Nothing to see here?

Deaths in custody and FAIs in Scotland – 2023

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Statement

This briefing is about deaths in custody and fatal accident inquiries (FAIs) into them, 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 motivation for doing this work is to raise awareness of deaths in state custody and how these are investigated, and through this to support efforts to prevent deaths and improve the effectiveness of investigations.

There are important ethical issues involved in this work, and we are constantly reflecting on how best to address them. A main concern is whether or not to anonymise information about individuals, and the impact on loved ones of whatever choice we make. There are arguments both for and against anonymisation. Family members may wish to protect their privacy and to avoid being exposed unexpectedly to upsetting information about the circumstances of a family member's death. At the same time, families have expressed to us that not naming the person can feel like a cover up, and a dehumanisation of the person who died. All the information we use in this report is in the public domain, but this does not exempt us from a duty to deal sensitively with personal information. In past reports we adopted the position of including only names where we are in contact with a family, and they wished this. We continue to start from this principle. However, in the section analysing FAIs, it would be impossible to discuss a serious issue we have identified without providing information that could make it possible to identify an individual, either because media reports mean there is a high profile surrounding the death, or because of the small numbers involved.

Our approach is not to name individuals, and to be conscientious about including only information necessary to explain a relevant point. In the section of the report dealing with FAI determinations, we have made the decision to use a person's initials based on a thorough discussion of the ethics and risks of this. In doing this, we are seeking to balance privacy with humanisation. We fully acknowledge that it may be possible to identify those who have died.

For those 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

Introduction

- This report presents data on deaths in all forms of care and custody in Scotland for which there was public information.
- This includes numbers and information for: prison or police custody (and after police contact); migration detention and asylum accommodation; detention under the Mental Health Act; looked after children and young people; and people with learning disabilities and autistic people.
- Gender, mental health and drug or alcohol issues, suicide all arise as themes across settings of custody.
- However, the framing in official documents reinforces a sense of most deaths being 'regrettable but inevitable'.
- Missing data, poor specification of categories and especially the labelling of deaths as 'natural' or 'expected' emerge as concerns in the analysis.

Part I Deaths in custody

- Four people die every week in Scotland while detained or under the control of the state – we counted 244 people who died in a year's worth of information, in various forms of state detention or care.
- Police: 26 people died in custody and 198 after police contact between 2015 and 2023. Police contact deaths are increasing.
- Mental health detention: 673 people died between 2018/19 and 2022/23. Deaths have been increasing among this group.
- Migration detention and asylum accommodation: 16 people died in Scotland between 2016 and 2023. Deaths have been rising since the pandemic in this group.
- Looked after children and young people: 111 died between 2014 and 2021. Deaths have been on the rise in this group.
- People with learning disabilities and autistic people: 14 people died while psychiatrically hospitalised between 2015/16 and 2021/22. Deaths in this group do not seem to be on the rise.
- Prison: 346 people have died in prison between 2014 and 2023. Deaths in this group have been rising for many years, and this accelerated in the pandemic.
- Investigations of deaths vary by setting of custody. Most are not subject to a fatal accident inquiry. Most are internally reviewed with no public reporting of outcomes.

Further information about deaths in prison

- 38 people died in prison between October 2022 and September 2023.
- The death rate in prison in 2021-23 was 618 (per 100,000) compared to 242 in 2008-10.
- Suicide (6) and drug deaths (7 plus 5 suspected) accounted for between one-third to one-half of all deaths in 2022-23.
- Over ten years, 2013-2022 inclusive, there were 50 deaths from drugs (including more than half of these occurring since 2020) and 99 suicides in prison.
- Suicide and drug deaths in prison are increasing, and drug deaths are much higher in Scotland than in prisons in other places, including England and Wales, Australia and Europe.
- There are more people committing suicide in prison who have been in prison for a period of years, raising questions about hope and activity for longer-term prisoners.

