Still nothing to see here?

One year update on prison deaths and FAI outcomes in Scotland

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30 November 2022

Statement

This briefing addresses dying in prison in Scotland, including information about the numbers and circumstances of deaths. Even when presenting statistical data, we never forget that these numbers represent individual people who were part of families and communities, and that their loss is deeply felt. Our motivations for doing this work are to raise awareness of deaths in custody and to provide rigorous evidence about this issue. Ultimately, we aim to prevent deaths and reduce the number of families and friends who are exposed to the often traumatising experience of a fatal accident inquiry on top of their bereavement.

There are important ethical issues involved in this work, and we are constantly reflecting on these and how best to address them. One concern relates to the naming of individuals who have died, and the impact this could have on loved ones. The position we have adopted in this report, based on internal discussions and consideration of practices in similar projects around the world is that names of individuals will not be used where we do not have the express consent of family members to do so, and some details of cases may be excluded to avoid easy identification. As the work herein makes use of records in the public domain, it is still possible that individuals could be identified, but we feel that the public interest of producing accessible information on an important issue provides a crucial counterbalance. Our main concern within this work is to ensure families are not subjected unexpectedly to seeing a loved one's name alongside upsetting information about the circumstances of their death.

For families and friends who have lost a loved one in custody, we recommend resources available through INQUEST. While their work focuses on England and Wales, they are an independent charity with a strong understanding of what families are going through and need to know following a death in custody. They provide numerous resources here: https://www.inquest.org.uk

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Executive Summary

This report provides a one-year update of our prior review of deaths in prison and FAI outcomes, published in October 2021. It is based on a review of all prison deaths between January 2020 and September 2022, and analysis of 32 FAIs published from early 2021 through September 2022.

Part I Rising rate of death in Scottish prisons

- There were more deaths in prison over the past three years than in any other three-year period in Scottish prison records: 121 people died in prison between January 2020 and September 2022 compared to 98 deaths between 2017-19, and 76 deaths between 2014-16. Covid was not the main cause of the increase in the current period.
- Suicide and drug-related deaths are the driving forces in rising levels of death. Together, they were the leading cause of death in prison in 2022.
- Comparison with earlier periods shows that the chance of dying in prison in 2022 is double that for someone who was in prison in 2008.
- Rough comparisons with England and Wales show Scotland's prisons had higher rates of deaths due to Covid, suicide and drugs.

Part II FAI time-frames, family involvement and results

- FAIs continue to take on average over two years to complete, the longest FAI took four years and four months and made no findings to prevent death in similar circumstances.
- Family involvement remains low in FAIs, no family presence was noted, nor legal representation, in 75% of FAIs.
- In only two of 32 FAIs was there a reasonable precaution or system defect identified and only one of these included recommendations; that's over 90% of FAIs where no finding to prevent another death in similar circumstances is made.
- FAIs of people who died during the Covid pandemic were shorter and faster than for those who died at other times, and did not consider pandemic restrictions on mental health, access to care or timely decision-making.

Part III Themes from FAIs – case excerpts

- Examples of avoidable death include those from conditions that are considered highly treatable in the community.
- Lack of scrutiny of a suicide prevention policy that has seen a 42% rise in suicides since being introduced.
- Most of the facts and evidence in FAIs is agreed prior to an inquiry taking place via a legal tool called the joint minute, designed for an adversarial legal process like criminal trials. In FAIs, joint minutes are signed off by those responsible for the care of people in custody, raising concerns about conflict of interest and independence.
- Deaths following miscommunication leading to critical delays in treatment.
- Deaths after being refused assistance with mental health, or where records of mental health were deemed too lengthy to read.
- Issues with timeliness, quality and effectiveness of care by health or prison staff.
- Sheriffs did not consider how conditions of prison during Covid affected delays in care or otherwise impacted access to timely care.
- The FAI process frames issues narrowly so that many systemic issues are ruled out of bounds. The Crown Office, in almost all cases, urges Sheriffs to make no corrective findings. Sheriffs rarely challenge joint minutes or ask for evidence beyond what is contained in them, further limiting opportunities of examining potentially systemic issues.
- Decisions to detain very unwell people raise wider questions about the use of arrest and detention.

Introduction and background

This briefing provides a one-year update since we published our reports *Nothing to See Here?* and *A Defective System* in October 2021. In that work, we analysed nearly 200 Fatal Accident Inquiry (FAI) determinations, comprising all the FAIs published of the 359 deaths in prison occurring between 2005 and 2019. FAIs are the only mandated, publicly accessible investigation into prison deaths that exists in Scotland and have the ultimate aim of preventing deaths in similar circumstances. Last year our analysis showed:

- Scotland's prison death rate has been steadily rising, with suicides and drug-related deaths driving faster growth in recent years
- FAIs take years to complete, often starting and stopping, adding enormous stress for the families of the person who died
- Sheriffs rarely identify any precautions, defects or recommendations in FAIs
- Families rarely attend, give evidence or are legally represented in FAIs
- Family involvement and Sheriff identification of concerns did not seem to increase after introduction of a new FAI law, which became effective in June 2017
- There are problematic assumptions and tones about deaths of people who had drug issues and for deaths labelled 'natural'
- There is a pattern of problematic conduct that we identified in the treatment of people who die by suicide in prison, but rarely do these translate into the identification of formal findings

We summed up this situation in the following way: '*FAIs take a long time…to find nothing could be done*.'

Shortly after our report was published, the Scottish Government-commissioned *Independent Review of the Response to Deaths in Custody* published its report. This review revealed further evidence of family confusion, distress and exclusion from FAIs. The review re-stated the human rights obligation of the state 'to carry out an effective investigation into deaths and ensure accountability where state responsibility arises' (p. 13). Yet, the rising rate of death in prison and a system of investigations which consistently excludes families and determines nothing can be done in over 90% of cases raises strong doubts that this obligation is being fulfilled. The Scottish Government accepted the findings of the report and, following the appointment of an independent chair in April 2022, established a 'deaths in custody action group', 'a family reference group' as well as working groups to take forward recommendations. The current FAI system is not within the scope of the Deaths in Custody (DiC) workplan. A one-year update on progress is expected by the end of 2022.

