SHRC
Scottish
Human Rights
Commission

Fatal Accident Inquiry Review: Call for Evidence

18 September 2025

The Scottish Human Rights Commission (SHRC) is a public body created by the Scottish Commission for Human Rights Act 2006.

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 SHRC 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.

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Introduction

The Scottish Human Rights Commission (SHRC) has been concerned about the human rights implications of Scotland's high rate of deaths in detention for a number of years.[1] Our current 2024-2028 Strategic Plan highlights human rights in places of detention, specifically the right to life and deaths in custody, as one of our priority areas of focus.

When a person enters detention, responsibility for their care and their lives lies solely in the hands of the State. The right to life, protected principally by Article 2 of the European Convention on Human Rights (ECHR), requires the State to refrain from unlawfully taking life and to take actions to proactively protect life. Where deaths do occur, the State must conduct effective, transparent, independent and impartial investigations, with involvement of a person's next of kin, to ensure accountability and to prevent similar loss of life in future.

The SHRC welcomes the opportunity to respond to the 2025 Fatal Accident Inquiry Review's call for evidence and looks forward to continuing to engage with the Review over the coming months. We have structured our response in the following way, in the hope that it will be useful to the Review, to other stakeholders working in this area, and to families and friends of those who have died in Scotland's places of detention:

- Background: a brief overview of SHRC's work on deaths in detention
- The human rights framework relevant to the investigation of deaths in detention and Fatal Accident Inquiries
- Required improvements
- A rights-based approach to reform

It should be noted that the majority of SHRC's detailed work on deaths in detention relates to prison deaths, although the human rights framework outlined below applies equally to all deaths where there may be State responsibility.

Background: a brief overview of SHRC's work on deaths in detention

In 2021, the Independent Review of the Response to Deaths in Prison Custody was published (Deaths in Custody Review). The Deaths in Custody Review was co-chaired by the former HM Chief Inspector of Prisons for Scotland; the Chief Executive of Families Outside; and the former Chair of the SHRC. Alongside the

SHRC's role as co-chair, the SHRC also conducted much of the research and was responsible for the human rights analysis for the Deaths in Custody Review. The Deaths in Custody Review made a number of recommendations for improving processes following a death in prison custody. While the terms of reference of the Deaths in Custody Review specifically excluded Fatal Accident Inquiries (FAIs) from its remit, our research - both desk-based and through interviews with those impacted by deaths in prison custody - highlighted FAIs as an area in need of significant improvement.

Following the Deaths in Custody Review, in July 2024 SHRC published a report with the National Preventive Mechanism (NPM) Review, Recommend, Repeat, which reviewed recommendations made by domestic and international human rights bodies over a ten-year period. The report focused on prisons and the forensic mental health estate and centred on recommendations relating to the right to life and the prohibition of torture and inhuman or degrading treatment or punishment. The report highlighted longstanding unimplemented recommendations directly relating to reform of the FAI system and the prevention of suicides in detention.

The SHRC has remained engaged in discussions around the implementation of the recommendations of the Deaths in Custody Review since its publication, and has continued to highlight slow progress and the need for concrete action in relation to Scotland's high rate of deaths in detention, for example through letters to Scottish Parliament Committees, direct engagement with the Scottish Government, through our membership of the NPM and in international treaty monitoring work.[2]

The SHRC has called for the establishment of a National Oversight Mechanism (NOM) to monitor the implementation of all recommendations relating to deaths in detention and to identify systemic trends. SHRC welcomed the Cabinet Secretary's commitment to its establishment in January 2025 and will continue to engage with the Scottish Government and other stakeholders as plans for the NOM evolve.

Finally, the SHRC has commissioned INQUEST to organise a Family Listening Day on 9 October 2025. The Family Listening Day, a model developed by INQUEST, will offer the Chair of the 2025 FAI Review, senior politicians and duty-bearers, policymakers and other stakeholders an opportunity to hear directly from family members about their experiences of the FAI system following their family member's death in custody. Our intention is that the Family Listening Day will inform the analysis and conclusions of this FAI Review and will inform SHRC's future work around the human rights implications of deaths in detention. The report of the Family Listening Day will be published and shared directly with the FAI review and will stand as a permanent record of families' engagement and experiences.

