Chapter 6

Deaths in Custody

1. INTRODUCTION

6.01 There has already been discussion of deaths that have occurred in custody, when explaining the mandatory nature of such FAIs held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (asp 2) (the 2016 Act). All deaths affect the deceased's survivors and unexplained deaths need to be investigated. This applies equally where the person who dies is in the custody of the police or the prison service, where such cases justify greater scrutiny to ensure transparency of process.

6.02 Before the commencement of the 2016 Act, and certainly in the years between 1895 and 1976, FAIs tended to be more focused on accidental deaths such as those occurring in the course of common forms of industrial employment such as in collieries, fishing or in fires. That may reflect the prevailing societal concerns over improving health and safety practices concurrently post-World War 2 with the rise and strength of the trade union- movement.

6.03 Today, there is increasing interest and awareness in considering a range of issues relating to deaths arising when the person who died was in custody. Certainly, the Scottish Government's recent policy development focuses on young persons within the criminal justice system in relation to exploring options of punishment

other than custody.[1] More generally, their interest extends to considering the mental health of prisoners and that relationship with custodial deaths that go on to result from suicides.

6.04 In Carmichael's seminal book on FAIs, he discussed '[s]ome interesting [i]nquiries'[2] in which only one is attributed to a death in custody. In the nearly 50 years since that book's original publication, it is recognised that there is an increasing need now to examine the practice of investigation into such deaths from a public interest perspective, not least as the death rates of those in custody are rising. The majority of FAIs being undertaken today, looking at the published determinations, arise from deaths in custody. This is not too surprising, given their mandatory nature under the 2016 Act and that COPFS appear to have prioritised holding FAIs into this specific category of deaths. These factors justify a closer examination of FAIs looking at this category of deaths, especially in relation to some of the issues of concern already highlighted within the current FAI practices in Scotland.

2. WHY ARE CUSTODY INVESTIGATIONS IMPORTANT?

6.05 **Chapter 3** considered the early historical role of the procurator fiscal in relation to deaths arising in custody. The procurator fiscal was integral when investigating deaths in custody, as they were responsible for the Crown's role in instigating the original criminal prosecution. Thereafter, the procurator fiscal was required to follow up on conviction in any cases where the then mandatory imposition of the death penalty, such as the capital sentence on a murder conviction, was imposed. They were required to certify that due legal process of carrying out the sentence had been satisfactorily undertaken.

6.06 **Chapter 2** looked at Scotland's responsibilities to respect Art 2 of the ECHR, which is highly pertinent in understanding the State's role in relation to death investigations. However, when people are deprived of their liberty, responsibility for their welfare and their health rests with those detaining them, effectively, the State. An independent investigation into their death in custody is required to be conducted, irrespective of the cause of death, so, this will ensue whether it was sudden, unexplained, suspicious, natural or otherwise. Even a natural cause of death could reflect unlawful killing, neglect, ill-treatment, inadequate conditions within the custody facilities, or failures in the medical attention administered during custody.

6.07 Deaths in custody involve the State as the detaining authority, be it usually the police or prison service. Transparency in ensuring the independence of process

1 This accords with the Scottish Government policy with regard to young persons who should not be sentenced to custody if other non-custodial options exist. The Scottish Sentencing Council Guidelines reflect this policy: Sentencing Young People, *www.scottishsentencingcouncil.org.uk/sentencing-guidelines/approved-guidelines/* (accessed on 25 November 2022).

2 Carmichael, *Sudden Deaths and Fatal Accident* Inquiries (Thomson W Green, 2005), Ch 9.

in investigating such deaths is essential, as well as being robust in order to negate any potential challenge as to a conflict of interest. In addition to Art 2 ECHR considerations, such deaths may well have implications under Art 3 of the ECHR – where no one shall be subjected to torture or to inhuman or degrading treatment or punishment. The UK, in effect Scottish Ministers, was found wanting for prison slopping out processes. These processes described as the process 'where in-cell sanitation[was] not available an electronic system is available for night time needs. This provides for electronic unlocking of cells to access communal facilities in response to the pressing of the cellular call button.'[3]

6.08 This system was approved as part of the ending of 'slopping out', where an 'age-old practice [referred to as] of "slopping out" and … considered by penal reform groups as the "single most degrading element of imprisonment this century".'[4]

6.09 Indeed these instances were held to have amounted to degrading treatment under Art 3 of the ECHR.[5]

6.10 As a starting point, for practices relating to deaths in custody, reference may be made to the International Committee of the Red Cross who have produced guidelines for investigating deaths in custody.[6] They acknowledge that there is 'no one internationally accepted document that offers practical guidance to detaining authorities and humanitarian workers on the standards and procedures to be followed when a death occurs in custody'. Under Annex 1 of their Report 'all deaths in custody must be investigated promptly by an independent and impartial body, regardless of whether the relatives of the deceased request it'. That need to investigate sits outside the wishes of the family and fully within the scope of fulfilling Art 2 ECHR requirements.

6.11 In Scotland, as has been already discussed, that responsibility to investigate such deaths is discharged by COPFS, undertaking its functions to investigate the circumstances of the death under the 2016 Act. In England and Wales, that responsibility as set out under the 2009 Act is carried out by the coroner and under the inquest system. That system involves mandatory use of a jury, with the appointment of lay persons, in such inquests when the deceased 'died while in custody or otherwise in state detention'.

3 Independent Monitoring Boards, *'Slopping out': A Report on the lack of in-cell sanitation in Her Majesty's Prisons in England and Wales* (August 2010), *www.justice.gov.uk/downloads/prison-probation-inspection-monitoring/In-Cell_Sanitation_Report_V2_Aug_10.pdf* (accessed on 21 February 2023).

4 Independent Monitoring Boards, *'Slopping out': A Report on the lack of in-cell sanitation in Her Majesty's Prisons in England and Wales* (August 2010), *www.justice.gov.uk/downloads/prison-probation-inspection-monitoring/In-Cell_Sanitation_Report_V2_Aug_10.pdf* (accessed on 21 February 2023).