Has anything changed? In this briefing we assess where things are one year later. We review deaths in prison during the Covid years (2020-22) and analyse all the FAIs published since our previous publication. In summary, since we last reported:

- There were a higher number of deaths in prison (121) during 2020-2022 than in any other three-year period preceding it
- 32 FAIs involving deaths in prison have been completed since early 2021; as of October 2022 there are 123 FAIs outstanding
- Sheriffs have identified even fewer precautions, system defects or recommendations than in our first report
- Family involvement remains low

This report contains three sections: (1) Review of deaths in prison 2020-2022; (2) Analysis of FAI time-frames, findings and family involvement; and (3) Case examples from recent FAIs. Data on deaths is taken from the tables published on the Scottish Prison Service website; FAIs are published by the Scottish Courts and Tribunal Service.

PART I. Deaths in Scottish Prisons

1. A record number of people died in prison between 2020 and 2022

121 people died in prison during 2020-22, including 29 by suicide and 25 from drugs (with eight deaths still awaiting classification). By the end of September 2022, there had already been nearly the same number of suicides in prison in 2022 as for the whole of 2021. Of the eight deaths that have not yet had a classification, at least some of these are likely to be drug-related (where lab tests are pending to identify substances in the body).

Table 1. Deaths in prison 2020 - (September) 2022 by cause

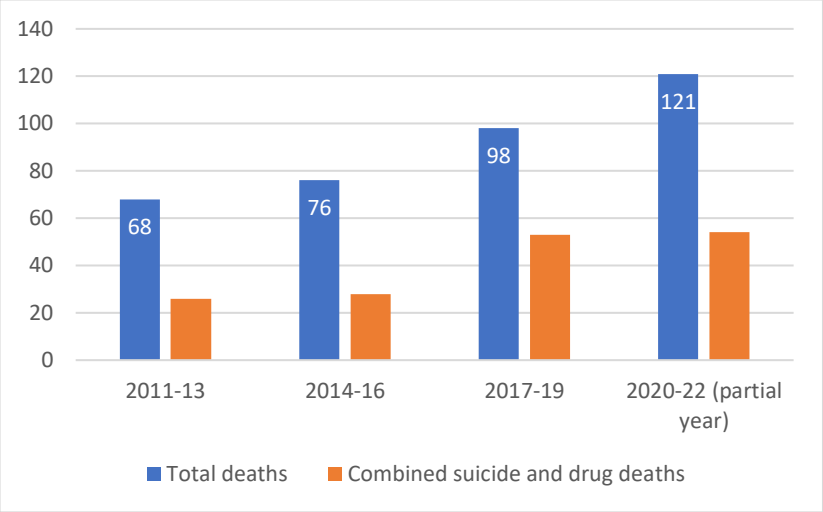
Cause	**2020**	**2021**	**2022**	**Total**
Covid	5	9	1	**15**
Suicide	5	12	12	**29**
Drugs	9	15	2	**25**
Homicide	1	1	0	**2**
Other (med conditions excl Covid)	13	16	12	**42**
Undetermined	1	0	7	**8**
Total	**34**	**53**	**34**	**121**

Source: Scottish Prison Service. Some causes of death updated based on completed FAIs and death certificate data.

The number of deaths occurring in the last three years is higher than for any other three-year period on record in Scotland. The figure below shows deaths (in three-year groupings) rising over ten years, as well as a rising trend in deaths by suicide and drugs. We have combined these two causes to isolate those which result not from a medical condition but, typically, from distress and loss of hope, which are of particular concern in assessing prison regimes and conditions. Once the 8 unclassified deaths have a cause of death determined, and full year data is available for 2022, it is undoubtedly the case that the number of drug and suicide deaths will be higher.

Deaths from medical conditions, commonly described by the SPS and in FAIs as due to 'natural causes', also raise concerns, especially in light of the nature of health care available to people in prison during the pandemic. Examples from FAIs discussed below in Part III illustrate some of these. It is notable that in 2021 there was a slight rise in the number of these deaths, though overall figures are small.

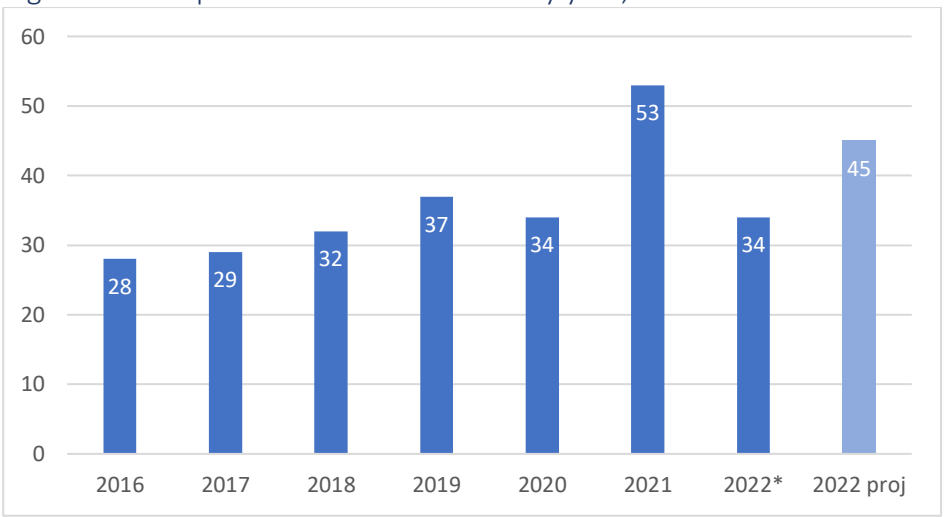
Figure 1. Total deaths and combined drug & suicide deaths, 3-year periods



Data for 2022 includes only January-September.

The pandemic years of 2020-22 show more fluctuations in numbers of deaths than the steady pattern of rising deaths in the years preceding Covid. The reasons for this are worth further study. However, the overall trend is one of growth during the pandemic. In the figure below, two numbers are given for 2022, the partial year total (through September there were 34 deaths) and an estimated total of 45 deaths for the full year, based on the assumption that a similar number of deaths occur in each quarter of the year. This errs towards underestimation as typically more deaths occur in the months from October to December than in other parts of the year.[1]

Figure 2. Total prison deaths in Scotland by year, 2016-2022



*Actual number of deaths; 'proj' is the estimated number of deaths for a full year.