Part II Fatal Accident Inquiries (FAIs)

FAIs over the past year

- There were 22 FAIs into deaths in custody published in the one-year period October 2022 to September 2023. Twenty of these FAIs involved deaths in prison; one was police custody and one was migration detention.
- Most involved health conditions and incidents (13 deaths); the rest were suicide (5) and drug (4) deaths.
- Over three-quarters of FAIs took more than two years to complete; over a third (8) took more than 3 years.
- Corrective findings are rare: Over 90% found neither a precaution or a system defect (2 FAIs in each case); 4 FAIs made recommendations.
- No FAI into suicide identified any precautions, defects or recommendations aimed at preventing deaths in similar circumstances.
- Families mostly were not involved in FAIs: only 7 had legal representation (32% of FAIs); 9 attended some or all of an inquiry; only three gave evidence.
- This contrasts with the involvement of those responsible for the care of the person who died. In terms of legal representation, the Scottish Prison Service had this in 100% of prison deaths; NHS Scotland or its staff were represented in 68% of FAIs; prison officers/Prison Officer Association lawyers were involved in 50% of prison death FAIs.

FAIs over the longer term

- We identified 227 FAI determinations involving deaths in prison published through September 2022, covering deaths occurring between 2005-2020.
- Of these, only 34 (15%) made a finding of precaution, defect or recommendation.
- Overall, the average time to complete an FAI was 735 days (about two years), and the median time was 655 days.
- Since 2017, when a newly reformed law came into effect, FAIs are taking longer, make fewer findings, and involve families less than FAIs before 2017.

- There have been no completed FAIs (as of September 2023) for anyone who has died of Covid in prison, nearly four years after the first such death occurred.

Themes and issues arising in FAIs

Few FAIs identify problems in the care or treatment of people in custody. Yet our analysis of FAI determinations over the past year flagged up numerous concerns resonating with issues we have previously raised:

- Care of people with drug issues: evidence that fear of being punished affects prisoner decisions to seek help in cases of overdose.
- Failure to follow procedures for checking on unwell detained people who later died, including not noticing that someone had died.
- Mental health care: acceptance of mental distress and unwellness in custodial settings and use of segregation to manage people experiencing profound episodes of mental health crisis.
- Failings in physical health care: lost hospital letters, missed appointments or recommended tests featured in FAIs where Sheriffs made no corrective finding
- 'Successful' FAIs still contain issues of concern: In an FAI where a Sheriff was highly critical of staff care that involved failing to identify the language spoken by a person experiencing multiple heart attacks and failure to seek interpreting assistance, there is no connection to systemic and structural factors of discrimination and the role of these health inequalities with mortality.
- Poor treatment and disregard of families: Sheriffs declining to explore discrepancies between official accounts and family evidence; countering family concerns about a loved one with observations of parents' own drug and alcohol issues; Crown dismissal of family concerns as irrelevant to the inquiry.
- The problematic use of 'joint minutes': a legal tool meant to save court time from un-contested issues not uncommonly constitute the entirety of evidence considered in an FAI and have the input only of the Crown and the parties responsible for a person's care.

Conclusions

- Deaths are only one, and the most extreme outcome for those in custody. Investigations into death also contribute to wider picture of how people are treated and wider issues of wellbeing and conditions of institutional environments.

Introduction

This is the third annual report we have published on deaths in custody in Scotland and the investigations into these.[1] Previously we have focused on prison. In this report, we are including deaths in as many forms of state custody where there was public information. This report therefore reports information about deaths for:

- prison
- police custody and contact
- migration detention and asylum accommodation
- detention under the Mental Health Act
- looked after children and young people
- people with learning disabilities and autistic people psychiatrically hospitalised

In the first part, we report on deaths of people in the care or custody of the state, over the past year and longer term. In the second part we analyse characteristics of Scotland's public system for investigating deaths – fatal accident inquiries or FAIs.

There is little public awareness of deaths in custody in Scotland, and inconsistent practice among statutory bodies in publishing or analysing this information. The motivation of our work is to shed light on deaths that otherwise happen far from public view, mainly among people and affecting families with the least power in society. If someone must be in the custody of the state, there is a legal responsibility to ensure that they are kept safe, and there is a public interest in supporting the transparency and accountability of the state in doing so. A death in custody may or may not arise from the actions of the state, but there is a legal responsibility and public duty to investigate and determine this. Deaths are increasing in most of the settings we explored, and we call for greater urgency in and scrutiny of conditions of control.

