Criminal Justice Committee

22nd Meeting, 2023 (Session 6), Wednesday 20 September 2023

Deaths in custody review

Note by the clerk

Introduction

1. In November 2019, the then Cabinet Secretary for Justice commissioned an independent review into the response to deaths in prison custody. The purpose of the review was to make recommendations for improvement to ensure appropriate and transparent arrangements for the immediate response to deaths in prison custody.

2. The Independent Review of the Response to Deaths in Prison Custody report was co-authored by Wendy Sinclair-Gieben, HM Chief Inspector of Prisons; the Chief Executive of Families Outside and the Chair of the Scottish Human Rights Commission and was published on 30 November 2021. The review made one key recommendation, 19 other recommendations and six advisory points.

3. All the recommendations and advisory points were accepted in principle by the Scottish Government.

4. In April 2022, **Gillian Imery** was appointed as an external chair to provide independent oversight and leadership to the implementation of all the recommendations of the Independent Review. A Deaths in Prison Custody Action Group (DIPCAG) chaired by Gillian Imery was established to oversee and support the work required to ensure effective, innovative and robust implementation of the recommendations and advisory points.

5. Membership of the Deaths in Prison Custody Action Group (see **Annex A**) is made up of representatives of agencies with responsibility for responding to deaths in prison custody along with representatives of those bereaved by a death in prison custody. A Family Reference Group was also established comprising of family members with lived experience of a bereavement in prison custody to support the work of the group.

6. At a previous meeting of the Committee, Members asked for a progress note from Gilliam Imery on the implementation of the recommendations made in the Deaths in Custody Report. This progress note is set out in **Annex B**. Gillian also provided an **update** in September 2023, which is also set out in the same Annex.

7. Gillian Imery will attend today's meeting to discuss her note and take questions from members.

8. Members may also wish to be aware that the Scottish Government published a report on 30 August 2023[1]. This provides an overview of all prisoner deaths in Scotland over the period 2012 to 2022 based on data published by the Scottish Prison Service (SPS).

9. **Annex C** sets out a short summary from the above report.

Action

10. **Members are invited to discuss the response from review group's chair at today's meeting**.

11. **Members may, amongst other actions, wish to write to the Cabinet Secretary for Justice and Home Affairs asking for an update on progress and commenting on the points made in the progress note**.

Clerks to the Committee
September 2023

[1] Deaths in Prison Custody in Scotland 2012-2022, Available at: https://www.gov.scot/publications/deaths-prison-custody-scotland-2012-2022/pages/2/

ANNEX A

Membership of the Deaths in Prison Custody Action Group

- Families bereaved by a death in prison custody
- Scottish Prison Service
- National Prison Care Network, NHS
- Crown Office and Procurator Fiscal Service
- Healthcare Improvement Scotland
- Police Service of Scotland
- Families Outside
- Scottish Government

ANNEX B

Response from the chair of the review group

Thank you for your ongoing interest in the implementation of the recommendations of the Independent Review of the Response to Deaths in Prison Custody (hereafter referred to as “the Review”).

As members are aware, the Review was commissioned by the Cabinet Secretary for Justice in November 2019, and the resulting report was published on 30 November 2021. The Review made one key recommendation, 19 other recommendations and six advisory points, all of which were accepted in principle by the Scottish Government.

The Scottish Government prioritised the key recommendation of the Review: a separate independent investigation should be undertaken into each death in prison custody and should be carried out by a body wholly independent of the Scottish Ministers, the Scottish Prison Service or the private prison operator and the NHS.

From discussions about how to progress the Review’s findings, it was decided to bring in an external chair and I was appointed to the role in April 2022 on a part time basis.

In May 2022, a working group comprising representatives from the Crown Office Procurator Fiscal Service, Scottish Prison Service, Police Scotland, NHS Scotland National Prison Care Network, Families Outside and bereaved family members, was formed to take forward the key recommendation. This group is chaired by the Scottish Government.

I chair the Death in Prison Custody Action Group; the Family Reference Group, and the Understanding and Preventing Deaths in Prison Custody Working Group, which were established in June and July 2022. Regular updates are sought from the Scottish Prison Service, NHS, and other colleagues to inform the work of these Groups. Minutes and other documents are published on the Scottish Government website.

On 14 December 2022, I published a Progress Report. In my opening remarks, I expressed disappointment that only three of the recommendations had been completed and one partially completed in the year since the Review was published.

On 18 December 2022, the Cabinet Secretary for Justice and Veterans and the Cabinet Secretary for Health and Social Care sent a joint letter to the relevant Chief Executives urging them to prioritise the work to implement the recommendations.