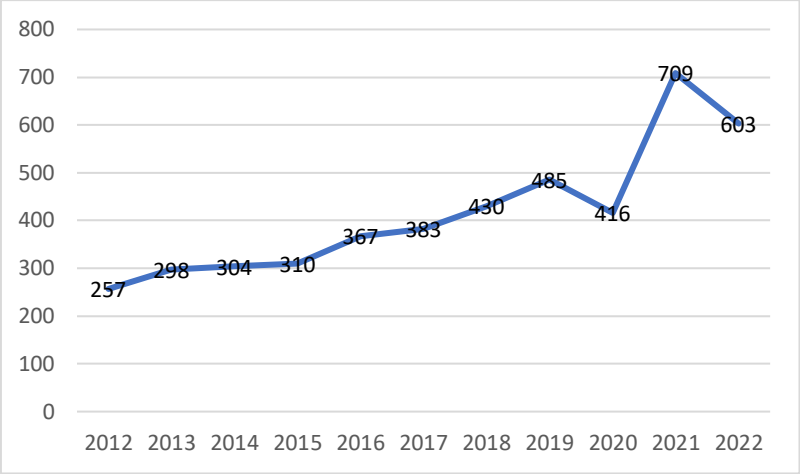
If the number of deaths by the end of 2022 reaches 45, then this would show that a consistent rising trend of prison deaths since 2015 is continuing during the pandemic. In

[1] For example, between 2012-19, a total of 216 people died in Scottish prisons, and 56 (or 26%) of these deaths occurred between October and December. Source: analysis of SPS data.

fact, there have already been five more deaths in October and early November, so that the number of deaths in 2019, which had set the pre-pandemic record, has been exceeded.

Looking at deaths in relation to the size of the prison population suggests that the rate of death in prison accelerated during the pandemic. This can be seen by noticing the steady rise in the death rate (number of deaths per 100,000 prisoners, using average daily population) between 2012-2019, followed by the jump in 2022 (using estimated full year data).

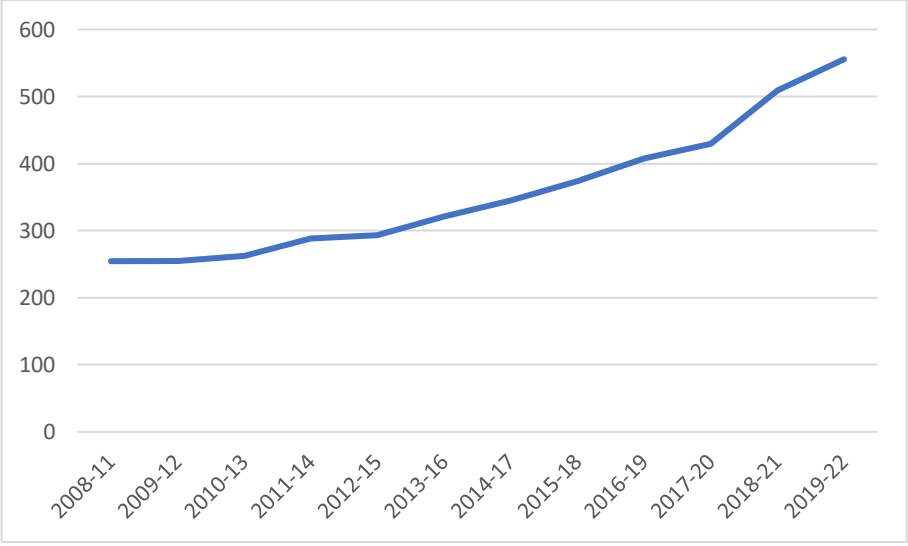
Figure 3. Annual prison death rate (per 100,000)



*Rate of death is calculated by dividing numbers of deaths by the average daily prison population for each year (using Scottish Government ADP data for 2021-22) and then multiplying by 100,000. The estimated figure for 2022 deaths of 45 is used to calculate the rate for this year.

The figure below smooths year to year fluctuations by using four-year moving death rates. It confirms a rising rate of deaths during the pandemic. Looking across this longer stretch of years shows a disturbing trend: a person imprisoned in 2022 is twice as likely to die in prison as someone imprisoned in 2008. This is a crucial context for the analysis of FAIs, in the next two parts of this report.

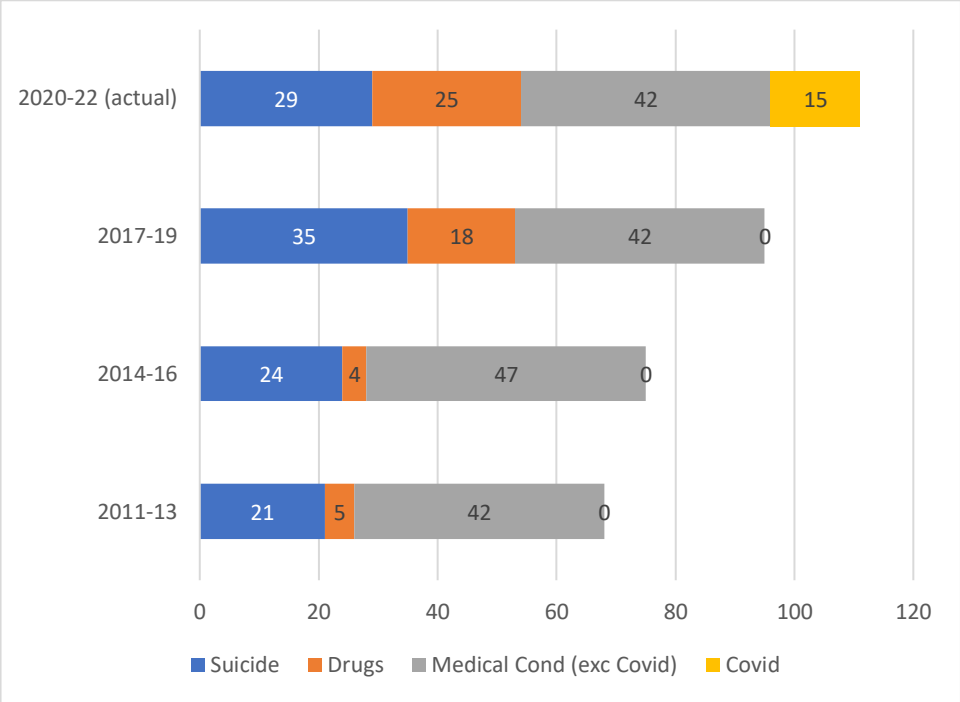
Figure 4. Prison death rate from all causes - 4-year moving averages



2. Suicide and drugs were a driving force behind rising death rates in Scottish prisons during the pandemic

Deaths from Covid played a role, but not the most significant one, in the record-breaking number of prison deaths in 2020-22, accounting for around an eighth of the total during this time. The larger influence has been deaths from drugs and suicide. This can be seen in the chart below. It shows that deaths from medical conditions (excluding Covid) have held fairly steady over a decade, while combined drug and suicide deaths have been on the rise. The reader is reminded that the number of deaths from suicide and drugs in prison during 2022 includes only partial year data (i.e. actual number of deaths through September 2022).