The sections that follow identify issues specific to particular contexts of custody and care. However, there are some themes that run through all of them.

First, are characteristics of the people who die. Gender arises as an important issue in state death: deaths among men outnumber those of women in every setting we reviewed, but where women are dying, it often is at much younger ages than their counterparts both in a particular setting of custody and in the general population. There is no systematic gathering of data on nonbinary genders and so we cannot say with even moderate confidence how many in this group are dying though we know of some cases from other sources. Ethnicity and religious background, very much tied in Scotland to dynamics of inequality, is also poorly or not at all recorded in most datasets on death, and in the case study section of Part II we raise concerns about institutional racism in the care of minoritized people.

Second, across almost every context of custody two issues stood out: mental health and alcohol/drugs. The reason people end up in detention, how they are treated while detained and the impact of detention on them all implicate these two things. That is to say, whilst many of the documents we reviewed frame mental health and drug/alcohol as problems people have before

[1] The first briefing, in 2021, comprised two documents, Nothing to See Here? and A Defective System; the second briefing was a single report covering the same areas, Still Nothing to See Here?, in 2022.

they come into custody, there was information to suggest that in many cases mental health issues and drugs/alcohol use worsened or went untreated during their custody.

Third, and connected to this, is suicide. In all but one forms of the custody reviewed, suicide was a substantial cause of death. Scotland has the highest rate of suicide among the four nations of the UK[2], and this pattern is clearly visible among detained people, raising questions about the appropriateness and effectiveness of detention.

Fourth, the categorisation of causes of death uses labels that at best obscures and at worst misleads by drawing attention away from a possible contributory role of the state. The designation of deaths by 'natural causes', for example typically is used where a person has a health condition or incident that is the direct cause of death. An extreme case is the death of Allan Marshall, who died in 2015 during restraint by over a dozen prison staff. His death remains listed on government websites as 'due to natural causes', despite a criminal investigation into corporate responsibility for this fatality.[3]

If there was a common thread in the official narratives from the different kinds of custody it is that many, if not most, deaths of people in custody are regrettable but inevitable. Evaluating the accuracy of this narrative requires high quality information about and independent, effective investigation into deaths in custody. The aim of this report is to support these efforts.

Data Sources and Methods

All the information used in this report comes from public sources and bodies. Where available, we made use of official datasets and documents like annual reports. Additional data comes freedom of information requests and investigative journalism. Sometimes we have simply screenshot tables directly from original sources; in other cases we constructed tables from raw data.

There is no central reporting of deaths in Scottish custody, which is a primary reason for undertaking this report series, and there is no standardised reporting format that individual agencies and organisations use. The diverse sources and contexts of data collection created challenges for attempting to present things in a consistent format. We have tried to be as transparent as possible about where we obtained data and how we use it. Data published for prisons remains the most detailed with key information missing for other state settings. For these reasons, our analysis continues to be most detailed for prison deaths.

Scotland is a small country and the number of deaths in absolute terms can make it difficult to confirm statistical significance. We did not perform tests of significance in this year's update, and so urge caution in interpreting the numbers. We follow scholarly conventions in the case of prison data in calculating mortality rates.[4] This allows for cross-national comparisons, and the more years of data there are increases the likelihood of demonstrating a real trend. We did not calculate rates for other kinds of custody.

[2] NRS (2023) Probable Suicides 2022.
[3] See P. Tomczak and R. Mulgrew (2023) Making prisoner deaths visible: Towards a new epistemological approach about the need for re-thinking how deaths in custody should be categorised.
[4] E.g. S. Fazel et al. 2017. Suicide in prisons: an international study of prevalence and contributory factors; and, e.g. the standard of calculating rates per 100,000 for prison populations here: World Prison Brief.

