SHRC
Scottish
Human Rights
Commission

A "brutal" system:

Families' experiences following a death in custody in Scotland

December 2025

Submission from the Scottish Human Rights Commission to the Independent Review of the FAI system for Article 2 Deaths in State Custody

Scottish Human Rights Commission
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

scottishhumanrights.com

Contents

Foreword

Taking a human rights based approach means grounding analysis and recommendations in the experiences of those affected by human rights issues. The Scottish Human Rights Commission is absolutely clear that Scotland will only improve its system of investigating deaths in detention if decision makers hear, truly listen to, and take account of the experiences of families who have had to go through this investigation process as it has functioned to date. That is why we took the decision to work with the legal charity INQUEST, drawing on their wealth of expertise and experience from work in England & Wales, to hold a Family Listening Day where we heard directly from people who have lost loved ones in detention in Scotland.

It was my privilege to attend the Family Listening Day in October 2025 and meet families who have lost a relative in detention. Their stories were deeply moving and deeply frustrating. While each person's story and loved one was unique, many of their experiences – such as poor treatment by State bodies, delays and a lack of communication – were strikingly similar.

My expectation is that this report, which captures the experiences of families whose loved one has died in detention in their own words, will have the impact it deserves to have on those with the responsibility and authority to change the system.

Scotland has a very high rate of deaths in its places of detention, and these deaths are rising. This is unacceptable and is a grave human rights concern. That so many people die in our places of detention should alarm us all, and Scotland must do better.

When a person enters a place of detention, whether that be prison, police custody, or mental health detention, responsibility for their care and their life lies 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 action to proactively protect life. Where deaths occur, human rights law requires that the State must conduct effective, transparent, independent and impartial investigations, with the involvement of a person's family or next of kin, to ensure accountability and, crucially, to prevent future loss of life in similar circumstances.

The SHRC has long advocated for reform of Scotland's system for investigating deaths in detention. My predecessor co-chaired the Independent Review into the Response to Deaths in Prison Custody, which reported in 2021. That Review recommended multiple, changes to the system. However, the terms of reference for the Review did not allow for explicit consideration of the Fatal Accident Inquiry (FAI) system. Since then, through the SHRC's continued work in this area, together with the growing evidence base of human rights denials,

it has become increasingly clear to the SHRC that Scotland's FAI system must be significantly and quickly reformed.

I welcome the ongoing independent Review of the FAI system, instructed by the Cabinet Secretary for Justice and Home Affairs and led by Sheriff Principal Abercrombie. Sheriff Principal Abercrombie's Review must lead to meaningful change and action. We simply cannot continue in this seemingly endless cycle of new reviews and recommendations while deaths in detention continue to rise.

We need to see policy and system change in Scotland, and ultimately, the goal must be to stop preventable deaths in Scotland's places of detention. Prevention is what drives and underpins human rights legal standards around the response to deaths in detention and must be the collective goal of government and duty bearers.

I end by thanking the INQUEST team for their work, and most importantly thanking everyone who let us listen to their stories.

Professor Angela O'Hagan
Chair of the Commission

About the Scottish Human Rights Commission

Our purpose

We are Scotland’s human rights watchdog. We are the National Human Rights Institution for Scotland, with "A" status accreditation from the UN.

Our job is to work with people and communities to understand their experiences, hold public bodies to account where human rights are not upheld, and help them to do better.

Our vision

A fairer Scotland where human rights are respected, understood, and where there is justice when things go wrong.

Our mission

To be a strong independent authority that works collaboratively to uphold everyone’s human rights in Scotland.

Our values

The Scottish Human Rights Commission (SHRC) delivers our work through the lens of a human rights based approach, known as the PANEL principles.

- Participation
- Accountability
- Non-discrimination, Equality
- Empowerment
- Legality

Acknowledgements

Thank you to INQUEST for their work on facilitating the Family Listening Day and producing this report. This work was awarded after a competitive public procurement process in Summer 2025.

We extend our gratitude to all those families who attended. It is never easy to describe traumatic events. They did so with consideration, honesty, insight, and care for others. We would also like to acknowledge the help and support provided by the Scottish Centre for Crime and Justice Research, Families Outside and lawyers who contacted and supported participating families.

About INQUEST

INQUEST is an independent charity providing expertise on State related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media, and parliamentarians.[1] Their specialist casework includes deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower fire.

Introduction

In June 2024, the Scottish Human Rights Commission (SHRC) and the National Preventative Mechanism (NPM) published an assessment of Scotland's progress in meeting its international human rights obligations in place of detention. The report – Review, Recommend, Repeat[2] - highlighted specifically that despite a recommendation of the Committee for the Prevention of Torture (CPT) to review the Fatal Accident Inquiry (FAI) system, no State-level review of the FAI system has taken place since the CPT made its recommendation in 2018.

On 23rd January 2025, the Cabinet Secretary for Justice and Home Affairs announced to the Scottish Parliament an independent review to consider the Fatal Accident Inquiry system as it relates to deaths in custody. Sheriff Principal Ian Abercrombie was appointed as the Chair of the review on 15th May 2025.

To inform the review process, in July 2025 the SHRC commissioned INQUEST to deliver an event to explore bereaved families' experiences of the FAI process following a death in custody, and to base that in the context of a human rights framework. This involved facilitating a Family Listening Day[3] to hear families' experiences of investigations and FAI hearings, and their recommendations for how the Scottish system could improve. This event was organised with a view to informing an Independent Review into the FAI process following a death in custody, commissioned by the Scottish Government and led by retired Sherrif Principal Ian Abercrombie.[4]

The Family Listening Day took place on 9th October in Glasgow. Bereaved families were invited, resulting in 33 people attending the day, representing 18 families, plus three families unable to attend who sent in written evidence.

Also in attendance were a group of Listeners. Listeners are invited to Family Listening Days to simply hear what families have to say. At this event in Glasgow, there were representatives from the team leading the FAI Review, Scottish Government, the Scottish prisons inspectorate, the police investigations and review commissioner, and the Crown Office. These representatives were invited because of their involvement in investigations which take place after a death in custody. The Chair and senior staff from the SHRC were also in attendance as Listeners.

Attendees spoke with heartfelt honesty, reflection, care and consideration for each other and a generosity of spirit to help the Listeners in attendance understand what it is like to experience the FAI process from start to finish, and the lasting impact beyond the conclusion of the inquiry.

This is the report of the day, shaped by the direct testimony of families which we hope will be used to positively inform the review of the FAI system and prompt further discussions on the treatment of families bereaved following the death of a loved one in custody.

Executive Summary

> I don't want any other family, mother, or father, to go through what my family have gone through. It's hell on earth. You don't ever get over it.

Families were asked a series of questions over the course of the day about their experience of the investigation process following the death of their loved one in prison or in circumstances involving the police. While there was a focus on the FAI hearing, discussions were facilitated so that families' entire journey following the death was covered. The day was broadly divided into the following sessions:

- discussion of families' interaction with various investigation bodies leading up to an FAI;
- experiences of attending the FAI hearing itself;
- and, importantly, families' own recommendations for change.

The experiences shared during the Family Listening Day provide a powerful and deeply human insight into the realities of the Fatal Accident Inquiry process as it is currently experienced by those most affected. Families' testimonies revealed a system that too often compounds their trauma rather than alleviates it, feeling as it does opaque rather than open, confusing rather than accessible, and detached from the values of dignity, justice, and accountability that a human rights framework demands.

Key issues identified

Communication gaps

Families consistently described communication from authorities (i.e. prisons, police, and investigation bodies) after a death as inconsistent, unclear, and highly impersonal. Many families received little to no proactive information about the process and what to expect, leaving them confused and distressed during already traumatic circumstances.

Plain-language explanations were rare. Instead, communication was often technical or legalistic, with minimal effort to ensure families understood their rights or the purpose and status of proceedings.

While some officials demonstrated care and responsiveness, others displayed dismissive or unhelpful attitudes. Several families recounted interactions that felt rude, abrupt, or even hostile and accusatory which further eroded trust.