Since then, I have continued to encourage the relevant parties to make the required improvements. Unfortunately, the pace of work continues to be slow and at this time I am only able to say that one more recommendation has been partially completed: a revised Family Support Booklet has been produced but is yet to be published on the Scottish Prison Service’s website (recommendation 3.3).

In my opening remarks to the Progress Report in December 2022, I was positive about the efforts of the key recommendation working group, which had met monthly

since May 2022. I acknowledged the work to map out existing processes (the Scottish Prison Service's Death in Prison Learning, Audit and Review (DIPLAR); the NHS Significant Adverse Event Review (SAER), and COPFS deaths investigation and Fatal Accident Inquiry (FAI) and to identify gaps that a new independent investigation should address. I stated that I was looking forward to seeing a draft new investigative process, ready to be piloted early in the new year. This did not happen.

Since May 2022, a number of workshop exercises have been carried out by the working group in an attempt to test the proposed new process. The need for the new process to be trauma informed has featured significantly in discussions. It has been acknowledged that there could be an adverse impact on staff of yet another investigative process being introduced, which will amount to four separate investigations into the circumstances of a death in custody: SPS process; NHS process; COPFS process, and the new one. Staff will face the prospect of being interviews multiple times as part of the different investigations.

A workshop exercise was also carried out with the family reference group to try to improve understanding of the needs of bereaved families. The draft new process sets out clearly when and how communication should take place with bereaved relatives, and proposes introducing a family liaison contact role, a family liaison strategy, and a family communication log.

These workshops led to various refinements and modifications to the proposed new process, all taking care to ensure the role of the Lord Advocate as independent head of the system for the investigation of sudden or suspicious deaths, is not prejudiced or impacted on.

These efforts have led to a draft new process being developed, which aims to help inform the bereaved relatives and to provide answers to questions families may have at an early stage.

The plan is still to carry out a pilot exercise to establish if the draft new process is workable in practice, which I am told will now commence in the summer of 2023. However, there are potentially contentious and time consuming matters to be resolved before any pilot can commence, such as producing information sharing agreements and confidentiality agreements. Guidance on how the pilot will actually be conducted in practice is also yet to be agreed by the working group.

I am doubtful that the pilot of the new investigative process will be concluded by the end of 2023, and cannot predict when the key recommendation will be complete.

As members are aware, the terms of reference for the original Review deliberately excluded the role of COPFS and the arrangements for FAI. Similarly, the terms of reference for my role as external chair explicitly state that it will not impinge on nor undermine the role of the Lord Advocate as independent head of the system for the investigation of sudden or suspicious deaths.

In my remarks at the beginning of the Progress Report, I acknowledged the limitations of my remit, however, I highlighted that it had been impossible to avoid criticisms of the FAI process when discussing how the response to deaths in prison

could be improved. Families feel the length of time FAIs take is far too long and that communication between COPFS and relatives is inadequate.

This echoes the findings of HM Inspectorate of Prosecutions in Scotland who carried out a thematic review of FAIs as long ago as 2016. In 2019 the Inspectorate published a follow up review which found the lack of progress in many areas was disappointing. In particular, there had been little progress in shortening the timeline for mandatory FAIs.

I expressed my opinion as the external chair that the key recommendation of the Review is aimed at treating the symptoms (time delay and poor communication with families), rather than the problem itself: the FAI system. My opinion has not changed.

Other recommendations that would help to improve the communication with families include those relating to the Scottish Prison Service's Death in Prison Learning, Audit and Review (DIPLAR) process (recommendations 5.1, 5.2, 5.3, 5.4 and advisory points 4 & 5). In particular, 5.1 recommends that every family should be informed of the DIPLAR and should know when their questions and concerns will be considered.

The Scottish Prison Service did not establish its DIPLAR Review Group until September 2022. At the time of the Progress Report in December 2022, I was assured that the Group would have a product ready by the end of January 2023. This has not been achieved.

I understand that the Group has recently arrived at a draft revised process that will address a number of the issues identified by the Review, however the process is still subject to amendment and has not been introduced. Despite seeking an update, I have not been given any timescales for when the revised process is likely to be in place.

In terms of next steps, I am due to provide a verbal update to the Cabinet Secretary for Justice and Home Affairs and the Cabinet Secretary for NHS Recovery, Health and Social Care at the start of August 2023. I expect to provide a further written Progress Report around November 2023, two years on from the publication of the initial Review. At that stage, my role as external chair is likely to come to an end. I do not expect that all of the recommendations and advisory points in the Review will have been addressed by November 2023.