PART I DEATHS IN STATE CUSTODY

Every week in Scotland, four people die whilst in the custody or control of the state (amounting to more than 240 annually). This includes people in prison, in police custody or contact, detained on mental health grounds, looked after children and young people, people hospitalised with learning disabilities and autistic people, and those in migration detention or asylum accommodation. There is no official publication that documents or explains these deaths, and for many categories, there is no regular reporting on how many are dying and why.

Table 1 Scottish deaths in different settings of custody and control

Form of detention	**Deaths in most recent year[5]**	**Deaths in 5 years[6]**
Prison	38	209
Police custody	2	13
Police contact	39	124
Mental Health	144	673
Migration and asylum	4	*16
Looked after young people	14	88
People with learning disabilities and autistic people	3	7
Total	**244**	

*Seven-year total; numbers for this category could not be disaggregated to isolate a 5-year period.

The data contained in this part of the report has been collated from a variety of sources, and we have relied on official published statistics and analyses wherever possible. In addition, we have made use of freedom of information requests, high quality investigative journalism and third sector or grassroots groups attempting to produce a public record of state death. Even with information about the scale of loss, much information is missing, and there are many qualifications to reading this data (see specific sections). Available information about people who die while under some form of state control is patchy and inconsistent, with race and ethnicity data being especially problematic.

Each category of detention deserves, and would easily fill, a lengthy report on its own. By bringing all the data together we necessarily have had to sacrifice nuance for comprehensiveness. There are also some reporting discrepancies we have identified which we did not have time to properly investigate. This is the first year we have published data on deaths across so many settings and it is a provisional account.

[5] Numbers are for most recent year where data was available: Prison (October 2022- September 2023); police (2022); migration and asylum (2022), mental health grounds (2022-23); looked after children and young people (2021, partial year); people with learning disabilities and autistic people (2021-22). See individual sections for links to sources.

[6] Prison (2019-23); police (2019-23); migration and asylum (2016-23), mental health grounds (2018/19-2022/23); looked after children and young people (2017-21); people with learning disabilities and autistic people (2017/18 to 2021/22).

A. Police custody and contact

Over eight years, between 2015 and 2022, 25 people died in police custody in Scotland, and 170 people died after police contact (Tables 2 and 3). These numbers come from a freedom of information request (FOI) to the Police Investigations and Review Commissioner for Scotland (PIRC) in October 2023, which showed that in one year (2022), two people died in custody and 39 people died after police contact.[7] Additional sources of data show slightly different numbers. Whilst some discrepancies are minor and can be explained by different reporting periods (FOIs count by calendar year and annual reports by financial year), there appears to be a large difference for police contact deaths in 2022.[8]

Table 2 Deaths in Scottish police custody, 2015-2023

Custody Deaths	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total
PIRC FOI	1	5	3	4	3	4	3	2	*1	26
Police Scotland FOIs	3	5	3	4	3	3	2	3		26
PIRC annual reports	2	3	3	4	3	5	3	1		24

*Deaths through July 2023. FOIs are calendar years; annual reports are financial year.

Table 3 Deaths after police contact in Scotland, 2015-2023

Contact Deaths	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total
PIRC FOI	16	18	15	25	10	25	22	39	*28	198
Police Scotland FOIs	12	18	14	19	8	28	21	27		147
PIRC annual reports	12	19	4	15	13	21	28	30		142

*Deaths through July 2023. FOIs are calendar years; annual reports are financial year.

Deaths in police custody include those where people are detained in police cells or otherwise under the control of police officers. Deaths after police contact include a broad range of situations. No breakdown, categorisation or explanation of circumstances is routinely provided, making it difficult to distinguish deaths where the police may have played a direct contributing role to those where they did not. For example, a police pursuit in a car or foot can result in death; police may be called to a report of a person experiencing a crisis who then dies with little or no interaction with police. Both count as deaths following contact.