The human rights framework relevant to the investigation of deaths in detention and Fatal Accident Inquiries

There is a substantial body of international legal standards and guidance relevant to deaths in custody and subsequent investigations. In this submission, we have concentrated on the right to life as protected by Article 2 ECHR as it is enforceable under the Human Rights Act 1998 and the Scotland Act 1998. The Deaths in Custody Review and its appendices include a comprehensive account of the full human rights framework, including international standards and guidelines, as it relates to deaths in detention.[3]

The right to life

Article 2 of the ECHR protects the right to life. Article 2 enshrines one of the most fundamental values of the democratic societies making up the Council of Europe. It is an absolute and non-derogable right. This means that the State cannot depart from its obligations even in times of war or other national emergency and the right cannot be restricted or interfered with, except in the very limited circumstances set out in Article 2.

The ultimate aim of Article 2's constituent parts is to protect life; in short, this includes preventing loss of life and investigating deaths where there may be State responsibility, ensuring lessons are learned for the future.

Article 2 is made up of three distinct parts:

- Negative duties to refrain from the taking of life except in very narrow circumstances. Use of force by State agents is strictly regulated.
- Positive duties to ensure the protection of the right to life through effective domestic law and punishment and the duty to protect life through the taking of specific actions.
- Procedural obligation to undertake effective investigations when a life has been lost in circumstances that may engage State responsibility.

For the purposes of this evidence, we concentrate on the procedural aspect of Article 2 as it relates to the investigation of deaths. In Scotland, the primary means by which the State discharges its Article 2 obligations is through the FAI system. All deaths in State detention could potentially engage State responsibility, so are therefore all subject to Article 2 investigation requirements.[4]

The standards of investigation required by Article 2 can be summarised as follows:

Independence

Those carrying out the investigation must be independent from those implicated in the events. This requires "not only a lack of hierarchical or institutional connection but also a practical independence".[5]

Adequacy

An adequate investigation is one that is capable of gathering evidence sufficient to determine if the behaviour or inactivity was unlawful.[6] Where there has been a use of force by State agents, the investigation must be adequate and effective in that it should be capable of leading to a determination of whether the force used was justified.[7]

Promptness and reasonable expedition

The European Court of Human Rights (ECtHR) has stressed that a prompt investigatory response is generally regarded as essential in maintaining public confidence in a State's adherence to the rule of law and in preventing the appearance or perception of a State's collusion in or tolerance of unlawful acts.[8] The ECtHR has also found that the passage of time is liable to undermine an investigation and will compromise the chances of it being completed.[9]

Public scrutiny and participation of next of kin

In all cases, there must be involvement of a deceased's next of kin to the extent necessary to safeguard their legitimate interests.[10] There will often be a lack of public scrutiny of Police investigations; however this can be compensated for by providing access for the public or a person's relatives during other stages of the available procedures.[11]

Non-discrimination

Non-discrimination is a central principle of human rights protection. Article 14 ECHR protects the right not to be discriminated against in "the enjoyment of the rights and freedoms set out in the Convention". The ECtHR has defined discrimination as "treating differently, without an objective and reasonable justification, persons in relatively similar situations".[12] It should be noted that Article 14 prohibits discrimination in the enjoyment of any ECHR right "on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or any other status". It is therefore

not limited to the protected characteristics contained in the Equality Act 2010 or to protections contained in the UN group protection treaties, such as the Convention on the Rights of the Child, or the Convention on the Elimination of All Forms of Discrimination against Women.

Article 2 taken together with Article 14 requires investigations to pay particular attention to questions of prejudice and discrimination and whether this may have been a factor in a person's death.

Improvements required

SHRC has analysed the human rights requirements around investigation of deaths in detention and the practice in Scotland and has a number of concerns about the way the current FAI system operates. SHRC previously outlined these concerns in a 2023 letter to the Convener of the Scottish Parliament Criminal Justice Committee, and we take the opportunity to expand below.