Overall, participants expressed a strong desire for regular, timely updates and respectful, accessible communication at every stage of the process.

Delays and timeliness

Long delays between the death, the investigation process, and the eventual FAI hearing were common, often taking a lengthy toll on families across many years. This report includes testimony from families who had to wait five or six years between the death of their loved one and the FAI hearing. Families described this prolonged uncertainty as "re-traumatising" because each delay meant a renewed period of grief, anxiety, and lack of closure. The absence of clear information about why delays were occurring further undermined confidence in the system.

Participants consistently called for greater transparency around the reasons for delays, and realistic timescales to prevent unnecessary and unexplained postponements.

Support and information deficits

Families reported very limited access to either emotional or practical support throughout the post-death processes. Many struggled to understand complex legal procedures, their rights within them or what to expect at each stage due to a lack of accessible, centralised information and guidance.

Participants highlighted significant unmet need for tailored support services that could help them navigate legal terminology, manage practical arrangements and cope with the emotional toll of traumatic bereavement.

Legal advice

Crucially, families received little in the way of legal advice or guidance. Those who knew to engage lawyers did so through anecdotal advice. Official advice from the organisations leading investigations on the need to, or benefits of, instructing a lawyer were rare.

Exclusion and lack of transparency

Families frequently described feeling excluded from investigations and key decision-making. There were few meaningful opportunities to contribute their insights, raise questions, or understand how conclusions were being reached.

The process was widely perceived as opaque and defensive, characterised by limited transparency about how and when investigations would be conducted, such as with the process of agreeing joint minutes without the presence of families, whether an FAI would be held and what its likely outcomes might be.

Participants expressed a strong desire for greater openness and involvement at every stage, emphasising that their knowledge and experiences should be valued rather than marginalised.

Narrow scope

Families also felt the scope of investigations and the FAI was too limited, suggesting opportunities for real preventative change were missed. It was felt that more thorough investigations into their loved ones' route into custody, the absence of community support alternatives, prison and police staff training, and broader questions around information sharing had the potential to positively impact future policy and practice change and prevent deaths.

Stigma and dehumanising behaviour

Families reported being treated impersonally, with officials sometimes using dehumanising language or making stigmatising remarks about their loved ones. Families felt their loved ones were regarded as statistics first, humans second.

Families believed their loved ones should have been kept safe in detention. Instead, families felt their relatives were viewed solely through the lens of 'criminality.'

Adversarial State conduct

The FAI hearings were described as intimidating, confusing, and distressing. Families were faced with power imbalances with an army of State lawyers, limited legal representation and a lack of basic consideration for their needs. Many believed the process would ascertain the truth and prevent future deaths, but the reality proved to be an adversarial environment in which the legal might of the authorities dominated, and their resources were utilised to

defend systems that had failed those that died and demeaned families who questioned the quality of care afforded their loved ones. Instead of searching for the truth, and in doing so improving the safety of current and future prisoners, families felt the State acted to defend themselves and deflect blame.

Lack of accountability after the FAI

After the inquiry, families felt abandoned, with little information on what would happen next and no information as to whether recommendations would be implemented. There was also concern about how rarely recommendations were made despite evidence about systemic failings.

The non-binding nature of FAI recommendations was seen as perpetuating systemic neglect. Families mentioned their desire to ensure others did not go through what they had but felt the lack of change meant deaths in custody would continue to blight the lives of other families in the future.

Recommendations for action

At the Listening Day, families made a series of recommendations which are practical steps towards meaningful change. Further detail on families' recommendations can be found in the Conclusion and Recommendations section of this report, but the key recommendations are to:

- Ensure early, humane, and coordinated communication
- Provide independent points of contact for families
- Set and enforce timelines for FAIs
- Guarantee access to legal representation
- Enable meaningful family participation during all investigations following a death
- Humanise all investigation processes
- Strengthen the quality and consistency of FAIs
- Mandate implementation and oversight of recommendations

1. Voicing concerns before the death of a loved one

Many families described trying desperately to raise concerns with prisons, police, or healthcare providers before their loved one died. In several cases, families reported repeated attempts to warn authorities about serious mental health crises, self-harm risks, or physical health problems, yet their concerns were ignored, minimised, or dismissed outright.

"We were raising concerns two days before he died. I'd raised concerns a month and a half earlier. They said, 'what, he's going to kill himself because he's not got a telly?'"

Others shared similar experiences,

"We raised a concern as soon as [loved one] was sentenced. We tried to get appointments with the doctor. The night before [they] took their own life, we raised a concern about their mental health. They told us, 'they'll be fine, we'll look after them'. The next morning [they] were found dead. They had plenty of opportunities to see them."

A relative described the family's concerns about their loved one's self harm, having been contacted by them to try and get a welfare check. The conversation with the prison highlighted a dismissive, callous approach to the family's concerns,

"I said, 'can you please tell me how people get the stuff to self-harm?' He [prison staff] said, 'well if they're going to do it, they'll find a way.'"

"The night before [they] took their own life, we raised a concern about their mental health. They told us, 'they'll be fine, we'll look after them'. The next morning, [they] were found dead.

These testimonies highlight a repeated pattern: families recognising and communicating escalating risks in detention but not being taken seriously. In several cases, families described calling prisons or the police directly to seek help, only for their warnings to be dismissed.

"I phoned the jail that day, pressed 9 to raise concerns for my [loved one]. I specifically said to them, 'I don't want to get that phone call saying my [loved one's] dead.'

It happened four hours later."

For others, pleas for medical or mental health intervention before custody were met with punishment instead of care,

"Prior to him going into prison, [they] were in psychosis. We called for help; six police officers came to the house. We wanted [them] sectioned. Instead, they jailed [them] for breach of the peace. We'd removed everything dangerous from the flat. If we had got the help before then, this wouldn't have happened."

Families linked preventable deaths to systemic failures within prisons, including inadequate staff training and poor information sharing between justice and health services,

"If someone's got ADHD or is on high alert, officers should know how to deal with that."

For many, these reflections were underscored by a profound sense of betrayal,

"When my son was in prison, I thought at least I knew where he was and that he'd be safe."

When my son was in prison, I thought at least I knew where he was and that he'd be safe.

Another added,

> "You never think you're going to have to visit your family in prison, it's horrendous, and you never think they're going die."

Families felt powerless in the face of systems that ignored them. They described the heartbreak of trying to alert institutions to the vulnerabilities of their loved ones, the desire to do something, anything, that had the potential to prompt authorities into action that could save a life. What became clear was that families knew that custody was often the wrong choice when what was needed was therapeutic interventions.

2. The immediate post-death experience

Families described the period immediately following the death of their loved one as profoundly distressing, confusing, and disorientating. Across almost every account, this first point of contact with the State was marked by a striking absence of compassion and candour. Many families spoke of the moment they were told as one that replayed vividly in their minds — an encounter that shaped how they came to view every subsequent stage of the process.

How families were notified

While formal protocols for notifying next of kin may exist, families' experiences revealed that in practice, the methods for informing them of a death were inconsistent and frequently insensitive. People were often informed abruptly, with minimal explanation, offered no emotional support, and no indication of what would happen next. Some were told by police officers who arrived at their homes without warning; others heard from social workers, chaplains, or hospital staff, all too often with little empathy or care.

For many, the way the news was delivered felt mechanical and detached, as if their loved one's death was a routine administrative matter rather than a profound human loss. This was not recognised as being a profoundly traumatic experience for families, who were not even given correct information in the first instance,

"I was initially told just as I stepped into my lounge, without the opportunity to sit down. The police then said my [loved one] had hung himself, then after a few minutes and a total breakdown from me, they said, 'oh no, wait a minute, he didn't hang himself, he was found on his bed on his back'.

That picture will stay in my mind's eye forever. Horrific, especially as he died of natural causes!"

