

141 HMIPS, [Inverness Inspection Report 2022](#) (2022) 33

142 For example HMIPS [Perth Inspection Report 2023](#), p. 38, 117;

- 143 See, eg. HMIPS Inspection Standard 8.1 – HMP Shotts 2022, HMP Castle Huntly 2022, HMP Inverness 2022, HMP Addiewell 2022, HMP Greenock 2023
- 144 [Letter from Scottish Government to CYPSCS, SHRC, EHRC, The Promise and Mental Welfare Commission](#) (January 2024)
- 145 SPS, [SPS Annual Delivery Plan 2023-24](#), (2023) 4
- 146 SPS, [SPS Annual Report and Accounts 2022/23](#) (2022)23
- 147 Information provided directly by Scottish Government
- 148 SPS, [SPS Annual Report and Accounts 2022/23](#) (2022) 23
- 149 [Written question and answer: S6W-21088 | Scottish Parliament Website](#)
- 150 [Response of the United Kingdom Government](#) to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the United Kingdom from 14 to 18 October 2019, p. 10-11
- 151 [Written question and answer: S6W-21089 | Scottish Parliament Website](#)
- 152 [Written question and answer: S6W-21089 | Scottish Parliament Website](#)
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- 161 [NHS Forth Valley Workforce Plan 2022-2025](#); [NHS Lanarkshire Workforce Plan | NHS Lanarkshire Workforce Plan](#); [NHS Greater Glasgow and Clyde Workforce Strategy 2021 – 2025](#) See also: [nhs-greater-glasgow-and-clyde-evidence-pack.pdf](#) ([parliament.scot](#))
- 162 [NHS Dumfries and Galloway Health and Social Care Workforce Plan 2022-25](#); [NHS Highland 3 year strategic workforce plan](#)
- 163 See [Improving prisoner healthcare – gov.scot](#) ([www.gov.scot](#))
- 164 Scottish Government, [Scottish Budget 2024-25](#) (December 2023). 37
- 165 For example, see workforce plans for [NHS Forth Valley](#); [NHS Lanarkshire](#) and [NHS Glasgow and Greater Clyde](#)

- 166 For example see IPM Monitoring report for HMP Greenock, available at: [Publications | HMIPS](#)
- 167 Scottish Government, [Understanding the Physical Health Care Needs of Scotland's Prison Population](#)
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- 177 [Letter from Cabinet Secretary for Justice and Veterans to the Health, Social Care and Sport Committee](#) enclosing Action Plan of the Expert Review of the Provision of Mental Health and Support Services for Young People Entering Custody at HMP&YOI Polmont, 28 June 2022
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