Long time periods between a death and an FAI

Article 2 requires a prompt and timely investigation. As set out above, the ECtHR has cautioned that investigations must be timely to maintain public confidence in the State's adherence to the Rule of Law, and also to ensure that evidence is not compromised by the passage of long periods of time. The circumstances of each death, and therefore the time taken to complete an investigation, vary. That said, there is too often an extremely long time period between a death and an FAI being held. Our report, 'Review, Recommend, Repeat', highlighted that in 2018, the European Committee for the Prevention of Torture recommended that authorities "review the operation of the overall FAI system to find solutions to speed up the process". The Scottish Government did not accept this recommendation.[13]

Despite legislative reform in 2016,[14] a review carried out by the Inspectorate of Prosecution in Scotland (IPS) in 2019 noted that "while COPFS continues to meet 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".[15]

Research by the Scottish Centre for Crime & Justice Research (SCCJR), published in April 2025, highlights the time taken to complete an FAI as a key concern.[16] The average time taken across all types of deaths and detention settings considered by the researchers was around three and a half years. In the time period considered by the research, prison FAIs were completed more quickly than FAIs involving police and mental health deaths, but still took on average nearly three years, with the

longest FAI in that time period taking almost six years. The research also highlights that, looking across a longer period of years, it is possible to compare the time taken for FAIs before the legislative reform referred to above. The research reveals that the time to complete an FAI has increased since legislative change, despite one impetus for reform being recognition that FAIs take too long to complete.

The Deaths in Custody Review noted that families wanted the FAI process to happen much sooner after the death.[17] The External Chair of the Deaths in Prison Custody Action Group 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".[18]

Barriers to family participation in an FAI

Article 2 requires the opportunity for involvement of the deceased's family / next of kin to the extent required to safeguard their legitimate interests. The Deaths in Custody Review highlighted the lack of family involvement in an FAI as a key concern.[19] Family experiences shared with the Deaths in Custody Review revealed that, of the 20 FAIs held within the Review's remit period, in 12 there was no mention of any family involvement. Of the eight families that were involved in the FAI in some way, only two families were formally represented by a solicitor. SCCJR research paints a similar picture, revealing low levels of family involvement in FAIs.[20]

Most families are not legally represented at an FAI.[21] When they are represented, there is often an obvious disparity between the level of representation that different State actors have - for example, the Scottish Prison Service (SPS) or the National Health Service (NHS) - and the representation of families, with reports of State actors instructing multiple lawyers in FAI proceedings, and families often only being represented by one solicitor.[22]

The Deaths in Custody Review recommended that families or next of kin of those who have died in custody should have access to free and immediate non-means-tested Legal Aid funding for specialist representation to allow for their participation in the different legal processes that take place following a death in custody. This accords with recommendations made by Dame Elish Angiolini's independent review in relation to police complaints handling, investigation and misconduct issues.[23] SHRC welcomes the Scottish Government's commitment to introducing non-means tested Legal Aid for families of those who have died in detention. This entitlement should start from the outset and should ensure family representation for involvement in all post-death formal processes.

Format of the FAI

Article 2 ECHR is concerned with the adequacy of an investigation into a death. This means that FAIs must be capable of gathering sufficient evidence to determine the facts surrounding a particular death and be able to identify learning points to ensure prevention of deaths in similar circumstances. Investigations must also be independent and be conducted in a way that allows for public scrutiny of the investigation.

Adversarial nature

FAIs are conducted in front of a Sheriff, usually in a court setting. The Deaths in Custody Review reported that families and staff called to give evidence at an FAI found the process intimidating and adversarial.[24] The purpose of an FAI is to establish what happened and prevent future deaths from happening in similar circumstances.[25] The Deaths in Custody Review reported that many people involved in the FAI process felt the FAI was less about trying to arrive at the facts of what happened, and more about trying to apportion or avoid blame.

Joint minutes of agreement

The agreement of joint minutes between parties at an FAI is, in SHRC's view, a practice that has the potential to negatively impact the depth of scrutiny afforded to certain deaths.

A joint minute of agreement is a document agreed by all parties to proceedings on issues where there is no dispute. They are commonly used in court proceedings as a means to focus the court's time on matters that are in dispute. While there are matters for which joint minutes are appropriate, they should be used with caution. The Deaths in Custody Review reported that of the 20 FAIs considered by the Review, 19 were agreed by joint minute, with only a handful calling witnesses before formal findings were declared.