One woman whose relative died in prison recalled being told "bluntly" by police while she was at home alone,

"I was given a slip of paper with small text and then had no more contact until I got a pitiful apology letter… that was it. I've been completely left in the dark."

Another family member described how his mother was handed "a bit of paper, very much a dismissal" when informed of his brother's death. He reflected,

"Thank God we had lawyers to support us. Because of our postcode and where we're from, people didn't care."

In other cases, families learned of the death through indirect or deeply distressing means, creating an information vacuum that, as many families felt, should have been the responsibility of the authorities to fill. Some were informed by third parties, or only after news had circulated on social media or appeared in the press. One participant recalled,

"Press find out more. There was a journalist at our door the day after [loved one] died. There's newspaper reports about [them], but we still didn't know where her body was."

For others, the first indication that something was wrong came from hospital staff making phone calls with vague or unconfirmed information. One mother described receiving a call from a hospital suggesting her loved one had "taken something," only to discover that they had been found dead in prison less than an hour later,

"We've been treated appallingly."

Another relative remembered that when the police came to deliver the news,

"They didn't know anything and said, 'at the end of the day they just take their own life'."

In several cases, social workers or chaplains were tasked with notifying families but did so in ways that compounded rather than alleviated distress. Some described being physically separated from their loved ones as the news was delivered, which was felt as a further loss of control in a moment already marked by shock. One woman recalled,

"They tried to take her [mother] into a room on her own and had to force me out... they tried to close the door on me."

Her five-year-old child was present during this encounter, witnessing the trauma firsthand.

Others recounted instances of police officers behaving insensitively or even inappropriately in moments of acute grief. One family member said,

"One of the coppers was making jokes, smiling, and laughing. We thought, how can you be doing that?"

Another recalled how officers stood outside a hospital room, refusing to let the family in until after life-support machines were switched off,

"Police didn't come near us until he died, and they turned the machines off. They stood outside and said he belonged to them, he was still in custody. It's horrible."

Several families described similarly dehumanising or callous behaviour by prison officers who were present at the hospital at the time of their loved one's death. One mother said,

"My [loved one] was dead, and they were still sitting at the end of the bed eating their packed lunch."

Families also spoke of dehumanising language and attitudes from officials. Several described being spoken to in ways that stripped their loved one of dignity in death. One mother was told that "[her son] belonged to them," while others recalled staff referring to the deceased only as "the body" or "the victim," erasing any sense of individuality or humanity,

"They didn't call him by his name, just 'the body'."

Such language, possibly bureaucratic in intent, was experienced as profoundly distressing. It conveyed that their loved one was seen not as an individual who had lived and mattered, but as an object within a system.

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They stood outside and said he belonged to them, he was still in custody. It's horrible.

What families were told about what would happen next

After being notified, families consistently reported receiving little or no information about what would follow,

"We had a booklet, with Cruse[5] etc and we phoned every single one and they were all rubbish, it was futile, 'here is a leaflet' they say, that's not enough."

"The only thing we were told was that there will be no criminal proceedings. We were left with no choice but to get information ourselves, no one sat down and told us, and the only information was from other families and from Families Outside."

No participants said they were told about their legal rights or the processes that would ensue. Practical information like seeing the body of their loved one and collecting belongings from prisons seemed to be dependent on individual staff decisions rather than based on established protocols. We heard how some families were invited to cells to see where their loved ones had died, others were not extended that courtesy.

"Showed me where they found him, really hard. I was not supported, I was taken in but told I had to be alone, not allowed anyone to support me. Took into see governor on my own as well."

One woman recalls being sent the wrong belongings, personal items and clothing that were not those of her loved one.

Showed me where they found him.... I was not supported, I was taken in but told I had to be alone.

There appeared to be no systematic process through which families were informed of their right to legal representation. Those who managed to access legal advice only did so through word-of-mouth advice, by contacting campaign groups such as INQUEST, or in two cases, through the Crown Office and Procurator Fiscal Service (COPFS).

This absence of explanation left families in an agonising state of uncertainty. They did not know whether there would be an investigation, when they might see their loved one's body, or how to retrieve personal belongings. One person captured the cumulative impact of this void,

"It goes into a snowball when you're not getting the answers."

The emotional devastation of this period was compounded by the sudden expectation that families would navigate a complex legal and bureaucratic landscape entirely on their own. Many described feeling paralysed by grief and confusion, yet simultaneously pressured to make decisions about post-mortems, legal representation, and funeral arrangements without any understanding of their rights or options. One relative only knew to contact a solicitor because a funeral director happened to mention it; another said they had to "Google INQUEST" to find guidance.

As it currently stands, there is no organisation in Scotland that can offer families the combination of expert legal advice, advocacy, and emotional support needed during this critical period. Families repeatedly emphasised that early information and guidance, delivered with compassion and candour, could have transformed their experience — helping them to feel less isolated and more able to engage with the processes that followed,

"The biggest thing is communication. Emails are cold. You need someone who talks to you like a human being."

"At the end of the day you're who's left and has to deal with [it] day in day out. [Them] in their ivory towers, looking at papers and not looking at us. Deal [with me] like I'm a person not a statistic. Look at how you're dealing with the person who's left with the heartbreak, they'll never be whole but should feel like they've been dealt with compassionately."

66 The biggest thing is communication. Emails are cold. You need someone who talks to you like a human being.

Families compellingly highlighted the flaws in the way investigations are conducted resulted in prolonged trauma, and grief denied, because of the withholding of information and understanding of the process,

> "I don't want any other family, mother, or father, to go through what my family have gone through. It's hell on earth. You don't ever get over it."

A small number of participants spoke positively about individual police family liaison officers or chaplains who showed empathy; checked in regularly, explaining what would happen next or more generally enquiring after families' well-being. These examples of good practice demonstrated the difference that humane, respectful communication could make. Yet they were described as rare exceptions within a broader landscape of confusion, silence, and neglect.

The immediate post-death period revealed a critical gap in Scotland's response to deaths in custody and detention. The absence of coordinated, trauma-informed communication at this stage left families without essential information, legal understanding, or emotional support, setting a tone of mistrust that persisted throughout subsequent investigations.

This early breakdown in communication not only compounded families' grief but also undermined their confidence in the integrity of the investigative process that followed. Establishing consistent, compassionate, and rights-based procedures for notifying families about the death of a relative is therefore not only a practical imperative but a necessary foundation for trust in the FAI that follows.

What families said needs to change

Ensure early, humane, and coordinated communication

Prisons, police, medical staff, social workers and / or anyone who comes into contact with families following a death need to guarantee consistent, candid and compassionate communication when notifying them about the death of their loved one. Contact should recognise the depth of their loss, provide clear, rights-based information about the processes ahead and offer guidance on available support.

3. Investigations: delays, exclusion and silence

Deaths in detention are investigated by several bodies in Scotland. These investigations take place before an FAI hearing. When a death occurs following contact with the police, the investigation is led by the Police Investigations and Review Commissioner (PIRC), an independent body tasked with examining deaths or serious injuries following contact with the police. A death in prison will result in a Death in Prison Learning, Audit and Review (DIPLAR), carried out internally by the Scottish Prison Service (SPS) and Significant Adverse Event Reviews (SAERs) are carried out by the NHS following events that have resulted in unexpected death or harm involving healthcare. Alongside this, the Crown Office and Procurator Fiscal Service (COPFS) investigate all deaths in custody, and the holding of an FAI is mandatory in these circumstances. Families consistently described the years leading up to the FAI as a period of painful waiting, defined by silence, uncertainty, and emotional exhaustion. This was compounded by their involvement in complex and overlapping investigative processes.

While each investigation was designed to establish facts, ensure accountability, and prevent future deaths, families experienced the system as fragmented and bewildering. Few could clearly distinguish between the roles of PIRC, DIPLAR, and COPFS, and most received conflicting or incomplete information about who was responsible for what. As one person explained,

"I got three versions of why my [loved one] passed in two days. Told by prison services, the officers came out and said they 'didn't have a clue'. They told me to contact [the prison], first person said it was natural causes, second said heart attack, third said he took his own life. Three causes of death in two days!"