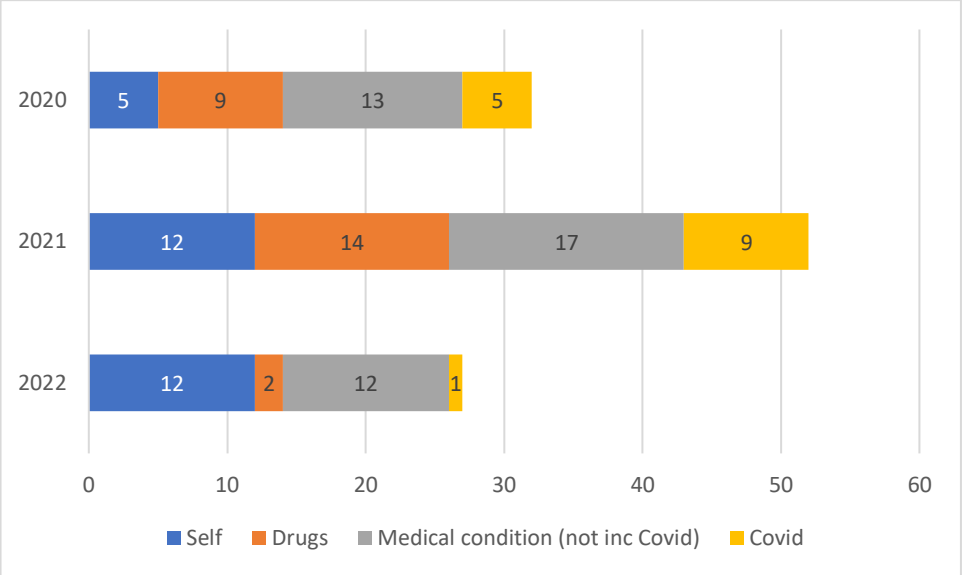
Figure 5. Main causes of death in prison, 3-year groupings 2011-2022



This chart does not include eight deaths where a cause is yet to be determined.

Figure 6, below, shows causes of death by pandemic year. A sharp rise in fatal and non-fatal drug overdoses in 2021 led the SPS to institute a ban on prisoners receiving letters directly in most prisons from late that year, thereby restricting one method of supplying drugs. This rule correlates with a fall in drug overdose deaths so far in 2022. However, there have been as many suicides in prison in nine months of 2022 than in all of the previous year. This suggests that while restricting the *supply* of drugs into prison reduced overdoses, the underlying issues driving *demand* for drugs – boredom, despair, distress and isolation – have not been addressed to the same extent. This is important as these factors of demand for drugs also commonly underly motives of suicide.

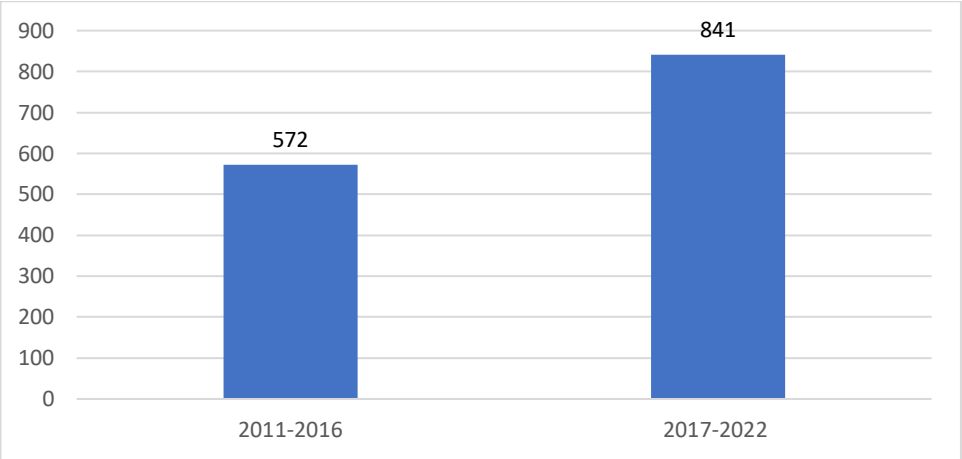
Figure 6. Leading cause of death in prison by pandemic year



This chart does not include 8 deaths where a cause is yet to be determined or 2 homicides, and only includes deaths through September 2022.

Since the introduction of the current SPS suicide prevention strategy, 'Talk to Me' (TTM), in December 2016, there have been 64 suicides in prison (January 2017 through September 2022). In the six-year period before this policy was in place (2011-2016), there were 45 suicides. Hence, following the introduction of the Talk to Me strategy there have been 42% more suicides than before it came into effect. The figure below translates these suicide numbers into rates.

Figure 7. Suicide rate (per 100,000) in Scottish prisons before and after TTM introduced



Rates are calculated using the average daily population for the two periods: 2011-2016 (7,864) and 2017-2022 (7,612). Source: Scottish Prison Service and Scottish Government prison population data.

3. Comparisons with England and Wales, changes in profile of those dying by suicide, recall deaths and deaths among women

In addition to the above points about the record number of deaths, and the role of suicide and drugs, there are other notable issues arising in prison deaths occurring in the pandemic years 2020-22. We highlight these below, though note that due to the short time-frame and overall small numbers, it is unclear whether these are evidence of broader trends or reflect distinctive patterns specifically related to the pandemic.

- Comparison with England and Wales, albeit using crude mortality rate calculations, shows higher death rates in Scottish prisons for key causes of death:[2]

Table 2. Crude mortality rate comparison of prison deaths (per 100,000)[3]

Death rate 2020-21 unless noted	**Scotland**	**England and Wales**
Covid	94	86
Suicide	114	96
Drugs	154	88*

*2008-2016, the latest available official calculation of drug death rates in prison in England and Wales; new figures due to be released in 2023.