SSCJR research also considers the use of joint minutes, concluding they raise questions about the independence and transparency of the FAI system. According to this research, where the entirety of the evidence in an FAI was contained in the joint minute, it was much more likely that the only parties to the FAI were State actors (95% of the time).[26] When families were parties to the FAI and were legally represented, it was much more likely that oral evidence and witnesses would be part of the FAI process.[27]

Lack of systemic focus and impact

The SHRC is further concerned that the current FAI system lacks systemic focus and impact. Both the Deaths in Custody Review and SSCJR research raise questions around the number of FAIs where no reasonable precaution is made, no finding of defect is made, and no recommendations are made that might improve practice or prevent deaths.[28] It is to be welcomed that the Scottish Government is progressing with plans to establish a National Oversight Mechanism, which is a mechanism to track, collate and analyse recommendations flowing from deaths in detention. However, the NOM will only serve its purpose if adequately considered and relevant recommendations are made in the first place. Similarly, while some FAIs have been heard together and some Sheriffs have referred to similar past FAIs in their determinations, there is no consistent mechanism requiring Sheriffs to take a more systemic approach. This means that many deaths continue to be considered in isolation.

A significant number of deaths in Scotland's prisons are caused by health conditions. Scottish Government data reveals that the second most frequent cause of death in prison custody between 2012-13 and 2022-23 was diseases of the circulatory system, accounting for 20.6% of deaths overall.[29] Deaths caused by cancer accounted for around 10.4% deaths in prison in that same period.[30] Article 2 investigations should interrogate all matters relevant to a person's death, including access to appropriate healthcare and opportunities for treatment. SSCJR research reveals that very few FAIs published in the relevant year made any finding in any of the deaths related to health conditions and incidents, with researchers questioning why these deaths seem to be treated as "unproblematic deaths and inquiries".[31]

SHRC is concerned that the current system of investigation of deaths may not place appropriate weight on deaths related to a health incident or health condition. Where a person dies of a health condition, the State's responsibility must still be closely scrutinised.

The DIPLAR process

The Death in Prison Learning Audit & Review (DIPLAR) is the SPS internal process of investigation of deaths in prison custody. Although internal processes, such as the DIPLAR, have a role to play in the prevention of deaths in detention, they are the prison service's own account of events, and their assessment of improvements required. As such they are not independent. Although they are often produced as evidence and are referred to in FAIs, it is the view of the SHRC that reliance on them

should be approached with significant caution in order to ensure investigations are compliant with the independence requirements of Article 2.

A rights-based approach to reform

As the National Human Rights Institution, the SHRC is focused on the human rights requirements of the system of investigation of deaths in detention. Above, we have pointed to areas of the FAI system we believe must be improved as a matter of urgency. However, it is not for the SHRC to make detailed recommendations or proposals around the specifics of reform. Rather, it is for duty bearers such as the Scottish Government and those with operational responsibility for the care of people in custody and the investigation of deaths to consider detailed reforms that adhere to human rights best practice and are practically workable in the Scottish domestic context.

In this section, following on from our assessment of the key problems with the current system, we suggest three overarching principles duty-bearers should use to structure their approach to reform of the system.

Listen to families

Key to a human rights-based approach is the meaningful participation of people with lived experience of human rights issues.[32] Reform of the system must place the experiences of families of those who have died in detention at its heart.

This is why the SHRC has commissioned INQUEST to organise a Family Listening Day around the FAI system. Senior public officials and Sheriff Principal Abercrombie, Chair of the 2025 FAI Review, have been invited to hear families' experiences of the FAI system and their thoughts on what must change. A standalone report of the Family Listening Day will be published and should be considered carefully by this Review.