5 *Robert Napier v the Scottish Ministers*, 2005 CSIH 16, *www.scotcourts.gov.uk/search-judgments/judgment?id=6b2c87a6-8980-69d2-b500-ff0000d74aa7* (accessed on 21 February 2023).

6 ICRC, *Guidelines for Investigating Deaths in Custody* (October 2013), *www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf* (accessed on 21 February 2023).

6.12 The Red Cross guidelines[7] go on to set out the standards for the investigation. It should be thorough. There is a need to obtain and preserve the physical/documentary evidence to identify who the relevant witnesses are and to record their evidence. The deceased needs to be correctly identified. The cause of death must be determined, along with establishing the manner, place and time of death. The process being undertaken should be 'prompt, impartial and [achieve an] effective investigation'. Importantly, investigations should consider 'any pattern or practice that may have caused it'.

6.13 Considering the Red Cross standards, does the FAI system meet these standards or not? By applying that criteria, it is questionable whether it successfully achieves these standards as fully as it could.

3. ISSUES WITH CUSTODY DEATH INVESTIGATIONS

6.14 A number of factors have already been discussed in relation to the FAI system. These are relevant when evaluating how successfully the FAI system operates in relation to deaths in custody.

6.15 Is the FAI carried out promptly? The delays in holding mandatory FAIs from the date of the death are as significant in relation to deaths in custodial cases as with other categories of deaths. As such FAIs are mandatory; there is certainty at the outset that an FAI needs to be held. It is important that these FAIs take a priority because the State is involved. The need to avoid delay therefore is important as opportunities to consider lessons learnt inevitably diminish over time. The circumstances of such deaths may therefore be repeated if problems are not satisfactorily addressed. Many deaths in custody may well relate to similar issues, irrespective of which prison in Scotland such deaths have occured.

The public inquiry into Sheku Bayoh's death, which is currently ongoing, commenced seven years and seven days after he had died in police custody. It was also two years after COPFS, through the then Lord Advocate, had advised the Bayoh family that no police officer would face charges for his death. There is always a need to remember the priority assigned to the completion of criminal investigations and whether charges are going to result. However, there is a need to recognise that there is a significant impact on all those involved, especially and including the family, so that such delays should be kept to the minimum. The evidence of the delays can be seen in concerns expressed in the press such as '"Staggering" fatal accident inquiry delays of up to eight years revealed'.

6.16 These concerns with delay are echoed in two FAIs yet to be held. These relate to the deaths of Linda Allan and William Lindsay in June and October 2018 respectively. Ms Allan was sentenced to 16 months in custody, following her conviction

7 They were aimed at humanitarian workers, detaining authorities and other stakeholders.

for a drink-driving incident where a teenager had been injured in an accident. Her family had expressed concerns to the prison authorities prior to her death about her mental state and with her being the subject of bullying within the prison. William Lindsay died in custody when he was 16 and on remand at the Polmont Young Offenders' Institution. His death took place within 48 hours of his arrival there. In September 2021, COPFS have brought no charges against SPS though there was an indication suggested that 'there was credible and reliable evidence of a breach of the Health and Safety Act by the Scottish Prison Service that materially contributed to the deaths of Katie Allan and William Lindsay, yet Crown Immunity means there can be no prosecution of the Scottish Ministers …'.[8] Common factors exist in that both these deaths involve the issue of mental health and young persons within the prison environment.

6.17 When these kind of delays in holding FAIs are considered, they can be contrasted with the coronial system in England and Wales. There is a monitoring requirement for reporting on delays in holding inquests. In Scotland, there are no targets for these FAIs to be completed. There is no need too for any reporting accountability as to why such FAIs have not yet been carried out.

6.18 Bringing in that sort of monitoring existing in England and Wales might help in keeping families advised and also looking at the need to identify lessons to be learnt as soon as possible.

6.19 **Scope of deaths in custody:** deaths in custody include prison deaths, but these are not the only source of deaths falling within this mandatory category of FAIs.

6.20 Deaths occurring within police custody[9] also need to be included. However, unlike the SPS who publish the statistics on the number of prison deaths, in Scotland there is no similar source from Police Scotland for the provision of similar information as to those in custody. However, England and Wales routinely include that type of information under the report issued by the Independent Office for Police Conduct (IPOC) on 'Deaths during or following police conduct'.[10] In providing this information, they differentiate among categories of deaths which adds clarity to understanding the range of deaths that may arise.

8 Aamer Anwar & Co, Press Release, *4 years since the suicides of William Lindsay & Katie Allan* (27 October 2022), *https://aameranwar.co.uk/news/press-release-27th-october-2022-4-years-since-the-suicides-of-william-lindsay-katie-allan/* (accessed on 21 February 2023).

9 In terms of European jurisprudence, there can be a debate about what being in custody means. For practical purposes, this means not being free to leave. Useful guidance may be found in the criminal context in *Ambrose v Harris* [2011] UKSC 43 at [71]: "The feature of this case …, although G had not yet been formally arrested and or taken into police custody, there was a significant curtailment of his freedom of action. He was detained and he had been handcuffed. He was, in effect, in police custody from that moment onwards.'

10 *https://www.policeconduct.gov.uk/deaths_during_or_following_police_contact_statistics_england_and_wales-202122* (accessed on 25 November 2022).

6.21 There are five categories defining what a death in custody or a death following contact with the police, which include[11] road traffic fatalities, fatal shootings, deaths in or following police custody, apparent suicides following police custody and other deaths following police contact that are subject to that independent investigation. These categories have been set out under **Appendix 1** in much greater detail as they provide a useful reference point to learn from the scope of these deaths as well as making any comparison. Further information is included in the Report as to gender, age and ethnicity which could be useful to be aware of and when considering any equality and diversity implications.