- Suicide is affecting older people and a higher number of convicted people than previously: During 2020-22 over 40% of those dying by suicide were 45 years or older; between 2009-19, those 45 years and older accounted for only half this level (22%) of suicides. Similarly, while most (51%) suicides between 2009-19 were among those on remand, in 2020-22, the vast majority (72%) of self-inflicted deaths were among convicted people.

- For the first time ever noted in SPS published data, 7 recalled prisoners died in 2020-22, four from drugs or suicide and one from Covid.

[2] Sources of data for England and Wales: Covid (https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(21)00137-5/fulltext; https://www.gov.uk/government/statistics/hmpps-covid-19-statistics-september-2022/hm-prison-and-probation-service-covid-19-statistics-september-2022#deaths); Suicide (https://www.inquest.org.uk/deaths-in-prison; Drug deaths (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsandsuicideinprisoncustodyinenglandandwales/2008to2016); and prison population size (https://www.prisonstudies.org/country/united-kingdom-england-wales; https://commonslibrary.parliament.uk/research-briefings/sn04334/). Sources of data for Scotland: Scottish Prison Service.

[3] Crude mortality rates (CMR) divide total deaths by total population (and multiply by 100,000). A better measure is age standardised rates, but prison populations are generally adult populations and by using CMRs for both jurisdictions a like with like comparison offers a useful gauge of comparative mortality in prisons north and south of the border.

- There have been eight recorded homicides in Scottish prisons since 1995; two of these were in the last two and half years.[4]

- Women made up a smaller proportion of deaths than in previous years, and two of the three deaths in this group between 2020-22, were from drugs or suicide. Suicide is the leading cause of death of women in prison (based on Scottish records since 1995).

The Covid years of 2020-22 have seen a large increase in the number of people dying in prison. Whilst this might be expected given the global pandemic and higher death rates among people in institutional settings, Covid deaths in Scottish prisons accounted for a relatively small proportion of all deaths. Deaths from causes associated with distress, despair and isolation – suicide and drug-related deaths – accelerated their rising trend during Covid. This should attract urgent concern and further study, particularly in relation to policies adopted in prison to address the Covid pandemic. There are few remaining mandatory Covid restrictions affecting people outside prison, but these continue inside, including reduced face-to-face visiting, reduced opportunities of prisoner out-of-cell time, and reduced staffing in some places. These factors have been thoroughly documented in increasing isolation and causing significant mental distress to people in prison.[5] The impact of Covid restrictions in prison are relevant and important issues for the national Covid inquiry as well as for FAIs.

[4] One of these homicides, where an FAI has not yet been conducted, involved an attacked prisoner waiting five hours for an ambulance before dying; the prisoners involved in the attack were convicted of culpable homicide.

[5] See https://www.uservoice.org/consultations/coping-with-covid/ for the UK, and specifically for Scotland, see, https://scotlandinlockdown.co.uk/2022/03/15/my-mental-health-has-gone-prisoner-experiences-of-covid-19-restrictions-in-scotland-during-2020/

PART II. How long do FAIs take, who is involved in them and what do they find?

Last year we analysed 196 FAIs that were published as of February 2021, covering deaths between 2005 and 2019. This year, we analysed all FAIs published since February 2021 through September 2022, amounting to 32 determinations.[6]

Since the reformed FAI legislation came into effect, in mid-June 2017, there have been 201 deaths in prison; 123 of these deaths are awaiting an inquiry.[7] These include:

39 drug-related deaths
55 suicides
2 homicides
82 deaths from diverse medical conditions
15 Covid deaths
And 8 deaths where a cause is yet to be determined

1. Areas of concern previously identified in FAIs have shown no improvement

Last year we noted that FAIs took years to complete, rarely involved family members and in over 90% of cases determined there were no precautions, defects or recommendations that might prevent a death.

This year, analysing the 32 FAIs completed since we last reported, we found that:

- On average FAIs completed in 2021 and 2022 took over 2 years to complete
- There was no improvement in completion times
- There was no real change in levels of family involvement
- Having legal representation did not increase the chance of a corrective finding being made
- Prisoners, often witnesses and people with knowledge of the person who died, almost never gave evidence (in only 1 case is this noted)
- There was no increase in the proportion of FAIs where a corrective finding of a precaution, system defect or recommendation was made
- The only consistent findings made in FAIs are the time, place and cause of death.

[6] The current dataset includes an FAI completed in February 2021 and another completed in 2020 that for unclear reasons were not published on the Scottish Courts website until recently.
[7] Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (effective 15 June 2017).

2. The only findings FAIs consistently make is to confirm information which is available within 8 days of a person dying

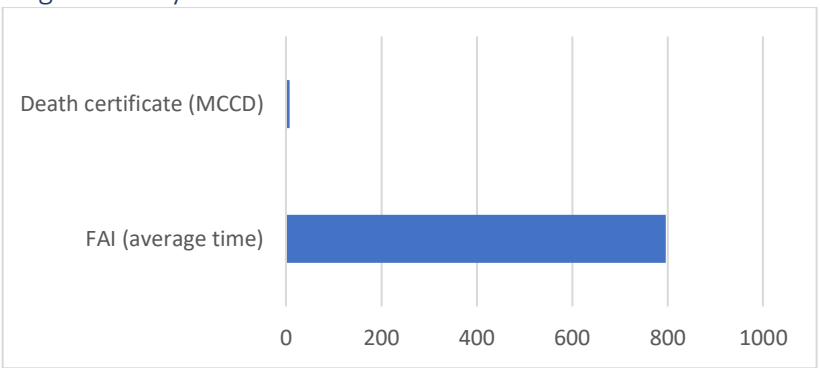
The 2016 legislation empowers, and indeed requires, Sheriffs to determine several issues in a fatal accident inquiry. This includes determining when, where and how someone died. In addition, the Sheriff is obliged to identify any reasonable precautions that might have prevented the death (section 26(2)(e)), any defect in a system of working which contributed to a death (26(2)(f)) and whether there were any other facts relevant to the circumstances of the death (26(2)(g)). Finally, a Sheriff may make any recommendations deemed appropriate (26(1)(b)). We refer to these precautions, defects and recommendations as 'corrective findings' to distinguish them from those findings establishing time, place and cause of death.