In the absence of clear communication, families found themselves piecing together information from multiple sources,

"We were never told who was in charge or what would happen next. You're just left to piece it together."

Another added,

"There is no one who is consistently telling you... it's like putting together jigsaw pieces, finding out from others."

Instead of transparency, families encountered defensiveness and silence,

"It's like they're protecting themselves, not finding out what happened."

Families repeatedly stressed that what they wanted most was compassion and honesty, even when answers were not yet available. They were keen to recognise that the authorities and investigative bodies could not answer every question in the timescale families wanted, but they expected to be treated with honesty,

"Compassion costs nothing. Just be honest. If someone said, 'I know that shouldn't have happened, I'm sorry,' that would've been a start."

"It's like they're protecting themselves, not finding out what happened."

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

Beyond formal investigations, families described confusion and exclusion surrounding the Death in Prison Learning, Audit and Review process. DIPLARs are intended to promote internal reflection and learning within the Scottish Prison Service following a death in custody. In practice, most families were unaware that the process even existed,

"We didn't even know what a DIPLAR was. An academic had to tell us."

Those who did learn about it were told it was an internal process in which they could not participate,

"We were told there would be a DIPLAR, and that we'd have an opportunity to ask questions. We were keen to be involved, but we didn't hear anything."

Another family said they "were made to feel like we were a major inconvenience".

Others were actively encouraged to submit questions but were hugely disappointed and frustrated by the secrecy surrounding the report findings,

"I was asked to submit questions on behalf of the family - which I did - to be considered as part of the DIPLAR process. Yes, it was made clear to me that it was an internal review document, but when I was given a copy of the final DIPLAR which was so heavily redacted it was meaningless and didn't address any of my questions or give the family any answers."

Another family were told they could not be a part of the DIPLAR but did have the chance to meet the governor and felt it was a good opportunity to seek clarification as to what had happened to their loved one,

"We were told we weren't allowed to be present at it. When we met the governor and had 22 questions all the replies were 'we can't comment'."

This exclusion reinforced the perception that DIPLAR was more about protecting the institution than learning from tragedy. As one parent said,

"You shouldn't have to fight to get information about your own child."

The Police Investigations and Review Commissioner (PIRC)

For deaths involving police contact, the PIRC was often the first body families heard from after initial contact with police. Families were typically told that investigations would take around three months, but few received meaningful communication or updates,

"The PIRC were there after the police and said there would be an investigation lasting three months. Then they asked who helped us draft our questions — no one did. When it was finalised, they had a meeting but didn't tell us what to expect."

In reality, these investigations frequently dragged on for months or years without clear outcomes,

"PIRC phoned us to say the post-mortem was 'inconclusive'. We've waited ten months."

Others described the frustration of being denied access to information, about their loved ones, entirely,

"I asked for a copy of the PIRC investigation and was told it's nothing to do with you, won't be getting it. Case frozen until FAI so desperately trying to get paperwork through. Very little medical info and what is there has been copy and pasted."

This echoed other participants' experiences, and fostered a feeling of suspicion and anger that families were the last to know what investigations into their loved ones' deaths had uncovered,

"We were told you won't get any information until the FAI. PIRC read out their report to us. You can't keep it all in your head but wouldn't give it to us [in writing]"

The absence of updates left families "frozen in time", unable to grieve or move forward. One family described the difficulty of the stop-start nature of the PIRC investigation,

"It prolongs everything. Every day you're asking another question."

In desperation, some turned to MPs or the media for information,

"It's bad enough what's happened in State care, and still the families have to Google, go to their MP. It's ridiculous."

For some there was a question mark over the independence of those investigating deaths following contact with the police. One participant felt the investigation was less independent and thorough than it should have been,

"I've got the PIRC report. They're ex police, though. To me, I don't think they investigated it the way I wanted it."

The Crown Office and Procurator Fiscal Service (COPFS)

The Crown Office and Procurator Fiscal Service holds statutory responsibility for investigating deaths in custody and determining whether a Fatal Accident Inquiry should be held. An FAI is mandatory following a death in police or prison custody, and COPFS are responsible for that investigation. Above the mandatory settings, COPFS will also determine whether an FAI must be held in deaths in other settings if it is in the public interest to do so, for example, if someone dies in mental health detention.

In principle, this provides independent oversight and accountability. In practice, families experienced an exhausting process marked by long delays, poor communication, and exclusion.

Families frequently reported long periods without any contact from COPFS,

> "We heard nothing after sixteen months. They said they would keep in touch, but we've had nothing except a few calls from the lawyer."

One family described poor contact with the Crown Office,

"all our contact with the CO was through us, [it was] not proactive, until we got a lawyer [...] we were told it would be two years which I thought was a long time, it's now been five years".

Another parent recalled,

"You are supposed to have regular communication from Procurator Fiscal. It was eleven months before any contact after [my loved one] had died. I sent an email to PF office, she sent a snotty email saying, 'you said you didn't want any contact.' I can't remember saying that. You feel like you're just left."

Others were contacted too early, before they were ready to participate,

"We were asked to give a statement less than 24 hours after finding out our [loved one] was dead. I think the timing of statements needs to be looked at."

For many, the process felt unequal and dependent on whether they had legal representation.

"Treated differently if you have a solicitor. More correspondence. Initially you're in shock. Fought for 18 years for my [loved one] to get proper treatment but in prison they didn't accommodate them. [They] were seriously mentally ill and now the PF knows I have a solicitor, now things are changing. Why should that have to be?"

Families questioned why access to communication and fair treatment should rely on having a lawyer, rather than being a standard entitlement.

There were, however, occasional examples of good practice that demonstrated how the system could work in the interest of families,

"PF did advise me to find a lawyer. She mentioned someone who was helping others and I contacted them. Only one contact with PF but she has checked in to see if I'd contacted the lawyer. She has kept me up to date and got me info like postmortem results."

For most families, though, years of delay were emotionally devastating,

"Timescale allows people to say they don't recall. Tick boxes, write files, gather dust. Year after year we welcome more families to this group."

One relative questioned the justification for such prolonged timelines,

"Why does it take so long? People are in an enclosed environment who should be questioned straight away. They've got all the documents. The authorities are trying to string it out."

Family Liaison Officers

Where Family Liaison Officers (FLOs) were appointed, experiences varied. Some families described FLOs who were compassionate and communicative, while others felt interrogated or mistrusted.

"We had a FLO, but not useful at all. We were interrogated, as if we killed our [loved one]. You are supposed to be a link to guide us through to the next step!"

Some felt that FLOs were more focused on assessing the family than supporting them, asking questions about home life or personal circumstances in ways that felt intrusive and cynical.

"It felt like they were looking for things to blame on our relative."

By contrast, families who experienced empathetic and regular liaison highlighted the positive difference it made,

"Our FLO was wonderful, she gave us timings, and she was kind."

Many families emphasised that liaison required specialist skills and should be carried out by independent staff rather than the institutions implicated in the death. Put simply, families felt unable to trust FLOs who were not independent.

Stigma and dehumanisation

Many families felt they were treated differently because their loved one had been in custody. Some investigators made stigmatising remarks or displayed indifference,

"The chief investigator said, 'Let's not forget [he] was just a criminal after all.'"

Others described officials referring to their relatives impersonally, this was perceived as callous,

"They call them 'the body' but not by their name. It's like they forget he was someone's son."

This stigma extended beyond institutional settings, with media coverage often compounding it, portraying relatives as undeserving or dangerous,

"He left a four-year-old child, and you're talking about his crime? He was paying the price; he didn't have to die."

Some experienced racist and hostile reporting, to the extent that families felt they had no option but to leave their communities to escape the scrutiny,

"The media were saying he was linked to terrorism. It was heartbreaking. I had to run away from the media circus."