6.22 Box A[12] of that report sets out the number of incidents by the type of death within the financial years 2010/11 to 2020/21, where the following table sets out a snapshot of the figures for illustrative purposes from 2010/2011 and 2020/21:

Category	Type of Incident	2010/11	2020/21
1	Road traffic incident	24	20
2	Fatal shootings	2	1
3	Deaths in or following police custody	21	19
4	Apparent suicides following custody	46	54
5	Other deaths following police contact	37	91

6.23 In comparison to Scotland, information is limited to those deaths that occurred in a custody facility, or when a person has been arrested/detained by police. Deaths following police contact include those where the person at or before the time of death had contact (directly or indirectly) with the police, acting in the course of their duty and there is an indication that the contact may have caused (directly or indirectly) or contributed to the death of the person.

6.24 What 'in custody' means for these purposes is presumably that the deceased was no longer free to go about their business. This seems a quite restricted definition. Ensuring that the specification of deaths in police custody is the same as it appears in the English reporting system would be a better approach. This would produce a greater degree of certainty as to which deaths require investigation. **Appendix 2** includes the FAI into the death of Shanie Collins which resulted when in police custody.

6.25 In practice, the distinction between England and Scotland practices may make little difference, though road traffic fatalities involving the police in Scotland may not result in a mandatory FAI being held. For any such road traffic death to require an FAI, the Lord Advocate would need to exercise their discretion, such as in the FAI to be held into the deaths of John Yuill and Lamara Bell from July 2015. This was a road traffic death where there was no contact from the police in following up

11 College of Policing, Deaths in Custody (23 October 2013, last updated 1 July 2020), *www.college.police.uk/app/detention-and-custody/deaths-custody* (accessed on 21 February 2023).

12 *https://www.policeconduct.gov.uk/deaths_during_or_following_police_contact_statistics_england_and_wales_202122* (accessed on 25 November 2022).

on the report of a car going off the road. The circumstances of that case resulted in successful criminal proceedings held against Police Scotland and a fine for breaches of the Health and Safety Act 1974. The conviction having taken place has meant that the relevant FAI can now be held.[13]

6.26 There is also a clear difference too as the deaths of serving police officers and their staff will be investigated by way of a mandatory FAI as these will have taken place within the course of employment. Deaths of civilians on their own would, unless arising under the ambit of their employment, not themselves justify an FAI. Discretion in such cases to hold an FAI lies with the Lord Advocate. In England, there is no discretion as an inquest must be held.

4. NUMBER OF DEATHS IN CUSTODY

6.27 **Police:** A Freedom of Information request[14, 15] provides an indication as to the number of the deaths arising in Scotland through contact by the police. There were 115 deaths (26 custody and 89 following police contact) arising in the period from 1 April 2014[16] to 17 March 2021. As no information is included as to deceased's names, it is not possible to check how many of these FAIs have since been completed, with the determinations subsequently issued. It should be noted that as well as these deaths requiring a mandatory FAI, these deaths are investigated under the auspices of the Police Investigations and Review Commissioner as required by Police Scotland, namely '[a]ll deaths following police contact must therefore be immediately referred to COPFS SFIU to ensure that an independent investigation is commenced at the earliest opportunity'.[17] That, though independent, is not the same as holding an FAI.

6.28 Going forward, consideration might be given to a clearer categorisation of the types of deaths, including what falls under those occurring within police custody. That will ensure that the holding of such FAIs is mandatory in order to satisfy the State's requirements under Art 2 of the ECHR.

6.29 **Prison:** Turning to the number of deaths in prison, that information is available on a quarterly basis. The following table shows the number of deaths arising from 1 January 2018 to 23 June 2022.

13 The Guardian, *Police Scotland apologises for failings that contributed to car crash death* (8 September 2021), *www.theguardian.com/uk-news/2021/sep/07/police-scotland-admits-failings-that-contributed-to-car-crash-death* (accessed on 21 February 2023).

14 *www.scotland.police.uk/spa-media/eqfpnpwb/21-0659-response.pdf* (accessed on 25 November 2022): this no longer seems to be available.

15 The information is supplied by the police's Professional Standards Department, but the national database did not operate until 1 April 2014. Prior to this there were eight legacy forces.

16 Information does not exist prior to this date as under the separate Scottish police forces, there was no means to systematically access the legacy forces records.

17 Police Scotland, *Death or Serious Injury in Police Custody National Guidance*, 2 June 2021.

Table of deaths

6.30

Year	Deaths in custody	Status – Prisoner/Other
2018	32	23/9
2019	37	31/6
2020	34	26/8 (5 Covid-19 related)
2021	53	41/12 (5 Covid-19 related)
2022 (statistics only available to 23/6/2022)	22	16/6

6.31 There are of course a wide range of reasons why prisoners die in prison. The categorisation adopted in the 'Report on Nothing to see here'[18] has been followed as it is a useful way to classify and consider what categories arise and for these purposes these are taken to comprise natural deaths, drugs deaths and self-inflicted deaths.

Natural causes

6.32 Natural causes, of course, of necessity, includes a broad category of many pre-existing conditions, such as cancer or heart disease. From the SPS statistics, deaths from these conditions appear to comprise the majority of natural deaths that occur in prison. These may be explained as the result of poor health, experienced by the prisoners. However, questions arise as to whether the death rate for other sections of the public would be broadly similar, though a possible explanation may lie in relation to alcohol and substance abuse playing an underlying role in such deaths.

6.33 At any FAI, the crucial issue should be whether all medical attention provided to the deceased prisoner was undertaken appropriately and timeously. Importantly, there should have been no discrimination as a result of their having been detained in prison. That may well require the commission of an expert and independent medical report to establish that medical attention was administered and what was provided was satisfactory.

6.34 In the FAI into the death of John Thomas Forsyth Hughes,[19] a natural death where no other findings were made, a joint minute was produced with no evidence being led at the FAI. Does this satisfy the requirement of the holding of a robust inquiry? At para [15], it states that:

18 Armstrong et al, *Nothing to see here? Statistical briefing on 15 years of FAIs into deaths in custody* (October 2021), *www.sccjr.ac.uk/wp-content/uploads/2021/10/Nothing-to-See-Here-Statistical-Briefing.pdf* (accessed on 21 February 2023).