All FAIs consistently achieve the purpose of determining the time, place and cause of death. We compared the extent to which these findings differ from the information provided in the certificate of a person's death, which requires the same information to be submitted within eight days in order for a death to be registered. We cross-checked publically available records with causes of death listed in FAIs and found that in only one case did the FAI provide a revised cause of death. In a small number of cases, the FAI added minor detail to the cause of death identified within days of a death. In one case, where the FAI that took over two years to complete, an initially 'unascertained' cause of death, remained 'unascertained' in the FAI.

Table 3. FAI deviations from initial cause of death

Compared to initially identified cause of death	**Different**	**Same**
FAI cause of death determination	1	31

Figure 8. Days taken to determine cause of death



3. FAIs take, on average, over 2 years to complete

We measured the time in days between the date a person in prison died and the publication date of the FAI determination. The table below provides this information and compares time-frames to our previous analysis (final column).

Table 4. Time taken to complete FAIs in 2021-22

FAI times 2021-22 (n=32)	average	shortest	longest	Average 2005-19 (n=196)
all deaths	*796*	*275*	*1590*	*720*
suicide n=9	964	493	1590	753
drugs n=6	1027	656	1388	836
other n=17	626	275	1025	668

The longest inquiry took over four years and made no findings beyond time, place and cause of death.

Average times are slightly longer than for the FAIs we previously analysed, but the small numbers of the dataset and the delays to court business during the pandemic should be taken into account.

4. Families are no more involved in FAIs than in our previous review

Three ways families can be involved in an FAI are by attending the inquiry, submitting evidence or giving oral testimony, or being represented by a lawyer. The levels of these forms of involvement over the past year has not improved since our prior analysis.

Table 5. Family involvement in FAIs

Family involvement	yes	no	% No	% No in 2005-19 (n=196)
present	8	24	75%	69%
gave evidence	4	28	88%	83%
legal representation	8	24	75%	77%
any of above	11	21	66%	59%
prisoner evidence	1	31	97%	87%

Of 8 families with legal representation, the Sheriff made a corrective finding in only one case, a worse outcome than we saw in our prior analysis, where legal representation showed a statistically significant correlation with the chances of a corrective finding being identified.

Other prisoners are valuable sources of information, who may be the last witnesses to a person's movements before they died. However, as with our previous report, their first-hand evidence is almost never included in FAIs. More commonly, FAIs mention prison staff relaying second-hand that prisoners observed or commented on something related to a person's death.

5. In over 90% of FAIs, no precaution, defect or recommendation is identified

Perhaps the most striking finding of our prior analysis was that the intensively resourced system of FAIs, involving years of evidence gathering and considerable time of legal, medical and other professionals, almost never identifies anything that contributed to a death or might have prevented a death, or anything which could be done to reduce death. This remarkably low rate of identifying anything to prevent similar deaths continues in the FAIs completed over the last year.

Table 6. Corrective findings made in FAIs

FAIs where corrective finding made (n=32)	**yes**	**no**	**% No**	**% No in 2005-19 (n=196)**
Precaution	2	30	94%	91%
Defect	2	30	94%	96%
Recommendation	1	31	97%	94%
Other facts	4	28	84%	89%

6. FAIs of people who died during Covid

Among the 32 FAIs completed in 2021-2022, are 11 inquiries relating to people who died during the Covid pandemic (i.e. from March 2020; the remaining 21 FAIs related to deaths occurring before Covid). None of these FAIs considers how the significantly reduced access to health care and other prison restrictions during this period may have affected those who died (see discussion in Part III). The FAIs completed for this group were faster, shorter and made no corrective findings at all. This raises questions about potential haste of some FAIs as courts manage pandemic backlogs.

Table 7. Characteristics of FAIs for people dying in prison during Covid

	Deaths during pandemic (n=11)	**All deaths (n=32)**
Average completion time (days)	546	796
Word count	2506	5086
FAIs making any corrective finding	0	4

PART III. Issues identified from FAI case analysis

In this final section, we present themes identified through our analysis of Sheriff determinations, the reports produced at the end of inquiries, beginning with a summary of what we found last year.

1. Previous concerns identified in FAI narratives

We identified a number of issues in FAI narratives in last year's report *A Defective System*:

Inappropriate medical care and uncaring treatment of those with drug issues:

- People who have had any issues with drugs have all their health complaints treated as 'drug seeking behaviour'
- Suicides by people experiencing severe drugs withdrawal, in some cases after they had requested help with addictions but had not received this fully

Inconsistent management of suicide risk and use of suicide prevention policy:

- Failures to conduct relevant assessments of risk
- Decisions based on lowered expectation of health care in prison
- Common belief that activating suicide prevention policy would increase suicide risk
- Disregard of prisoner concerns about another prisoner

'Successful' FAIs, where a precaution, defect or recommendation is identified but failed to effect systemic change and prevent death:

- Findings often narrowly address an individual circumstance
- Sheriffs often decline to make a finding when assured the prison policy has since changed
- There is no enforcement mechanism or consequence after a Sheriff identifies significant issues contributing to a death

Case analysis and issues recently completed FAIs

In the following case examples, we found similar issues are continuing to arise as we noted in our previous review. Most of the cases described below did not lead to identification of any corrective findings. Many of these examples also suggest there continues to be a lack of dignity and compassion experienced by people who die in custody.

2. Deaths from avoidable and treatable causes

Avoidable deaths refer to those which can mainly be avoided through timely and effective healthcare including secondary prevention and treatment.

One example is the death of a person from cellulitis and septic shock arising from a skin condition: An issue for health investigation was identified, with the person referred for

consultation with a specialist a month later which did not take place. A month after this, a routine nurse appointment led to immediate admission to hospital and he died in hospital that day. The Sheriff found, 'He was given appropriate medical treatment during his time in custody'. (Cellulitis is a 'common' cause of hospitalisation but a 'low risk condition' where typically only 1% of these admissions result in death.[8]) No corrective findings made by the Sheriff. (1-01)

3. Lack of scrutiny of prison suicide prevention policy

As noted in Part I, there have been 42% more suicides in prison under the current suicide prevention policy, Talk to Me (TTM), compared to the period before its introduction. In spite of this, the efficacy of Talk to Me, (which prison and health staff regularly testify in FAIs they are reluctant to implement because of its worsening impact on prisoner wellbeing), is never questioned by Sheriffs or the Crown, the latter of which typically urges Sheriffs to make no findings beyond cause of death. Instead, as with last year's review, we have found that in cases of suicide, a prisoner saying they have no thoughts of self-harm, and appearing otherwise well in the opinion of non-mental health professionals is sufficient for Sheriffs to conclude a person was at no risk of suicide, often despite many other markers of risk including previous attempts of suicide and recent life changing events.