Thank you again for your interest. I would be happy to provide any further information and to come and speak to the Committee in person if that is helpful.

Gill Imery
External Chair
Oversight of implementation of recommendations
Independent Review of Response to Deaths in Prison Custody
19 June 2023

September update for Clerk to Criminal Justice Committee

As you will recall, on 19 June 2023 I submitted an update on the implementation of the Independent Review of the Response to Deaths in Prison Custody.

On the last page of that update, I wrote:

> "I understand the Group [the Scottish Prison Service's group to review its Death in Prison Learning, Audit and Review process] has recently arrived at a draft revised process that will address a number of issues identified by the Review, however the process is still subject to amendment and has not been introduced. Despite seeking an update, I have not been given any timescales for when the revised process is likely to be in place."

I should clarify that I did receive a response from the Scottish Prison Service on 12 June 2023, in time for inclusion in my submission dated 19 June 2023. It was my mistake that I missed the reply from the Scottish Prison Service at the time.

The Scottish Prison Service response stated that the next Tasking Group was due to take place on 13 July 2023 when the Death in Prison Learning, Audit and Review documentation would undergo a final assessment and it would then be presented to the Executive Management Group to approve and agree to implementation across the prison estate.

I wrote to the Scottish Prison Service seeking an update on 2 August 2023. They explained that a pilot of the revised process had been carried out at one establishment, and they had decided to test it further with a different cause of death. The new process was to be presented to a meeting of the Tasking Group on 10 August 2023, then sent to the Scottish Prison Service Executive Management Group to approve the process.

I understand that the Executive Management Group approved the new process at the end of August, and an instruction was issued from the Scottish Prison Service's Chief Executive on 31 August 2023 that all establishments must follow the new process with immediate effect. This is likely to address some of the recommendations, but I will consider this at the next meeting of the Death in Prison Custody Action Group.

General update

On 30 August 2023 an initial report was published analysing available data on deaths in prison 2012-2022. Over that period, 350 people died in prison, which is an average of 31.8 per year.

There have been 23 deaths in prison so far in 2023, most of which have taken place since June.

The briefing I was due to provide to the Cabinet Secretary for Health and the Cabinet Secretary for Justice at the start of August was cancelled. A new date for September has also been cancelled. I am now due to meet the Cabinet Secretaries in November 2023.

In the December 2022 progress report, only three recommendations were described as completed, with another partially complete. Since then, the partially complete recommendation has been completed and a further one could be said to be addressed, therefore at September 2023, five recommendations (out of 20) are completed.

I hope this information is of interest but please let me know if you need any more detail. Thank you.

Gill Imery
External Chair
Oversight of Implementation
Recommendations of Independent Review of Deaths in Prison

ANNEX C

Key points from the Deaths in Prison Custody in Scotland 2012-2022 report

The analysis shows that:

- Between 2012 and 2022, 350 people died whilst in prison custody in Scotland. This is an average of 31.8 deaths per year.

- The number of deaths in prison custody per year increased between 2012 and 2022, with the highest number of annual deaths recorded in 2021 (53).

- Drawing on the national statistics on the prison population, it is possible to estimate the rate of death in prison custody per 1,000 population based upon both the total number of individuals that experienced imprisonment at any point during the year, and the average daily prison population. To do this, only deaths occurring in the full financial years of data that match the time periods covered by the national statistics are considered (i.e. 2012-13 to 2021-22, 306 deaths in total).

- While both measures of death rates have fluctuated over the time period considered, both have been rising overall. The estimated rate of death per 1,000 average daily population was 2.12 in 2012-13, trebling to 6.40 in 2021-22. Similarly, the rate of death per 1,000 individuals experiencing imprisonment more than trebled over the same period, rising from 0.85 in 2012-13 to 3.33 in 2021-22.

- The increase in rates of deaths appear most pronounced across 2020-21 and 2021-22, years impacted by the Covid-19 pandemic. Accordingly, the pandemic may be a factor in the recorded rate of death in custody. During these years, both the total number of individuals that experienced imprisonment at any point during the year and average daily prison population were also much lower than pre-pandemic levels, which may also be a factor in the higher estimated rates of death in these years.

- Of the 306 people who died between 2012-13 and 2021-22, 96% or 294 were men and 4% or 12 were women. This proportion broadly mirrors the gender split in the overall prison population. The small number of deaths amongst women makes analysing any differences in deaths in prison custody by gender difficult.