19 [2019] FAI 31.

> 'Mr Hughes' death was due to natural causes as indicated in the post mortem report. *No information available to the court suggests that his being in custody at the time contributed to his passing*. He did seek medical intervention regularly for the discomfort being caused by his persistent cough. *The Crown raised no concerns that the treatment he received in this regard* was in any way impacted as a consequence of his being in custody and thus required examination by the inquiry.' (emphasis added)

6.35 This section illustrates some of the difficulties. The court should be in a place to answer that the medical care given to the deceased was adequate and their being in custody did not contribute to their death. It is not for the Crown to raise concerns. Another way to consider this issue is to consider had the death not occurred in custody, would a post mortem examination have been instructed? If so, would the procurator fiscal have accepted the cause of the death without further investigation? Probably, yes but that would usually depend on a report from Police Scotland confirming that there were no suspicious or unusual circumstances or indeed any concerns expressed by the deceased's family. The family were not represented at this FAI. How therefore should the FAI system replicate and provide assurance for custody deaths that indeed there were no issues arising from the deceased's incarceration and the provision of medical treatment to them?

Drug deaths

6.36 Prisoners are on occasion able to access illicit drugs in prisons. The cause of death may be clear, but challenges can be found in identifying the exact cause of death even after a forensic post-mortem examination. This can mean a finding of the death is made as being unascertained in an FAI. The FAI into the death of Tammi Bruce was one such death[20] That remained unascertained even after the FAI had been held.

6.37 Where such a death is due to consumption of drugs that needs to be recorded as the cause of death.

6.38 However, FAIs should not be about right and wrong, as accords with the statutory requirement that findings are not made as to any civil or criminal liability. Any sense of judgement on the actions taken by the deceased therefore should be avoided. In the FAI into the death of Steven Gunn,[21] at para [1.5], it states that 'in terms of section 26(2)(e) of the Act, there were, on the available evidence, no precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or the accident resulting in the death, being avoided, *other than Mr Gunn refraining from consuming said unprescribed drugs.*' (emphasis added)

20 [2020] FAI 12 at [4].
21 [2022] FAI 28.

6.39 Though inevitably true that had the deceased not taken drugs, they may not have died, this is perhaps in a similar category as stating in an accident had the car not been driven in a careless fashion, the accident would not have occurred. It seems to add nothing to the determination and indeed, may not be seen of comfort to the deceased's family. As was stated in the *Report on Nothing to see here,*[22], this 'moral tone in FAIs … …appear inconsistent with Scotland's public health approach to addiction'.[23]

6.40 The issue of drugs in prison is of a wider societal concern. As the sheriff in the FAI into the death of Mark Allan[24] indicated at para [11], she was not content:

> 'with the terms of the joint minute and that I required evidence of the protocols and procedures which were in place at the time of the deceased's death in relation to the prevention of the introduction of drugs into the prison estate and also the measures which ought to have been taken to search prisoners and their cells for banned substances and items.'

6.41 She sought to focus the FAI on the need 'to examine is whether the policies, which were not in fact being criticised, were properly followed and applied in this particular case'.[25] This chapter returns to the need to look at the systems, including drug searches and monitoring, in place within prisons to learn lessons and avoid similar deaths occurring.

Self-inflicted deaths

6.42 These comprise a range of deaths. Though the cause of death may be clear, as a suicide, that does not exclude the need for a robust investigation to be completed into the death, as there are management strategies in place in prison to look at reducing the risk of suicide in prison. This is similar to the point regarding the monitoring of drug deaths in prison made above. Various reports have been commissioned and have focused on the deaths in custody and suicides which are discussed below. Turning back to the SPS's statistics on deaths in prison, though the prisoner's names are provided, changes have been made to the recording of the cause of death over the past four years so that they now record only the medical cause of death, such as hanging rather than suicide.

6.43 To complete any comparison, given the change in referencing, the FAI determination itself would establish whether suicide was established as the cause of death. Where an FAI has been held and the determination subsequently published,

22 Armstrong et al, *Nothing to see here? Statistical briefing on 15 years of FAIs into deaths in custody* (October 2021), *www.sccjr.ac.uk/wp-content/uploads/2021/10/Nothing-to-See-Here-Statistical-Briefing.pdf* (accessed on 21 February 2023).
23 *A Defective System: Case analysis of 15 years of FAIs after deaths in prison*, October 2021.
24 [2020] FAI 8.
25 [2020] FAI 8 at [13].

this can be completed. However, it would be helpful if the cause of death was subsequently cross referenced and updated in the SPS records, as this would provide a check as well as a reference to when FAIs were completed. It would help establish how many deaths were indeed through suicide. This is not a practice routinely undertaken.

6.44 The terminology regarding the status of the prisoner too has varied on occasion from 'untried', 'remand', and 'recall', without any explanation as to what this means or why this was changed. Why this matters is of course where decisions as to remanding in custody may be questioned as to whether the deceased should have been in prison in the first place. This is particularly pertinent when looking to consideration of the timing of Covid-19 and its cause of death in prison deaths as many more prisoners were held on remand for longer.

6.45 **Covid deaths:** Covid-19 has been recorded as a cause of death in approximately 12 deaths, though none of the relevant FAIs have been completed to date. Looking at how Covid-19[26] was managed within prison, and within SPS as a whole, as well as avoiding the incidence of suicides, reflects the need to look at these deaths in a systematic manner. Emergency Covid-19 legislation meant that there were delays in court process with the suspension of statutory time limits on certain trials taking place, meaning more were held in remand for longer. How SPS managed those on remand within the prison to avoid exposure to Covid-19 is relevant in examining lessons to be learnt. Holding FAIs into such deaths in due course will be mandatory. Crucially, the public Covid-19 inquiry by the Scottish Government does not include such deaths within its remit. Provision exists under s 14 of the 2016 Act for the Lord Advocate to exercise their discretion to conduct such an inquiry into all these Covid-19 prison deaths. No such decision to do so has yet been taken.