We include two examples here, which are typical of other FAIs in cases of suicide from this last year as well as in the previous 15 years.

In the first example, a man with a history of anxiety and depression, a family history of suicide and who had previously attempted suicide on at least two occasions was not placed on the suicide prevention policy, Talk to Me (TTM), after being suspended from a community placement he valued. He subsequently committed suicide, after reporting low mood following the loss of his job. The Sheriff comments that despite being 'required [by the risk management team] to undertake sessions with a psychologist before it would consider his return to placement…by the time of his death some five months later those sessions had neither taken place nor been scheduled' which 'deprived him, for five months, of the therapeutic benefit which the psychology sessions were likely to provide. It also meant that, for a prolonged period, he was left in position of uncertainty and apparent anxiety over his position…and I find that [the delay this caused in regaining his placement] was a factor which contributed to his decision to take his own life.' (2-03)

It is notable that, as with most suicide FAIs, staff testified that a person did not give any clear 'cues or clues' of intending to end their life. Unusually the Sheriff identified precautions and system defects and made recommendations, effectively declining to accept this evidence as convincing. In a legally required response to the Sheriff's recommendations, the SPS declined to implement one of them, and in response to another simply affirmed staff were trained in the suicide prevention policy, TTM.

[8] See, https://shmabstracts.org/abstract/mortality-of-hospitalized-patients-with-cellulitis-a-systematic-review-and-meta-analysis/.

Another case involved a man who committed suicide the day after he was sacked from his passman job, a role which conferred a great deal of independence within the prison, due to failure to wear prison issued jogging bottoms. His sacking also triggered his removal to a new cell. Despite having been placed on the Talk to Me strategy in the six months before his death after concern was raised by his family, the recent abandonment of his appeal of an over 20-year sentence, the search of his cell for drugs three days before his death, and observation of his upset at losing his job, the Sheriff wrote that: "All agreed that there were no indications that Mr [Name]was going to take his own life. He engaged with staff and they knew him well with all agreeing that there were no cues and clues that were missed which could have prevented this death." No corrective findings made. (3-03)

4. Use of joint minutes raises concerns about conflicts of interest and independence of FAIs

Joint minutes (JM) are typically used in adversarial criminal proceedings in which opposing parties agree non-contentious facts. JMs have now become overwhelmingly common in the non-adversarial FAI. They typically involve agreements among the Scottish Prison Service (SPS), the National Health Service (NHS) and the Crown Office (COPFS), where SPS and NHS are the bodies responsible for the care of prisoners. By agreeing all uncontentious 'facts' via the joint minute, families and other interested parties are not privy to discussions about what is or is not contestable. This raises significant questions about transparency, accountability and independence of the FAI as well as about the meaningful participation of those with right to participation in an inquiry. For example, in one death, the NHS, SPS and COPFS urged the Sheriff to make no findings other than time, place and cause of death, despite the family raising concerns about the death. No corrective findings made. (4-02)

In an FAI into a suicide, the joint minute 'formed the entirety of the evidence', and was agreed between the SPS, NHS and Prisoner Officers Association. These parties urged the Sheriff to make no findings beyond time, place and cause of death, with the Sheriff noting that 'None of the parties made any criticism of the care which had been provided to the deceased within HMP [Name].' The Sheriff noted that 'No independent medical evidence was presented'. Where the only parties relied on to assess a person's care are the same parties who are responsible for delivering that care, and who may be exposed to liability in a civil action, significant concerns of independence arise. No corrective findings made. (5-02)

5. Treatment delays involved in death

Miscommunication meant a nurse's instruction to call an ambulance was not carried out for two hours, in a case where a man died of a ruptured aneurysm, a condition requiring rapid medical attention. The person had been reporting headaches for three days before this. This was another death during Covid restrictions in prison, though this was not mentioned in the FAI (for example, to assess whether miscommunication might have arisen due to staff coverage during the pandemic). No corrective findings made. (6-02)

6. Asking for help and not receiving it and ignoring medical records

A person with a history of suicidal thoughts and attempts was refused a self-referral request for help with his mental health until he 'provide[d] further information detailing why he required to be seen and by whom.' He committed suicide without responding. The Sheriff made no findings of precaution, defect or recommendation as the NHS offered assurances that practices had since changed and requests for help are managed 'proactively'. There have been two further suicides in this prison since this determination. (7-04)

A Sheriff wrote that reviewing a person's medical notes is not 'realistically practical', after the suicide of person with extensive self-harm history where 'medical notes' are 'voluminous with much irrelevant material in them. The best available evidence of a prisoner's current condition is the patient sitting in front of the Healthcare Team member.' A 'trawl through' notes would not have been effective according to the determination. The Sheriff continued: 'If "Talk to Me" were deployed in the case of every patient who had a previous episode of low mood or suicidal thoughts, then it would quickly become overwhelmed, and those in immediate need would be missed'. This raises questions about the purpose of recording medical concerns at all. No corrective findings made. (8-05)

7. Deaths which implicate medical practice or prison care

A person who died after being placed on a medicated withdrawal programme that was initiated without GP examination or monitoring: A man died within a day of being imprisoned with only therapeutic levels of prescribed drugs in his system. These were prescribed while he was in detention to manage withdrawal from an extensive substance use issue, without a GP ever seeing the person, and where the 'extent of both his drug use and alcohol consumption while at liberty were unknown, therefore his tolerance level could not be assessed nor whether the prescribed sedatives would be sufficient to manage his alcohol withdrawal'. Despite citing UK guidance and local NHS practice about 'the importance of carrying out regular reviews of prisoners on … drug reduction programmes' and noting that the man received no such monitoring, the Sheriff declined to identify any precautions or system defects in his treatment. The Sheriff speculated that 'Had Mr [Name] survived' he would have received an in-person consultation the next day. (9-04)