Humanising the person who has died

Families described efforts to humanise their loved ones as essential. They brought photographs or small pen portraits to meetings or inquiries to ensure officials saw the person, not just the 'case'. One participant described a mother who wanted to explain more about the person who had died,

She put photos of [them] in front of the people she was talking to, 'this is my [son], who has passed away. Before we discuss you should see the person, that he had a life.' She was passionate about letting people know he wasn't a statistic, he was important. Though there weren't any answers given, she wanted them to see who he was, and they impacted everybody in their life."

Another showed a short video to an inquiry to convey the reality of a life once lived, whilst other noted small acts of inquisitive kindness

"When I gave evidence, the Procurator Fiscal asked, 'what were [they] like?' That was nice."

Families agreed that these moments should be routine and that pen portraits should be introduced at the start of every FAI to humanise the legal processes and enable a focus on the individual in life, not just in death. As one family put it,

"if they would just look at the person you would feel that they were talking about your loved one, not someone on a piece of paper."

Mishandling information

Errors and poor handling of sensitive information further deepened mistrust. This was especially upsetting in relation to postmortems, but families felt that a casual approach to administrative accuracy was somehow symbolic across a whole system that did not respect those that had died, or their families, enough to spell names correctly or get dates of birth right,

"They put the wrong date of birth on his death certificate. How can they get that wrong?"

Postmortem reports were another key cause for concern. Families described receiving postmortem reports by email without warning or context,

"The Crown Office emailed the postmortem, no warning, that was not an easy thing to read."

It was pointed out that if the family knew there were inaccuracies within the postmortem there was no information provided as to who to contact to challenge what was written. Another family was told before the postmortem was delivered, but it contained different information than the family had been led to believe about their loved one's death,

"I was in total shock as it said something else, the PF did say it was harrowing, I told the PF not to call me again."

Others encountered different postmortems being sent out by the prison service,

"We got three different reports, each one said something different. How can you trust that? They [prison officers] had no idea how [loved one] died"

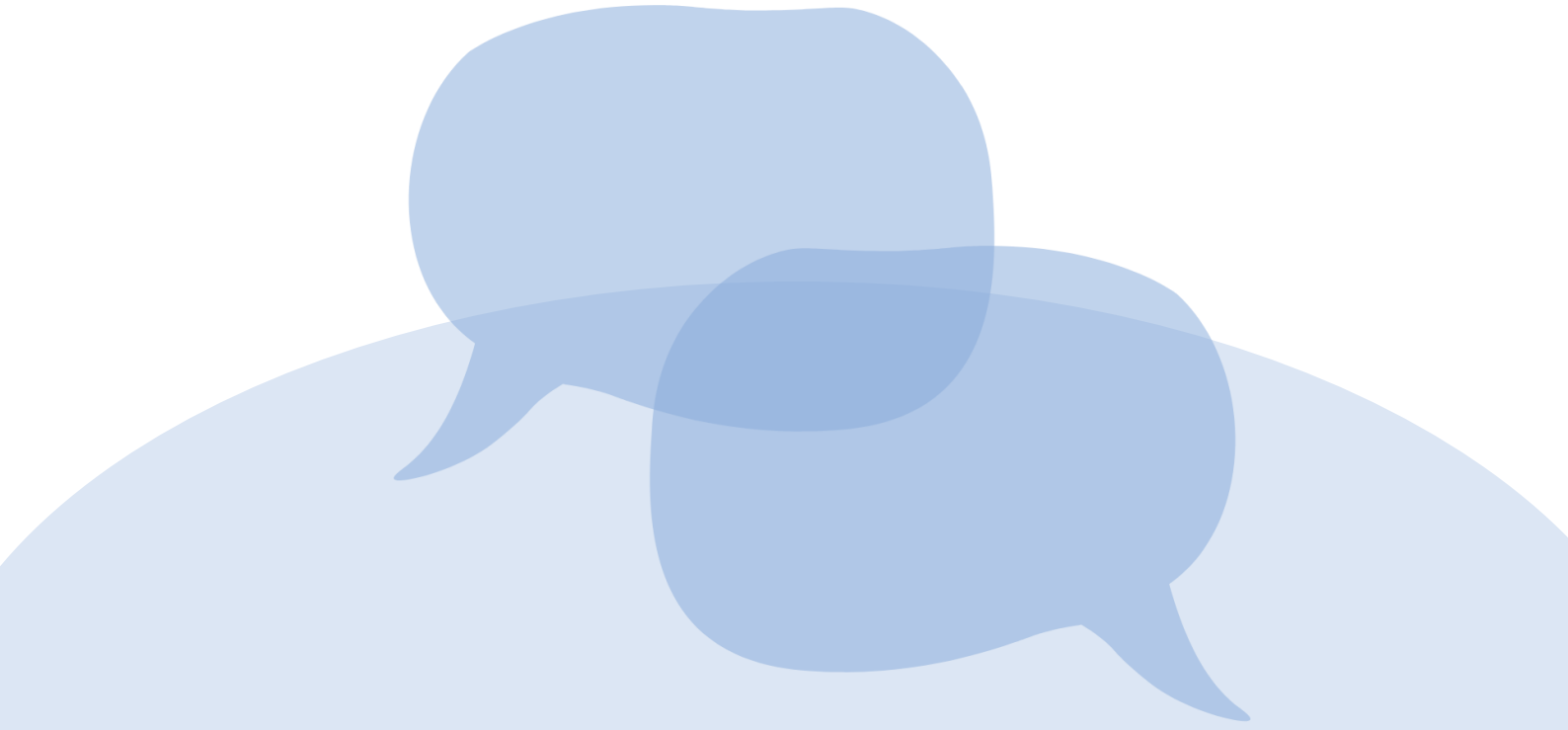
While these may appear to be 'minor' administrative errors, the impact on families was huge and they were adamant that the very least they would expect was the sensitive information to be delivered with support and care, and that 'minor' details like names and dates of birth should be correct.

Many spoke of the emotional cost of being treated as outsiders to a process that should have centred their experiences. The combination of stigma, defensiveness, and lack of compassion left families feeling alienated and mistrustful,

"It's like they're protecting themselves, not finding out what happened."

The cumulative effect of these overlapping investigations was a system perceived as defensive and unaccountable, compounding harm rather than preventing it. Families described it as "a second loss", a process that extended their grief and eroded trust in public institutions. As one participant concluded,

"The way the system acts after a death is a further lack of duty of care."



What families said should change

Provide independent points of contact

Each family should have access to a single, named point of contact from the investigative bodies who communicate with empathy, consistency, and clarity throughout the investigation. These points of contact should also proactively provide families with information about the process, their legal rights and available support. Any emotional and practical advice and support should be entirely independent of the detention authorities.

Set and enforce timelines for FAIs

There should be set timeframes for each stage of the FAI process, with clear milestones, maximum waiting periods, and mechanisms for oversight to prevent indefinite delays. Updates on progress should be regularly communicated to families.

Guarantee access to legal representation

The Scottish Government should ensure information about and access to legal support is provided from the point of a death taking place. Families should receive non means tested funding for legal advice and representation from the outset.

Enable meaningful family participation during all investigations following a death

Investigation bodies should ensure families are regarded as active participants throughout investigations. Engaging with families to raise their concerns, questions and to provide important context can broaden and inform the scope of investigative processes and ultimately the potential scope of the FAI.

4. Families' experiences of Fatal Accident Inquiries

The FAI is a public hearing to establish what happened to cause a sudden, unexplained, or suspicious death. They must take place after someone dies in legal custody, for example police and prison custody, and are presided over by a Sherrif. They can be preceded by a preliminary hearing at which the Sheriff will determine who is taking part and what evidence needs to be heard. The aim is to find out what happened and to prevent future deaths. The FAI is the principal way in which the State is able to discharge its obligations under Article 2 of the European Convention on Human Rights (the right to life) following a death in custody.