6.46 The number of suicides in prison would also appear to potentially vindicate the requirements of s 14(1)(b) of the 2016 Act occurring 'otherwise in the same or similar circumstances'. With a similar view could be taken in relation to the Covid-19 deaths.

5. THE ROLE OF THE FAI

6.47 FAIs are conducted under the auspices of an independent sheriff. By considering the role and effect of the judicial inquiry, this helps consider how robust and effective these FAIs are and what they can achieve.

6.48 A practice has developed, especially with FAIs, into deaths in prison where evidence is frequently presented by means of joint minutes. Joint minutes are found commonly in criminal proceedings to allow the parties, the accused and the Crown to

26 The public inquiry into the Covid-19 pandemic does not include such deaths with its scope.

agree non-contentious evidence and avoid witnesses coming to court unnecessarily. The circumstances in an FAI do not replicate that adversarial criminal process.

6.49 Joint minutes may have their place in ensuring efficient court process in that they seek to agree evidence without the need for witnesses to attend the FAI. They may be useful where the evidence is not contentious and is substantially factual. There are however limits to the use of such joint minutes and even where they are to be used, other witnesses such as experts may still be required to give opinion evidence in person. The joint minutes are agreed by the parties to the FAI but frequently they do not include the deceased or their representatives so they may well be unaware of their terms.

6.50 It is not possible to ascertain from the published determinations whether such joint minutes are indeed read out in open court so that the deceased's relatives can hear the evidence.

6.51 A significant number of FAIs conclude on the basis of the joint minutes where there seems no significant inquiry into the evidence they provide, which in effect has led to the findings made by the sheriff in the determination. The practice as to the use of joint minutes needs to be reviewed – and indeed a consistent practice identified – if they are to be used as well as providing training as to what should be their limited purpose in a FAI.

6.52 Alternatively, use could be made of expert affidavits in terms of r 10 of the Rules which still simplifies the process. Affidavits are sworn statements, usually in the presence of a notary public or commissioner for oaths, who must also sign the affidavit. These could be used to confirm, for instance that, based on that undisputed factual information, the system of medical treatment in relation to management of ongoing physical or mental conditions was adequate and appropriate. Significantly, it has not disadvantaged the prisoner on account of their liberty being restricted. This statement does not seem to be routinely included.

6.53 Joint minutes are drawn up by COPFS. However, that is not the only responsibility which COPFS has. Their role in the FAI is central in presenting evidence. They also make submissions at the conclusion of the evidence along with any other parties to the FAI. However, and this is important, their role in representing the public interest should reflect the evidence which has been led. There may be some issues about what their role is where the family is not represented at the FAI. The family may well have a separate interest from that of COPFS in the role of the State.

6.54 Arguably, part of the practice in not providing legal aid to the family is that their interests are already represented in the public interest factor of ascertaining the circumstances as to the deceased's death. There may well be an overlap of interests, but this omits the fact that there may be issues relevant to the family that are not covered or included from a public interest perspective. These could include the deceased's state of mind at the time of their death or the operation of the visiting policy. Covid-19 involved lots of lock downs with prisoners restricted through the risk of infection from visitors; this may well have

had implications for their mental health. These issues may not directly relate to the cause of death but are factors which the family may want explored. Given a public inquiry represents an intrusion into very personal circumstances of a family's grief, the family may have issues that they perceive are relevant to the death to be explored, even if they are excluded ultimately by the sheriff in making the actual findings in the determination. Achieving that balance satisfactorily in the judge issuing the determination is a matter for their legal judgment.

6.55 In many of the FAIs into custody deaths, the deceased's family are neither represented nor a party to the FAI. What then results is that they in particular do not have the opportunity to scrutinise or indeed question the evidence that is led. Why they are not represented may be down to personal factors or indeed, relate to the absence of automatic legal aid by way of advice and assistance.

6.56 The percentage of families represented at an FAI into custody deaths seems low. The Report *Nothing to See Here?*[27] outlined that families were only present in 31% of FAIs (this presumably means in attendance in court as compared to observing within the court.) Only 16% had legal representation. They indicated that only 17% gave evidence at the hearings. Again, whether this means giving evidence refers to evidence in person, as it is possible that their evidence can be agreed by joint minute to save them from any further upset by appearing in court. Their evidence may well be uncontentious. It is not possible to make any conclusion other than this illustrates an area for future research to see why these figures are so low and any relationship with the current legal aid provision. The practice too of the use of joint minutes and submissions from the Crown tends to invite only the making of formal findings. Does that fully address the family or public interest in the death investigation?

6.57 Acceptance of joint minutes has been subject to criticism on occasion by the sheriffs. In the FAI into the death of Darren Kerr Smith,[28] Sheriff Lindsay Foulis outlined that:

> 'the role of the sheriff at an inquiry is different from that played in adversarial proceedings. This is made clear by reference to the provisions of section 20(2) of the 2016 Act. It accordingly appeared to me that the parties entering a joint minute and intimating to me that this dealt with the matters which were to be the subject matter of the inquiry did not constrain me from seeking certain information to ensure that there were not matters upon which I should consider evidence in an appropriate form to be presented to me.'[29]

6.58 The sheriff required the Crown to lodge a list of their proposed witnesses, accompanied by a synopsis of the subject matter of the evidence from each witness.

27 Armstrong et al, *Nothing to see here? Statistical briefing on 15 years of FAIs into deaths in custody* (October 2021), *www.sccjr.ac.uk/wp-content/uploads/2021/10/Nothing-to-See-Here-Statistical-Briefing.pdf* (accessed on 21 February 2023).

28 [2018] FAI 40.

29 [2018] FAI 40 at [5].

Affidavits were then required from witnesses who appeared to him to have 'something material to impart'. These focused on three issues including the respective benefits of providing manual as opposed to automatic defibrillators in prison, the respective difference in their cost and the reasons why two nurses did not respond to an alarm. Though, ultimately, this evidence did not affect his FAI findings, it did ensure that a robust examination of the circumstances of the death took place. However, at para [6], there was surprise from parties to the FAI when the sheriff indicated that he was not content to proceed on the basis of the joint minute. This perhaps promotes the need for better understanding of the respective roles of the parties to the FAI and more scrutiny of the appropriateness of using joint minutes and agreement of evidence.