Ground the system explicitly in human rights

The system, as it currently stands, is not explicitly grounded in human rights. Although the FAI may be the primary mechanism by which the State discharges its Article 2 duties following a death in detention, it is not designed around the requirements of Article 2, and there is little evidence that those responsible for carrying out FAIs are doing so in a way that explicitly considers human rights. For example, content published by COPFS explaining their role in investigating deaths is silent on the human rights requirements underpinning investigations of deaths in

detention.[33] Similarly, the legislation governing the conduct of FAIs fails to explicitly mention Article 2.[34]

There should be a much stronger and more explicit emphasis on Article 2 throughout the system. For example, when a person dies in custody, an approach based on Article 2 would see State authorities, as a matter of course, informing families of their rights under Article 2, providing information on how to obtain legal representation and encouraging their participation in an FAI to maximise scrutiny and transparency.

More explicit focus on Article 2 requirements, including consideration of Article 2 caselaw, as part of the formal process may also encourage more in-depth scrutiny on, for example, "natural cause" deaths and questions of appropriate healthcare in detention.

An explicit human rights focus would also emphasise one of the primary purposes of investigation as the prevention of deaths. As part of that emphasis, consideration should be given to whether the FAI system itself should require a more systemic approach, such as requiring evidence to be gathered and presented to the court on similar or related deaths and the status of improvement action being taken.

Linked to the above point, consideration should be given as to what links can be made between the future National Oversight Mechanism and the FAI system in ensuring systemic trends are identified and addressed promptly. This would also include more robust data and transparency in reporting of FAIs, which can, in SHRC's experience, be difficult to access and analyse.

Learn from other systems

The Deaths in Custody Review recommended a separate, independent system of investigation, grounded in human rights, which would complete an investigation around the circumstances of a death in a matter of months. The intention was that the independent investigation could then inform the subsequent direction of the FAI. It was also thought that the independent investigation could help to address the long wait for answers that families face and would ensure quicker learning for the prison and health services following a death. When this key recommendation came to be tested, questions arose as to whether this system was possible in practice given the primacy of the Lord Advocate and her responsibility for the investigation of deaths in detention Scotland. It was decided by the Scottish Government not to progress this recommendation.

Of course, any system must work in Scotland's domestic context; however, this recommendation was based on strengths of comparable systems, and we still

consider a human rights based independent investigation could usefully play a part in Scotland's system.

In England and Wales, following a death in prison custody,[35] the Prisons and Probation Ombudsman (PPO) launches an independent investigation. The PPO investigation is shared with the bereaved family and the relevant service provider (for example the prison service if the person died in prison). The PPO investigation is also sent to the coroner, who is responsible for conducting an inquest to establish how the person died. In England & Wales, although we understand there are significant improvements that could be made to the system,[36] there is a much greater focus on Article 2 requirements.[37] Comparable systems also exist in the Republic of Ireland and in Northern Ireland.[38]

It should also be noted that the Police Investigations & Review Commissioner in Scotland conducts an independent investigation into deaths involving the police when instructed by the Crown Office and Procurator Fiscal Service (COPFS) and then submits its report to COPFS.[39] The SHRC is not clear on the rationale for the difference in the approach to the investigation of police custody deaths and prison deaths and we believe these differing approaches should be closely considered by the Review.

Although the justice systems differ significantly between Scotland and England & Wales, people do not die in markedly different circumstances in Scotland's places of detention. There are exceptions; however, it appears that the average time taken to process an inquest is significantly shorter in England & Wales compared with the time delays experienced in Scotland. Coroner statistics 2024: England and Wales reveal that the estimated average time taken to process an inquest in 2024 was 31.2 weeks.[40] Questions should be asked as to why a comparable jurisdiction is able to process post-death investigations in such as significantly shorter time period.

Conclusion

The SHRC has significant concerns about the way the FAI system operates as a response to deaths in detention in Scotland.

The procedural obligations of Article 2, which Scotland is legally obligated to comply with, require investigations which are: independent; adequate: prompt; transparent; and conducted with the involvement of the deceased's next of kin. SHRC believes a strong argument could be made that, in some instances, Scotland is not meeting those requirements. Among our concerns are persistent long delays between a death and an FAI, barriers to family participation, the format and adequacy of the FAI itself and lack of systemic focus and impact monitoring.

SHRC believes the system of investigation of deaths would benefit from a much greater emphasis on human rights requirements, particularly Article 2 and Article 14 ECHR, and those requirements should be reflected clearly in all stages of the investigation process.