- In terms of death rates per 1,000 population over the time period analysed, the pattern observed for men largely mirrors the pattern observed when looking at the overall prison population. As men account for most of the deaths occurring this is to be expected. Given the small number of deaths amongst women, the rates observed for women fluctuate considerably over the time period analysed.

- The official national prison population statistics show a changing age profile of the average daily prison population over time. The long term trend is a decline in the number of young people and younger adults, while the number of people aged 35 and above has been increasing. The average age of

prisoners has increased from 31.8 years in 2010-11 to 36.9 years in 2021-22, and the proportion of prisoners aged 55 or over has more than doubled in the last decade rising from 3.5% to 8.1%. The single largest number of deaths in prison custody occurred in the ‘55+ years’ age group (96), followed by the ‘45-54 years’ age group (79).

- While there is a degree of fluctuation, the rate of death per 1,000 average daily population has remained low for the youngest age groups (16-44 years collectively) over the time period analysed. The rate of death per 1,000 average daily population has been substantially higher for the older age groups, with noticeable spikes in the rates for 2020-21 (55+ years group) and 2021-22 (45-54 years group). As stated above, these are years impacted by the Covid-19 pandemic.

- When assessing deaths in prison custody by legal status, the majority of deaths occurred in the sentenced population. Over the period 2012-13 to 2021-22, around 76% of deaths in custody were amongst those who were serving a custodial sentence and just under a quarter of the people who died in custody were being held on remand. This is broadly in line with the overall proportion of the prison population.

- The rate of death in prison custody by legal status has varied over time. The rate across the remand population spiked between 2015-16 and 2018-19 and was considerably higher than that for the sentenced population. However, the rate of death increased substantially in the sentenced population across 2020-21 and 2021-22.

- Between 2012 to 2022, there were 17 prison establishments operating in Scotland. These establishments hold different prison populations which have varying housing requirements. Therefore, the age, gender and legal status profile of prisoners varies by establishment.

- Prison establishments also differ in capacity, so the number of individuals housed in each varies considerably. For example, the average daily population in HMP Inverness was 110 in 2021-22 whereas the average daily population in HMP Barlinnie was over 10 times that figure at 1,215. The analysis shows that the highest number of deaths in prison custody have occurred in the larger prisons. However, in any given year, the number of deaths per prison establishment is small.

- In line with the small and scattered distribution of deaths in custody by prison establishment in any given year, it is hard to discern a clear pattern in differences in deaths rates across establishments. As per the overall pattern of deaths occurring, there appears to be a higher rate of death occurring in some establishments in more recent years but there are no clear trends emerging.

- SPS publish the cause of death for every death occurring in prison custody. In 2019, the way in which cause of death was collected and published was amended. To allow comparison of cause of death over time, SPS analysts have attributed cause of death to one of three broad categories across the

time series. The categories are: intentional self-harm; poisonings; and other deaths, this category includes disease, illness, natural causes and homicide.

- Of the 350 deaths recorded between 2012 and 2022, the majority (57% or 199) were classified within the ‘other deaths’ category (3 of the 199 were recorded as homicide, whilst the remainder were attributed to disease, illness and natural causes). 29% (103) occurred due to intentional self-harm and 14% (48) were attributed to poisonings.

- Looking at the cause of deaths by year, shows that in most years (with the exception of 2016 and 2017) deaths attributed to disease, illness and natural causes accounted for the majority of deaths in prison custody. Deaths attributed to these causes also appear to have increased across 2020-2022 – a period impacted by the pandemic.

- Deaths attributed to ‘poisonings’ (deaths where any drugs were mentioned in the cause of death) comprise a small number of deaths in most years (except 2015), although there was a spike in deaths by ‘poisonings’ in 2021. The number subsequently reduced in 2022.

- There is no clear trend in the number of deaths attributed to ‘intentional self-harm’ (deaths where hanging, suspension by ligature or asphyxia were mentioned in the cause of death) which has fluctuated between 4 and 14 per year across the time period analysed.

- Of the 350 deaths in prison custody that occurred over the period 2012 to 2022, around half (173) occurred within 1 year of the individual entering their most recent prison establishment. 25 individuals died within 7 days of entering their most recent prison establishment, and a further 35 within 30 days.

- SPS record the residential address and postcode (where available) of each individual who enters custody. This information is held for 320 of the 350 individuals who died in prison custody over the period 2012-2022. Of these, 149 arrived in custody from an address within the most deprived areas of Scotland – SIMD quintile 1. This is comparable to the composition of the prison population at large.