6.59 This issue of shrieval discretion in hearing evidence is important to remember. Court resources are finite in time and costs so unnecessary, inquiry or leading of evidence should be avoided, though not at the expense of failing to ensure an effective and thorough FAI is undertaken.

6.60 The FAI into the death of Ian Alexander Jolly[30] illustrates this potential dilemma where the determination proceeded on the basis of 'the hearing of unchallenged evidence'. Just because the evidence is not challenged by the parties at the FAI does not reduce the need for the sheriff to undertake a robust inquiry. There need to be no gaps in the evidence, especially it is submitted where the FAI has had no family representation.

6.61 The FAI into the death of John Hanley Harrison[31] also illustrates this point as that was another inquiry proceeding by way of a joint minute. The sheriff's determination, at para [22], states that 'in light of the evidence before the Inquiry and the submissions made, I am satisfied that the medical care provided to Mr Harrison within both hospital and prison as is relevant to the remit of this Inquiry, was entirely appropriate'.[32]

6.62 While this may be correct, the determination lists various documents but crucially does not refer to any SPS Death in Prison Learning Audit and Review (DIPLAR), nor whether the delay in taking the deceased to hospital from the time when he became unwell mattered. Did that have any effect on his death? Was the medical care given at the prison and in hospital satisfactory? These seem to be potential gaps in the determination. It seems that there would be merit in ensuring judicial training reflects an understanding of the DIPLAR process – it is an internal SPS investigation but does not discharge the sheriff from ensuring that the determination covers the essential questions. That is to ensure that the death of the deceased in custody was not as a result of any inadequate medical attention.

30 [2020] FAI 35.
31 [2022] FAI 31.
32 [2022] FAI 31.

6.63 There is an absence in the determinations issued in prison deaths in identifying or making any recommendations, though there are as identified in **Chapter 5** few recommendations made generally in relation to FAIs. Quite why this should be the case is not clear, though recommendations do not require to be implemented, so lack any robust mechanism to ensure that such matters have been resolved. However, identification of any reasonable precautions or system defects should be made where possible and pertinent.

6.64 Part of the reluctance to make any findings may indeed be the acceptance within an FAI that internal reviews were conducted under the DIPLAR system and have identified all necessary issues with all systems thereafter having since improved. DIPLARs are an important process and have the advantage of being conducted in a timely fashion, soon after the event, but they are internal to SPS process. They do not necessarily have the robustness of an external independent inquiry such as within an FAI, though of course they are important.

6.65 Notwithstanding any recommendations from a DIPLAR and its implementation, recommendations under s 26 of the 2016 Act could still be made so that other prisons can learn if appropriate from the circumstances of that death. Is there an aspect for SPS in administering palliative care, or ensuring dignity in death with prisoners suffering from terminal conditions?

6.66 The FAI into Andrew Croall Hutchison[33] made no findings as to any defects or precautions to be taken following his death. Similarly, no recommendations were identified or made. However, a DIPLAR (prison) and an Adverse Event Review (medical) were both undertaken. These disclosed learning points albeit that they were said to have been remedied by the time of the FAI as their recommendations had since been implemented.

6.67 For the prison, through the DIPLAR, it highlighted that the Risk Management Team NHS representative should discuss any patient due for discharge who has complex health care needs with the relevant SPS clinical staff. With patients being discharged from hospital following an episode of care, a timely discharge letter/plan should be sought. Direct contact between the prison and hospital should establish care and treatment needs.[34] Paragraph [27] notes that these recommendations had been completed but does not state how these systematic changes were made and how to avoid such deaths in the future. Is there a possible wider application from such finding on the discharge of patients for both the NHS and SPS?

6.68 In this death, no post-operative discharge information was made available and could not be immediately obtained as the unit was closed. Though this was remedied in this case, what changes were required to be made to the system? Did they go wider than merely dealing with the circumstances of this death?

33 [2022] FAI 33.
34 Paragraph [27] notes that these recommendations have been made.

6.69 Overall, by accepting the internal reviews, verbatim, valuable as they are, there is perhaps a suggestion that the organisations have "marked their own homework", vindicated by no further inquiry or recommendations being made in court. This has and must give rise to some concerns over the effectiveness or indeed the purpose of undertaking such FAIs. If the reviews have been conducted satisfactorily, why use further public resources to rubber-stamp these findings within the FAI process?

6.70 Again, looking to the English and Welsh coronial system, they have powers to make Recommendation 28 Reports where their scope, as discussed in **Chapter 7** seems much broader. The narrow focus of causation and use of joint minutes may on occasion restrict more robust and thorough inquiries being made in Scotland.

6. THE ROLE OF THE FAI AND AN INQUIRY

6.71 When considering the scope of the current public inquiry into the death of Sheku Bayoh in May 2015 when in police custody,[35] the narrowness of the FAI process can be seen. This inquiry is being conducted by Lord Bracadale[36] as a public inquiry under the Inquiries Act 2005. That allows any causal link to be established as to the allegations of possible racism that may have been operating within the police at that time. Its Terms of Reference focus on the immediate circumstances leading to the death of Mr Bayoh, how the police dealt with the aftermath of his death, the subsequent investigation undertaken into the death and whether race was a factor. They have also produced FAQs which is a practice to consider extending more widely possibly in relation to the conduct of FAIs.[37] These FAQs provide practical answers to key questions such as what is a public inquiry, the key stages in the inquiry, and outlines the respective roles in the inquiry. It is suggested that production of these would assist the public and the families navigate the FAI process.