Not everyone who participated in the Listening Day had experience of the FAI. Those that had, described decidedly mixed experiences. In keeping with other processes following a death in custody in Scotland, families complained about a lack of information, exclusion from taking an active role, in part fostered by lawyer led proceedings, hostility, intimidating court environments and what they considered failures in broadening scope and remit for ascertaining what structural flaws contributed to their loved ones' deaths.

Delays

For families, delays were not procedural inconveniences but sources of deep distress. The constant uncertainty meant that grief remained unresolved, frozen between official processes,

"Life has to carry on, but you're stuck waiting."

Families spoke of how delays continue right up until an FAI hearing.

A mother reflected that it took six years to get to the FAI hearing for their relative. While they "couldn't have coped with the FAI in the first year, six years is ridiculous". Another family was told it would take five years.

One participant said the "system is failing" as she detailed the experience of a family still waiting over ten years for a conclusion to the legal processes surrounding their loved one's death,

"setback after setback, they don't realise the impact this has on families... all of these things are so hard".

Lack of information and knowledge of the process

When hearings were finally announced, families often entered the process with little understanding of what to expect. Key stages such as preliminary hearings or the agreement of joint minutes were rarely explained, and official communication was couched in legal jargon. Several participants said they had never received even the most basic explanation of what the FAI would involve,

"I don't know what a preliminary hearing is. Nobody has ever told me."

Families were repeatedly told that the FAI was "not about blame" but a "fact-finding exercise", yet this did not prepare them for the intensity, complexity, or adversarial nature of proceedings.

"We were told it's just about facts, but that doesn't tell you anything about what's really going to happen."

One family spoke about their involvement in a criminal legal proceeding which they said was "easier than this process, you knew everything, you were better informed" such as, for example, there being a speedier process with a clear timeline given to those involved. She went on to say, "this is so much worse, this should be easier".

One participant witnessed the fundamental inconsistency of the supposed purpose of the FAI versus the reality of lived experience of the process,

"The whole point is to inform, to get to the truth, not to point fingers. Yet all four bodies were just defending their own, people [giving] different stories about what was going on, people just didn't turn up, or [didn't turn up] from ill health. The governor [of the prison] didn't turn up because of ill health. It [the FAI] doesn't necessarily get to the truth."

Some found that key procedural decisions that preceded the inquiry were made without their knowledge or involvement. One family described their concerns with joint minutes. Joint minutes are means by which evidence is agreed between the parties in writing, meaning that evidence is not the subject of discussion in court. These can be agreed by all parties, including where the family is legally represented. However, in practice, families report that

they were rarely involved, meaning the joint minutes were agreed by State bodies. Others spoke of similar matters with significant implications for accountability,

"We were told not to attend preliminary hearings because it was 'lawyer talk'. That's when immunity was granted. Our lawyer didn't tell us at the time."

Ultimately families felt extremely frustrated at the lack of information and guidance around the different stages of the FAI,

"There's nobody from the side of the FAI telling you information, nobody reassuring you. You're left to put together jigsaw pieces. Nobody is there to answer our questions. The what ifs, the not knowing for years."

Another family added that,

"it's not treated like a service to us, families are not told by the people who run it, the only way we get information is from each other, no one is saying 'this is what to expect'".

Inequality of access to legal representation

Access to legal support varied widely and often depended on families' ability to secure legal aid or the intervention of campaigners or NGOs. Some waited years before securing representation, others were never able to find a lawyer at all,

"We were told, 'it's up to you to get a lawyer'. It took three years before we got one."

Even when represented, [some families] did not feel adequately supported or informed, describing a sense of exclusion within their own legal teams,

"They're all friends, laughing and joking with each other. You start to wonder whose side anyone is on."

One family described calling more than 30 law firms before finding one willing to take their case,

"I phoned 35 lawyers and as soon as I said it was a death in custody, they said no. Because it was in the same area as [another death], they wouldn't touch it. I had to go to city lawyers, only one would do it."

This inaccessibility of legal representation left families feeling disempowered from the outset. There was also major disparity in what families can access in comparison to lawyers for the public bodies involved.

Families also talked about the need for trust in the relationships they formed with professionals during the investigative and inquiry process. Families felt professional trust had to be earned,

"Our PF we later discovered was on TikTok promoting bras. I was raging. I know she is a lawyer, and she is also entitled to live her life, but we discovered that on the morning of the day she met us, she was on TikTok saying, 'this is the outfit I picked for today'. She was then sitting with us listening to the details of how our loved one died. I kind of lost respect, it is mockery. This landed with us so badly."

By the time they entered the courtroom, families found that every institution involved in the death — the Scottish Prison Service, NHS, Police, and Government — already had teams of lawyers, including KCs, prepared to defend their interests,

"They all had lawyers and KCs. You're just there, sitting behind them."

One family stressed the importance of the legal 'equality of arms' otherwise families can enter the rigours of the FAI unrepresented, placing them at a huge disadvantage,

"It should always be a level playing field. You should never be in a position where all you've got is your PF and then you're up against three or four KCs. It should be mandatory to have a KC."

Families identified a lack of lawyers with human rights expertise as there is simply not a big enough pool of specialists who are willing to, or have capacity to, take on deaths in custody cases. This felt important to families as they believed legal representation gave them a better chance of meaningful participation, advice, and information,

"Lawyers took us through [the process] step by step telling us what to expect."

For most of those we heard from, legal representation significantly improved their experience, and it was only after securing this, that families began to get information held by the institutions in which their loved ones died, and background and an understanding as to what was happening during investigations and the FAI,

"Lawyers delivered a lot of support; there's a big difference in treatment once you have a lawyer."

Adversarial environments and power imbalance

Barriers to participation

Families described FAI hearings as intimidating, alienating, and emotionally exhausting. Families argued that the inquiry process is not designed with families in mind, placing them at a disadvantage. People described the emotional and practical burden of participating in an inquiry,

"It was exhausting. You're trying to remember where things were left from the last hearing [in an FAI that had stops and starts with months in between] and you're getting back to normal when it starts up again. Each session was a full day and then you have meetings with your lawyers at the end of the court day. You can't work, you have your own life and families to look after [and that gets disrupted]."

It was pointed out that lawyers are paid to be there, but that's not the case for families who had to incur the cost of travel and subsistence whilst attending,

"Why does the FAI have to be in the Sheriffdom where they died? It means you have to travel from where you live, it can be far away."

Another family agreed,

"We had to travel to Edinburgh every day [from Glasgow]. Our travel wasn't covered, no one ever offered."

Families reflected that a central element of the investigation should be to deliver the truth. However, disclosure of evidence was not forthcoming from the public bodies involved. For example, some families discussed issues in accessing or sorting through hours of CCTV footage which they believed would have given them answers, or that the footage had not been saved.

One person said that their lawyers

"were also struggling to get answers, [there are] things missing, inconsistencies, what hope is there - what chance have we got - if lawyers are not getting answers."

The lack of proactive transparency during investigations undermined their value in families' eyes,

"you can only get to the truth if people tell the truth".

Intimidating surroundings

The proceedings were dominated by legal professionals — "fifteen wigs and gowns," as one participant put it — leaving bereaved relatives feeling intimidated and overwhelmed.

The physical environment and courtroom arrangements offered little privacy or space for emotional support. Families described being retraumatised by the experience of sitting through testimony that misrepresented or minimised their loved one's life and death,

"We were rubbing shoulders with prison officers who had locked [my loved one] up the day before she died. We were even using the same toilet."

"You're sat behind all of them, listening to people lie. It's brutal."

Questioning sometimes strayed into personal or irrelevant territory, such as family relationships or mental health history, compounding their distress. People described the Crown representatives speculating in court on potential divorce or relationship breakdowns in an effort to shift blame onto the families, rather than institutional failings,

"It is an adversarial process no matter what anyone says. I was cross examined about my marriage being on the rocks as the reason [they] took [their] own life. How can they be allowed to cross examine you on death of your child? The NHS KC was brutal and adversarial in questioning. It has to change and be what it says it is – non-adversarial."

Others agreed,

"It's meant to be non-adversarial, but it's not. It feels like you're on trial."