Finally, we trust the Review will put the experiences of bereaved families at the heart of its work and are confident that the forthcoming Family Listening Day will be important in informing and shaping the Review's recommendations.

[1] Deaths in Prison Custody 2012-13 to 2022-23, Official Statistics in Development, March 2025.
[2] SHRC Parallel Report to the United Nations Human Rights Committee on the 8th examination of the United Kingdom of Great Britain and Northern Ireland under the International Covenant on Civil and Political Rights (ICCPR), 4th February 2024; SHRC Letter to Convener of Scottish Parliament Criminal Justice Committee, 11th October 2023.
[3] Independent Review of the Response to Deaths in Prison Custody, November 2021; HMIPS - Death in Custody Review - Appendices, November 2021.
[4] It should be noted that, in Scotland, mandatory FAIs are not in place for deaths in mental health detention. This is an Article 2 compliance gap. Work has been undertaken by the Scottish Government and the Mental Welfare Commission for Scotland to introduce a system of investigation of deaths in mental health detention, but progress appears to have stalled.
[5] Armani da Silva v UK, no. 5878/08, 30 March 2016.
[6] Armani da Silva v UK, no. 5878/08, 30 March 2016.
[7] Armani Da Silva v UK, no. 5878/08, 30 March 2016.
[8] Al-Skeini and Others v UK, no. 55721/07, 7 July 2011.
[9] Mocanu and Others v Romania, nos. 45886/07, 32431/08 and 10865/09, 13 November 2012.
[10] Al-Skeini and Others v UK, no. 55721/07, 7 July 2011.
[11] Hugh Jordon v UK, no. 24746/94, 4 August 2001.
[12] Zarb Adami v Malta, no. 17209/02, 20 September 2006.
[13] See answer by Minister for Community Safety (Elena Whitham), 'Question Reference: S6O-01538' (10 November 2022).
[14] In response to a 2009 review of FAIs (the "Cullen Review"), the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 was passed.
[15] Inspectorate of Prosecution in Scotland, 'Follow-up Review of Fatal Accident Inquiries', August 2019.
[16] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[17] Independent Review of the Response to Deaths in Prison Custody, November 2021, at page 73.
[18] Scottish Government, Independent Review of the Response to Deaths in Prison Custody, Second progress report, 12 February 2024.

[19] Independent Review of the Response to Deaths in Prison Custody, November 2021, at page 71.
[20] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[21] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025; Independent Review of the Response to Deaths in Prison Custody, November 2021, at page 72.
[22] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[23] Independent Review of Complaints Handling, Investigations and Misconduct Issues in Relation to Policing, November 2020.
[24]Independent Review of the Response to Deaths in Prison Custody, November 2021, at page 69.
[25] Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, s 1(3).
[26] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[27] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[28] Independent Review of the Response to Deaths in Prison Custody, November 2021; 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[29] Deaths in Prison Custody 2012-13 to 2022-23 - gov.scot
[30] Deaths in Prison Custody 2012-13 to 2022-23 - gov.scot
[31] 'Nothing to see here?", Deaths in custody and their investigation in Scotland - 2024, Sarah Armstrong, Linda Allan, Rachelle Cobain, Deborah Russa & Betsy Barkas, 29 April 2025.
[32] The SHRC uses the PANEL principles as a way of breaking down what a human rights based approach means in practice. The principles are: Participation; Accountability; Non-discrimination; Empowerment; Legality. More information, including detail on how to take a human rights based approach in practice can be found on our website.
[33] Our role in investigating deaths | COPFS
[34] Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

[35] The PPO has a wider remit than solely prison custody. Investigating deaths – Prisons and Probation Ombudsman
[36] See, for example, the work and recommendations of INQUEST. Justice and Human Rights | Inquest
[37] Article 2 Inquests: An Overview and Update - Landmark Chambers
[38] Independent Review of the Response to Deaths in Prison Custody, November 2021, at pg. 78.
[39] Police and Fire Reform (Scotland) Act 2012, s 62.
[40] Coroners statistics 2024: England and Wales - GOV.UK