35 Now set up as a death in public inquiry under Lord Bracadale. Evidence is due to resume in November 2022. It will examine inter alia the post-incident management conducted by Police Scotland, the cause of death, the investigation conducted by the PIRC and the Lord Advocate and the issue of race. The Terms of Reference are set out at *www.shekubayohinquiry.scot/sites/default/files/2020-11/Inquiry%20terms%20of%20reference.pdf* (accessed on 21 February 2023).

36 Public Inquiry into the death of Sheku Bayoh – Terms of Reference, *www.shekubayohinquiry.scot/sites/default/files/2020-11/Inquiry%20terms%20of%20reference.pdf* (accessed on 21 February 2023).

37 Sheku Bayoh Inquiry – Frequently Asked Questions, *www.shekubayohinquiry.scot/faq* (accessed on 21 February 2023).

7. CURRENT POSITION ON DEATHS IN CUSTODY

6.72 As discussed above, the number of deaths in prison is increasing.[38] There are various explanations to put forward for this, including that the prison population is getting older.[39] That observation is not unique to Scotland, being driven partly due to an increase in the number of older adults being sentenced for sexual offences, and specifically, for historical sexual offending. Increases too in the length of sentences being imposed means that more people will grow old and die in prison from natural causes. These deaths albeit natural still require an FAI.[40]

6.73 The projection is that the older prisoner population will continue to increase so that the requirement for more such FAIs to be completed will continue to increase. This will need resources factored in to complete these FAIs. These prisoners will require greater medical attention for diseases and disability in order to satisfy their health and social care requirements.[41] Such deaths when they arise will still require thorough investigation.[42]

6.74 Various reports now evidence that growing interest and concerns over the deaths arising in custody. These consider different aspects in looking at how best lessons are to be learnt from these prison deaths, though there is some overlap as well as similarity in the recommendations that they make.

6.75 In May 2019, the HM Inspectorate of Prisons for Scotland undertook the *Report on an Expert Review of the Provision of Mental Health Services, For Young People Entering and in Custody at HMP YOI Polmont*.[43] Its background was that '[e]very death of a young person is a tragedy, for them, their families and their friends, but also for Scottish society that has lost the opportunity of their talent and potential

38 Daily Record, *Deaths in Scots prisons are on the rise as shock figures confirm 'worst fears' of grieving families* (22 January 2022), *www.dailyrecord.co.uk/news/politics/deaths-scots-prisons-rise-shock-26017387* (accessed on 21 February 2023).

39 House of Commons Justice Committee, *Ageing Prison Population*, Fifth Report of Session 2019–21, HC 304, *https://committees.parliament.uk/publications/2149/documents/19996/default/* (accessed on 21 February 2023).

40 The FAI into the death of Angus Sinclair was one where the deceased was sentenced to a minimum term of 40 years in respect of his conviction for the girls in the Worlds End Murders: [2020] FAI 14. He had longstanding health issues – but where the sheriff notes at para [0] that '[t]here is no criticism directed to the care of the deceased within the prison'. As evidence was agreed by joint minute it is unknown whether that is a factual recording evidence from external evidence.

41 House of Commons Justice Committee, *Ageing Prison Population*, Fifth Report of Session 2019–21, HC 304, *https://committees.parliament.uk/publications/2149/documents/19996/default/* (accessed on 21 February 2023).

42 Armstrong et al, *Nothing to see here? Statistical briefing on 15 years of FAIs into deaths in custody* (October 2021), *www.sccjr.ac.uk/wp-content/uploads/2021/10/Nothing-to-See-Here-Statistical-Briefing.pdf* (accessed on 21 February 2023).

43 HMIPS, *Report on an expert review of the provision of mental health services, for young people entering and in custody at HMP Yoi Polmont* (May 2019), *www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Report%20on%20Expert%20Review%20of%20Provision%20of%20Mental%20Health%20Services%20at%20HMP%20YOI%20Polmont%20-%20Final%20Version.pdf* (accessed on 21 February 2023).

contribution'. Though the focus was on young persons, similar points apply to any person entering custody as the issues, examined, included:

- information provided to SPS prior to entering custody;
- reception, screening and assessment arrangements;
- health and wellbeing culture linked to ongoing support and supervision;
- treatment and interventions during their time in custody;
- arrangements by SPS for their return to the community.

6.76 The recommendations identified that there was a lack of proactive attention to the needs, risks and vulnerabilities of those on remand and in their early days of custody. Of significance, it highlighted that there should be enhanced and more consistent DIPLAR processes, as flagged above, undertaken by SPS to maximise learning from previous incidents. The follow up from the report can be tracked through the report by Scottish Government to the Scottish Parliament.[44]

6.77 In October 2021, *A Defective System-Case analysis of 15 years of [FAIs] after deaths in prison* was published. That briefing presented information from a review of 15 years of FAIs, covering 196 deaths in custody (mainly within prison) in Scotland between 2005–2019.[45] It was mostly focused on the family's position. It recognised that:

> 'every death in custody has a profound impact – for the family of the person who has died, for the prisoners who cared for or were near to them at death, and for the staff responding to and dealing with mortal emergencies. Each one raises questions about the quality of care and accountability of the state on whom those in custody depend.'

6.78 That review also looked at the need to consider:

> '[t]he effectiveness of holding such an inquiry after such a delay …, evidenced … where no recommendations are made, not because there were no defects or precautions that could have been taken, but because the necessary changes have already been made by those involved. This does not even begin to take into account the distress which in many cases will be occasioned to families in re-opening the circumstances around the painful loss of a loved one so long after the event.'

6.79 In November 2019, the then Justice Secretary Humza Yousif MSP requested Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) review the

44 The Scottish Parliament, *Expert review of Mental Health support for Young People entering and Custody,* correspondence at 30 June 2022, *www.parliament.scot/chamber-and-committees/committees/current-and-previous-committees/session-6-health-social-care-and-sport-committee/correspondence/2022/expert-review-of-mental-health-support-for-young-people-entering-and-in-custody* (accessed on 21 February 2023).