Several families described Crown representatives who appeared detached, defensive, or dismissive,

"The Procurator Fiscal didn't even acknowledge us. He walked out of a lift to avoid me."

There were a few examples of good practice and for the families fortunate to experience them it made a huge difference. One family's experience was derived from a public inquiry, rather than a FAI, but the provision of a private, family space is one that could be replicated during FAIs,

"Having it [a private room during the inquiry] makes a big difference. They really gave us our privacy, not interacting with other lawyers or witnesses at all. We had our own toilet. Very private. We felt we were well looked after in the inquiry."

Narrow terms of reference and limited exploration of systemic issues

Even when Sheriffs conducted proceedings with fairness or empathy, families perceived the process as constrained, unwilling to probe institutional failures too deeply. All too often the process seems to project a mere tolerance of families, rather than an actively empathetic and considerate environment designed to facilitate real understanding, to seek improvements and learning.

Families repeatedly raised concerns about the restricted scope of FAIs, which often excluded examination of broader systemic issues such as sentencing decisions, healthcare provision, or prison conditions,

"The scope of an FAI doesn't involve families enough. We wanted them to look at sentences and why they ended up there but we had no say in what the scope of the FAI was, so you end up focused on physical environment [of the prison] and things like that."

Some attributed the narrow scope to how efficiently, or otherwise, the initial investigations had uncovered systemic failings that could have better informed the remit of the inquiry,

"The Sheriff at the FAI was asking more questions than the Prosecutor Fiscal. He came back with a 109 page report, and 13 recommendations.

Narrowing the remit to just considerations of the custodial settings left families feeling that the process avoided rather than confronted the root causes of preventable deaths. These concerns echoed families' despair at the refusal to respond or even listen to their repeated warnings around ill health when trying to contact prisons and police in order to share information that may have kept their loved ones safe.

Families' experiences reveal deep structural and cultural flaws in the FAI system. The harm begins long before the hearing itself, through years of delay and exclusion, and continues in courtrooms that feel adversarial, intimidating, and institutionally protective. Hearings that are meant to uncover truth and prevent future deaths instead leave many families retraumatised and disillusioned.

Across testimonies, the message is clear: families want transparency, accountability, and prevention. The current system struggles to deliver any of these with consistency or compassion. Until FAIs are reformed to prioritise humanity, truth, and learning, families will continue to experience the process as another layer of injustice.

Families' accounts of the FAI process highlight not only procedural failings but a deeper crisis of trust in the State's ability to deliver justice and learning after a death in custody. As one relative said,

"They should be doing everything they can to get our trust back and meet us with compassion. They should be doing everything in their power to rebuild the trust and to support us in this process, instead of making us feel like we're being prosecuted ourselves."

The experiences described here expose systemic patterns — delay, defensiveness, and institutional protection — that persist beyond individual cases. The following section considers what happens after the FAI and what changes families believe are necessary to ensure that future inquiries serve their intended purpose: truth, accountability, and prevention.

What families say should change

Humanise all investigation processes

Those leading investigations should adopt trauma-informed practices. The Pen Portrait[6] should be promoted by those leading FAIs at the start of the process, as in other parts of the UK, allowing families to make real the lives of their loved ones, using names and photographs of those who have died. Families also want irrelevant details of offending history excluded from reports and ensure hearings take place in environments that provide privacy, dignity, and emotional support.

Strengthen the quality and consistency of FAIs

Develop a national template for determinations and appoint specialist Sheriffs for deaths in custody to ensure consistency, expertise, and a focus on prevention. Consideration should be made to establishing methods for regular training for Sheriffs on deaths in custody, Article 2 investigations, and related issues such as mental health, neurodiversity, and trauma.

5. Determinations, recommendations, and the aftermath

For many families, the conclusion of the Fatal Accident Inquiry did not bring closure, but rather a renewed sense of abandonment and "unfinished business." The months following the inquiry were often characterised by silence and uncertainty. The absence of communication from authorities after the publication of determinations was described as "a second silence"—a painful continuation of the darkness they had been left in long before the hearing itself.

Inconsistencies

Experiences of how and when families were informed of determinations were varied. One family described a painful year-long wait for publication, during which time the Sheriff conducted further investigations into related deaths,

"For us, there was a year between the FAI starting and the report... Once the FAI had happened, we actually were quite well informed. That was because of the Sheriff."

The family acknowledged that, due to the robust scrutiny provided by the Sherrif, they felt they had answers to questions that may otherwise have gone unanswered.

In contrast, another family only learned of their FAI outcome through the media,

"We weren't told the FAI determination had come out, and it was a member of the press who knocked on the door to ask what we thought of it."

Families were acutely aware of the significance of inquiry determinations, yet their experiences revealed deep concerns about their scope, length, and consistency, with the length and depth of reports varying dramatically from a few pages to several hundred, with no clear standard for content or approach,

"No Sheriff should be able to write a two-page FAI for a death in custody. It's an insult to the family."

"One of the things is inconsistency within FAIs. You look at an FAI of one person who died from suicide and its three pages long, and our FAI [determination] in the same circumstances is over 400 pages.

It was felt a standardised approach to determinations, a template, might help, allied to the introduction of specialist Sheriffs,

"We actually need to have a bank of Sheriffs who only work in FAIs, then you'd get more consistency across the board."

Oversight of recommendations

There was widespread scepticism about the purpose and impact of recommendations, which are not legally binding and lack any formal mechanism for follow-up or oversight. As one family put it,

"Six years of us on our knees. What difference has it made?"

If recommendations are rejected by the public bodies involved, families believed they should be told why,

"There needs to be justification – why are there not recommendations in place, why are there delays? They're not having to justify this to anyone."

Six years of us on our knees.
What difference has it made?

Another asked,

"Does anyone even look at them? Who implements them? Who checks?"

The overwhelming sentiment was that while FAIs have the potential to expose systemic failings, their outcomes rarely translate into meaningful accountability or change,

"We knew it wouldn't prevent anything. It would just retraumatise us."

Families repeatedly highlighted the structural weakness of a system that allows recommendations to remain optional. There was unanimous support for an independent body with statutory powers to monitor, audit, and help enforce implementation, one person suggesting,

"If people aren't held accountable, lessons will not be learned,"

adding,

"Clearly it's not working — year after year we welcome more families to this group."

Families were frustrated that their input continued to be dismissed,

"There were six changes recommended, and I'd like to know if they were implemented. At no point was I allowed to speak during that FAI. These things have got to be implemented to save someone else."

"I watched them saying they've made all these changes and just thought, 'you're full of shit.' These are all preventable deaths. They didn't need to die."

Others spoke of the need for transparent and public reporting on progress against recommendations, including justification/explanation where they are not adopted,

"It should be mandatory to say why something hasn't been implemented, and everyone should be able to see that online."

Families also proposed that FAI recommendations be subject to statutory follow-up and independent audit, similar to inspection regimes used in health and social care. Some suggested that His Majesty's Inspectorate of Prisons for Scotland (HMIPS) or another independent body could take on this assurance role. As one family member put it,

"It's not good enough for the police or prison to say they've done it. There needs to be a robust system to make sure that's true."

The need to centre the person who has died and their families

Many felt that specialist Sheriffs should preside over deaths in custody FAIs to ensure both subject expertise and sensitivity.

Several families criticised the language used in determinations as cold and dehumanising. They called for the use of names rather than terms like "the deceased" or "the body," and for the removal of irrelevant details such as offending histories,

"They still call them 'the deceased', or even 'the body'. It's clinical and cold. He was my brother – he had a name."

Another crucial factor that would help centre families in the process is the need for prompt, time lined investigations and FAIs. The constant delays, often with little or no explanation, is a huge source of frustration and anger for those we heard from. It is abundantly clear that families are unable to properly grieve whilst the investigative processes are on hold, and this is retraumatising and emotionally damaging. Delay and denial do nothing to build faith in the process, it neither serves the investigations nor the families and as such should be addressed immediately.