A case where no corrective findings were made despite significant mistakes in prescribing and a witness found not to be credible**:** A man committed suicide who in prison had been on 700 mg of an antipsychotic medication that was mistakenly reduced to 200 mg when he was released from prison, then raised to 400 mg when he returned to prison and was having psychotic episodes. The Sheriff found that medical testimony claiming there were regular mental health checks was 'not an entirely accurate representation of the facts. There had been no follow up by any nurses' for the two weeks leading up to the man's death. Despite this, the Sheriff 'had considerable sympathy for [the medical] witness who is clearly passionate about [their] role and is doing what [they] can to help devise and develop better methods by which to identify patients who are at greater risk of taking their own lives. I am in no doubt that overall the level of input provided is of a high quality'. The Sheriff identified no precautions, defects or recommendations. (10-04)

In another FAI, an elderly man confined to bed in hospice care with end stage cancer was denied compassionate release because the attending doctor determined he still presented a risk to public safety. The person died 11 days later. (11-02)

8. Deaths during Covid restrictions in prison

Almost a third of FAIs we reviewed involved people who had died during the Covid pandemic (though not necessarily of Covid). We pointed out above that these FAIs were faster and the resulting determinations were shorter than FAIs for people who had died before the pandemic, raising questions about the haste with which these have been completed. After looking at the content of these reviews, our concern deepened. None of them took into account the restrictions and conditions that were in place during the pandemic, including high levels of in-cell isolation, loss of in-person visits and most activities, as well as significantly restricted access to health care. Staffing shortages and re-deployments of both prison and health staff changed how decisions were made during this period. In one FAI where Covid is mentioned this is in relation to whether SPS followed its self-isolation policy, with no consideration of whether a person's deterioration and death might have been hastened by staffing or other pandemic changes. (12-02) In a separate case, a terminally ill man died in custody, more than a month after an application for compassionate release had been initiated, with the application still pending a decision by the Parole Board. (13-02) In yet another FAI of someone dying during the pandemic, there is a three-month gap in a person reporting serious health issues and their removal to hospital where they died shortly thereafter as a result of this issue; questions about their access to treatment in this gap are not addressed. (14-02) In an FAI involving a suicide during Covid restrictions, where the only evidence considered was contained in the joint minute and the hearing taking place in a single day, the potential impact of Covid restrictions on movement and support were not considered. (5-02)

9. Narrow consideration of issues that prevents addressing systemic problems

Health care access issues for the prison population is ruled outside the remit of inquiry: The death of a person who was prescribed drugs via authorisation from a telephone consultation of an out-of-hours GP service, the only weekend GP provision for the rural area in which the prison is located, raises questions about adequacy of medical services for the prison population in such areas. But the Sheriff removed this issue from consideration: 'Whether that is appropriate for a prison establishment which has responsibility for hundreds of vulnerable individuals 24/7, is not an issue for this inquiry. That factor had no impact on Mr [Name]'s death'. There is no discussion or evidence proffered in support of this conclusion. (9-04)

We have also pointed out above that the Crown Office almost uniformly urges Sheriffs to make no findings, including identifying defects of systems, and that Sheriffs almost uniformly follow this line.

9. Wider questions about use of imprisonment

Some FAIs indirectly raise questions about the use of detention in Scotland. We include two examples from recent FAIs where very unwell people, who did not clearly present a threat to public safety, were detained and died shortly afterwards. In neither case were any precautions, defects or recommendations identified (though other relevant facts were identified in one case). These cases raise further issues of care and dignity in custody.

Police were called by members of the public reporting a woman wandering, confused and cold in pyjamas and a coat on a cold autumn evening. They had given her a cup of tea when police arrived, who on checking her record and noting outstanding warrants (for theft), arrested her. She was moved through three different police offices over several hours that night, and at each of these a flag on her record of medical issues requiring her to be seen by a health care professional whenever in custody was missed. The next morning she was taken to court where she spent seven hours waiting in a holding cell. By the time of her court appearance late in the day she could not stand or walk unaided and was placed in a wheelchair where she sat 'slumped' as the Sheriff denied her bail. After her bail hearing she was returned to the court holding cell, her health deteriorating for another two hours. At this point paramedics were called and arrived, and she was taken to hospital, where her health continued to deteriorate and she died six days later, never leaving hospital. No corrective findings made. (15-03)

A very unwell man with multiple debilitating health conditions, some affecting his mobility, was discharged early from hospital for disorderly behaviour. Police reversed an initial decision not to arrest him when an outstanding warrant was found in his name. He stayed in police custody for two days. He then spent a day at court where he was 'slumped over and uncommunicative' and at some point 'soiled himself' but nevertheless was transported to prison on remand 'without being changed or cleaned'. After two days in prison custody he was still wearing 'paper trousers, presumably from the hospital'. A doctor who had assessed him in the back of a police car testified he 'would not report [Name] as "fit for custody"' if he had been asked, but can only remember being asked if the man required hospital admission which he had not at that time. He was dead within three days of being remanded in prison. (16-04)

Conclusion: Still nothing to see here?

One year has passed since we reported that deaths have been rising in Scottish prisons, and that FAIs to investigate these take a significant amount of time only to conclude in almost all cases that no changes are needed. Since then, deaths have continued to rise, accelerating during the pandemic for reasons beyond Covid, and FAIs are continuing to take years with the same low rate of determining nothing could, or can, be done. We conducted this review in a fairly compressed period of time, and for this reason are unable to include many other issues we identified where further, in-depth analysis is merited. One of these relates to ongoing inconsistencies in how Sheriffs make and report their findings in FAI determinations, which was one focus of their reform. For example, the issue of 'hindsight' continues to be employed in contradictory ways, where in one determination a Sheriff claimed the value of hindsight to clarifying precautions, defects and recommendations they made, whilst another Sheriff in a separate determination claimed that no corrective findings could be made because they were only visible by hindsight. However, pointing out such issues, feels secondary to the fundamental questions this report raises about what, precisely, FAIs contribute to accessible, effective and accountable justice. We have compiled and produced this analysis because no Government body is doing so. The analysis of this public data raises some significant questions about the quality and contribution of the only public system of death investigation in Scotland for those who die in the state's custody, and one wonders how Scotland's high level of death in prison can be addressed in the absence of consistent oversight of the operation and outcomes of death investigations.