45 Barkas et al, A Defective System. Case analysis of 15 years of Fatal Accident Inquiries after deaths in prison (October 2021), *www.sccjr.ac.uk/wp-content/uploads/2021/10/A-Defective-System.pdf* (accessed on 21 February 2023).

response to deaths in prisons. That Independent Review of the Response to Deaths in Prison Custody[46] adopted a human rights approach with the report being published in November 2021. It made a number of recommendations including that:

- An independent body should carry out an investigation into every death in prison custody stating that this would complement the current inquiry processes. This was said to bring Scotland in line with England, Wales and Northern Ireland.
  Exactly what 'independent' means in this context is unclear. One could reflect on the context of Art 6 of the ECHR, where it states that 'In the determination of [their] civil rights and obligations …, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law'.
  COPFS are indeed independent in conducting any FAI in the public interest, though ultimately the judge is responsible for making the relevant findings. By suggesting that the FAI should be carried out by 'a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS, it is not clear what the role of the Crown would be under that model'.[47]
- For families or next of kin, investigations into prisoners' deaths must be completed within a matter of months.
  That may not be possible where there is complexity in investigating some deaths. Introducing a method of recording the progress of such investigations publicly however would seem to be good practice. It would provide a much more rigorous means of scrutiny.
- The investigation process must involve the families or the next of kin of those who have died in prison custody.
  That does occur though many families do not take a formal part in the procedure. Understanding the reasons why this may be the case is important. There may be a need to look at an automatic grant of legal aid or some alternative State funded resource to help in achieving their representation.
  The purpose of the investigation should be to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Art 2 of the ECHR. All investigations must result in a written outcome.

46 HMIPS, *Independent Review of the Response to Deaths in Prison Custody* (November 2021), *www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Independent%20Review%20of%20the%20Response%20to%20Deaths%20in%20Prison%20Custody%20p6%20%281%29%20WEB%20PDF.pdf* (accessed on 21 February 2023).

47 HMIPS, *Independent Review of the Response to Deaths in Prison Custody* (November 2021), *www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Independent%20Review%20of%20the%20Response%20to%20Deaths%20in%20Prison%20Custody%20p6%20%281%29%20WEB%20PDF.pdf* (accessed on 21 February 2023).

These recommendations seem entirely in line with the observations made above about looking at systems and how best to consider what lessons can be learnt.

- The independent investigatory body must have unfettered access to all relevant material, including all data from SPS, access to premises for the purpose of conducting interviews with employees, people held in detention and others, and the right to carry out such interviews for the purpose of the investigation. Corresponding duties should be placed on SPS and other relevant institutions requiring the completion, retention and production of relevant information in their possession.

  Full powers exist for COPFS at present to instruct such inquiries. It is the use of joint minutes that might provide a basis of why all materials may not be before the FAI effectively in each case.
- Access to full non-means-tested legal aid funding for specialist representation throughout the processes of investigation following a death in custody should be provided, including at the FAI. This seems to be appropriate.

8. CONCLUSION

6.80 There are long delays in FAIs into deaths in custody being carried out, with a significant backlog due still to be heard against a background of rising concerns about the nature of these deaths of those in custody. The Independent Report[48] concluded that from the 'evidence … heard from bereaved families that existing practice fails to provide them with choice and control – two pillars of trauma-informed practice. At every step of the journey currently, there is a noticeable lack of family engagement.' Families need to be engaged and supported to command respect and ensure trust in the FAI process.

6.81 Similarly, the independent report concluded that there seemed to be a lack of clarity in leading in respect of the various organisations tasked with investigating a death and where any criminal proceedings might be in contemplation. Should the other organisations await the outcome of the criminal investigation by COPFS and/or Police Scotland before undertaking their own?

6.82 Paragraph 159 of the report[49] recognised that it was important that the gathering of evidence in criminal proceedings was not prejudiced. The factual evidence will be the same, but complications may well arise where it is the organisation itself which is at the core of the investigations, such as Police Scotland

48 Scottish Government, News, *Death in Custody Review* (30 November 2021), *www.gov.scot/news/death-in-custody-review/* (accessed on 21 February 2023).

49 Ibid.

or SPS. These have been seen recently in both the FAI into the deaths on the M9[50] where Police Scotland were prosecuted and the suicides in prison where no criminal proceedings can be taken against SPS due to Crown immunity.[51] Delays are also not good for anyone as recognised in discussions on delays in FAIs, partly because of strain but also to refer to their memory of events. It must be possible to agree at the outset a potential timescale for concluding investigations with provision made for undertaking regular reviews.

6.83 There appears to be a lack of join-up of relevant information from the provision of statistics of the number of deaths in prison to the issue of the actual determinations. Why are the SPS death statistics not regularly updated with information about whether an FAI has been completed or noting when it is being scheduled? When the FAI is completed, and the determination issued, the cause of death and other information should be cross referenced. Why are statistics not routinely provided on the number of deaths in police custody? Only by joining up the information from death within the relevant organisation to the issue of the determination can meaningful references be undertaken to allow trends and systemic issues, to be identified and to make recommendations seeking to promote good practice.

6.84 There needs to be a robust approach taken to the use of joint minutes to identify where they can be used to good effect and without any reduction in the quality of the evidence or robust nature of the FAI.

6.85 The promotion of better understanding of the roles adopted in an FAI is required to understand what the Crown can and indeed should present by evidence. The need is for the independent reviewer as in the judges undertaking their role to ensure that they demand robust and thorough scrutiny of the evidence.

6.86 In general, the FAI system seems neither to be ill-equipped nor resourced to ensure that FAIs into deaths in custody are completed in a manner that fully satisfies the guidelines discussed by the International Red Cross. Whether or how the Scottish Government will implement any of the report of their recommendations remains to be seen.

50 Central FM, *Fatal accident inquiry after M9 crash deaths* (26 October 2022), *www.centralfm.co.uk/news/local-news/fatal-accident-inquiry-after-m9-crash-deaths/* (accessed on 21 February 2023).

51 BBC, *Families' anger as no prosecution over young prisoner suicides* (27 October 2022), *www.bbc.co.uk/news/uk-scotland-63416035* (accessed on 21 February 2023).