Beyond the process itself, families expressed frustration at the limits of the Sheriff's powers. They pointed to the inability to compel attendance of prison officers who claim to be "too traumatised" to give evidence,

"If you took someone's life, you should have to go and answer for it."

Underlying all accounts was a shared recognition that meaningful change requires more than words on paper. One person was clear in their belief that the current FAI system was not really focussed on accountability,

"Sitting here, there's a pattern here and someone higher up can't see this pattern that everyone here can see. When it comes to people, young and vulnerable people, there are patterns. People making excuses, immunity, lying. Nothing happening.

"It's not about the loved one or families, it's all about the system covering their arses while body bags are still coming out of the prison. When is the change going to happen?"

As one family starkly concluded, looking around the group in attendance,

"If there's another 20 families in 20 years' time, what's the point?"

What families said should change

Mandate implementation and oversight of recommendations

The Scottish Government and investigation bodies should put in place better, independent, systems to ensure oversight and follow up of recommendations made over the course of their investigations into deaths in detention. Reports on oversight should be published regularly, written justification issued when recommendations are not acted upon, and families regularly kept informed about the progress following a death in custody.

Conclusion and recommendations

The Family Listening Day revealed the profound human consequences of a system that too often heightens the pain of those it is intended to support. Families described experiences marked by uncertainty, exclusion, and avoidable harm. They also brought extraordinary insight into what a system based on candour, trust, accountability, and genuine learning could look like. They made clear that the current FAI process is not just slow, confusing, and defensive, but structurally ill-equipped to meet the needs of those at its centre. Families hope for change,

"It's nice for the Listeners to be here, to really hear our experiences. I hope they take it back and help make changes."

Across the discussions, families offered both critical insight and real opportunities for change. Their reflections pointed towards a system in which compassion is not an optional extra but a foundation, where the search for truth is not obscured by silence and secrecy, delays, or defensiveness. They want to be treated not as passive spectators to a legally administrative process but as essential partners in understanding what went wrong and how future deaths can be prevented. While some believe that "if it's done right, an FAI, it's very good, the whole concept is very good", Scottish Government need to start "thinking outside the box" because "just reworking what we have now won't work".

What emerges from their collective testimony is a clear blueprint for change: a process that communicates openly from the outset, supports families through independent, rights-based guidance, moves forward within predictable timeframes, and is capable of examining evidence with both rigour and humanity. It is a vision of a FAI system that values the lived experience of families, humanises those who have died, and focusses on the prevention of future deaths.

The recommendations that follow translate these principles into practical steps. Together they call for a transformation in culture as much as in structure; a commitment to transparency, timeliness, and accountability; to trauma-informed practice; and to a system that does not simply tolerate families but works with them. Above all, families' recommendations reflect the conviction that meaningful change is both a possibility but also an imperative. By acting on what families have so generously shared, Scotland can move closer to an FAI process that honours life, learns from loss, and ensures that no bereaved family is left to navigate this journey alone.

Recommendations for action

1. Ensure early, humane, and coordinated communication

Prisons, police, medical staff, social workers and / or anyone who comes into contact with families following a death need to guarantee consistent, candid and compassionate communication when notifying them about the death of their loved one. Contact should recognise the depth of their loss, provide clear, rights-based information about the processes ahead and offer guidance on available support. Rights-based information would, for example, provide information on the State's human rights obligations following a death in detention under Article 2 ECHR, and information on rights and entitlements for families under other domestic legislation, such as the right to legal aid and information on how to obtain legal representation.

2. Provide independent points of contact

Each family should have access to a single, named point of contact from the investigative bodies who communicate with empathy, consistency, and clarity throughout the investigation. These points of contact should also proactively provide families with information about the process, their legal rights and available support. Any emotional and practical advice and support delivered should be entirely independent of the detention authorities.

3. Set and enforce timelines for FAIs

There should be statutory timeframes for each stage of the FAI process, with clear milestones, maximum waiting periods, and mechanisms for oversight to prevent indefinite delays. Updates on progress should be regularly communicated to families.

4. Guarantee access to legal representation

The Scottish Government should ensure information about rights to legal support and how to access it is provided from the point of a death taking place. Families should receive non means tested funding for legal advice and representation from the outset to help them navigate and engage with the post-death processes. This should include DIPLAR and PIRC processes, as well as FAIs.

5. Enable meaningful family participation during all investigations following a death

Investigation bodies should ensure families are regarded as active participants throughout investigations. Engaging with families to raise their concerns, questions and to provide important context can broaden and inform the scope of investigative processes and ultimately the potential scope of the FAI.

6. Humanise all investigation processes

Those leading investigations should adopt trauma-informed practices. The Pen Portrait[7] should be promoted by those leading FAIs at the start of the process, as in other parts of the UK, allowing families to make real the lives of their loved ones, using names and photographs of those who have died. Families also want irrelevant details of offending history excluded from reports and ensure hearings take place in environments that provide privacy, dignity, and emotional support.

7. Strengthen the quality and consistency of FAIs

Develop a national template for determinations and appoint specialist Sheriffs for deaths in custody to ensure consistency, expertise, and a focus on prevention. Consideration should be made to establishing methods for regular training for Sheriffs on deaths in custody, Article 2 investigations, and related issues such as mental health, neurodiversity, and trauma.

8. Mandate implementation and oversight of recommendations

The Scottish Government and investigation bodies should put in place independent, systems of oversight and reporting on recommendations made over the course of their investigations into deaths in detention. Reports on progress should be published regularly, written explanations issued when recommendations are not enacted, and families kept regularly informed about the progress of recommendations.

Appendix 1: The Family Listening Day Model

The Family Listening Day model, developed by INQUEST, is committed to the empowerment of families enabling them to control not only their own situation but also to contribute to the work of reform. The aims of the listening day are to:

- Provide opportunities for families to speak directly to organisations that either influence policy and practice, or State agents responsible for making policy work in practice
- Describe their cases and the impact such deaths have had on their lives
- Provide a personal reflection on, and the impact of, the post-death processes, investigations and inquests and inquiries
- Participate in finding solutions to problems that exist within the current system
- Place families' experiences on record; archiving evidence that contributes to the debate on how the State looks after people in its care
- To describe their experiences to invited Listeners, their role being to actively listen without interruption.

The Family Listening Day (FLD) model encapsulates the following features:

- Planned – in conjunction with commissioning organisations, families, and INQUEST staff
- Facilitated – by experienced staff, briefed and knowledgeable on the key issues, and with an understanding of the families' particular cases
- Thematic – to provide focus and to avoid the events from becoming too wide-reaching and broad-based
- Discursive – by encouraging participants to discuss the issues in a safe and understanding environment, allowing a free flow of ideas and thoughts surrounding a theme
- Inclusive – ensuring a wide range of families affected by the issues under discussion feel able to attend and speak
- Confidential – information shared during the FLD is honest and heartfelt, and families recognise what is shared within the group should not be used outside the FLD environment other than for an agreed purpose (reviews, reports, anonymised quotes, etc).
- Compassionate – compassion and understanding are crucial to the success of the process
- Reflective – offering a chance to rebalance power structures and give participants the chance to reflect on the impact of events and use personal experience to inform structural change
- Archived – the families' contributions are noted and placed in the public domain in the form of a report outlining the key themes, contributions, and recommendations

Endnotes

[1] Inquest | Website homepage

[2] Scottish Human Rights Commission | Review, Recommend, Repeat: An assessment of where human rights have stalled in places of detention (2024)

[3] See Appendix 1: The Family Listening Day Model

[4] This Review is no longer accepting evidence. It is expected to report later in 2025. You can find out more information on the Scottish Government website: 2025 Fatal Accident Inquiry Review – call for evidence - Scottish Government consultations - Citizen Space

[5] Cruse Bereavement Support – A UK charity offering care and support following a bereavement.

[6] Inquest | Pen Portraits

[7] Inquest | Pen Portraits