Causes

Causes of death tied to police custody and contact are not made public on a consistent basis. Indirect information can be gleaned from media and other reports. For example, the Police Investigations and Review Commission's (PIRC) 2022-23 annual report makes the following statement:

> *'Of the 31 deaths [in police custody or after police contact in 2022-23], 14 (45%) of the deceased had a background of mental ill health. Seven of the 14 deceased also had a history of drug addiction or alcohol dependency. Tragically, seven of the deceased suffering from mental ill heath completed suicide. In addition, four of the referrals concerned three persons who had a history of drug addiction and one who had a history of alcohol dependency. The reason for police involvement varied.*

[7] PIRC FOI Oct 2023 (FO I889); Police Scotland FOI (FOI 23-0729, FOI 23-0075).

[8] PIRC notes that it receives reports of police contact deaths from agencies besides Police Scotland, for example British Transport Police. The 39 police contact deaths listed in the PIRC FOI all specify a Police Scotland command.

Notably, only 12 of the deaths (39%) were directly associated to allegations of criminality.[9]

PIRC is responsible for investigating serious injuries and deaths involving police officers in Scotland. It is not clear what 'deaths…directly associated to allegations of criminality' mean nor how histories, as opposed to present experience, of addiction or ill health explain deaths. It may be someone died directly from this cause or that the information is provided as context for another, unspecified cause. The statement echoes, as paraphrased from the 2021-22 PIRC annual report, the Angiolini on report on deaths in police custody (2017) of 'an increasing demand on policing and observ[ation] that the police service is not always the most appropriately skilled service to provide people [experiencing MH and drug/alcohol crises] with the specific help that they need.' [10]

This point is clearly illustrated in of the FAIs we analysed in last year's update. In that case, police responded to a call made by worried residents about a person outside in the cold by arresting them after doing a check and finding a warrant for a non-serious, non-violent offence. Police custody staff missed a health care flag on the person's record, and despite deteriorating health was kept in cells overnight, taken by van to court, waited in court cells for several hours and by the end of the day could no longer stand and was taken to hospital where they eventually died.

Age, gender and ethnicity

Gender information was not provided in the PIRC FOI data, and ethnicity was missing for many records. Police Scotland noted in its FOI response that it is not required to collect or report ethnicity data. This strikes one as a significant lapse especially in light of the current inquiry charged to consider whether race played a role in the death of Sheku Bayoh during police restraint. Among police contact deaths were several young people under the age of 16, and generally the ages of those dying is younger than in other settings, such as prison or mental health detention.

Table 4 Age of those dying in police custody, 2015-2023

Age groups	N	%
Under 25	4	16%
25-40	13	52%
41-55	8	32%
Not specified	1	4%

Table 5 Age of those dying after police contact, 2015-2023

Age groups	N	%
13-16	7	4%
17-25	20	10%
26-40	52	26%
41-55	48	24%
56 or older	34	17%
Not specified	37	19%

[9] PIRC Annual Report 2022-23, p. 18.
[10] PIRC Annual Report 2021-22, p. 16;' see, the Angiolini Review into Deaths and Serious Incidents in Police Custody (2017).

Investigations

Deaths in police custody are required by law to be investigated through a Fatal Accident Inquiry (FAI) though we found only one police custody death had an FAI in 2022-23; it is included in the analysis of FAIs in Part II of this report. It is impossible to determine from public information how many FAIs for deaths in police custody remain to be completed as so little information is published about people dying in this setting. Media coverage has brought to light that one FAI into the death in custody of Warren Fenty, a young man in Aberdeen, still has not reported despite the death happening nearly a decade ago.[11] Deaths after police contact may have an FAI but this is discretionary and decided by the Crown. PIRC provides limited information about its investigations; referrals to it are triaged through initial investigation to determine whether more detailed investigation is required. It has no published an investigation report of a death. These are shared internally with the police and Crown. The latter has the power to decide on further investigation and action, including criminal proceedings but does not report systematic data on its decisions or actions.

[11] Bryan Rutherford (2024) Press and Journal reporting.

B. Mental health

People experiencing mental health conditions have a higher rate of mortality. 'This is a very well known and longstanding inequality.'[12] Concerns have been raised about the independence, public scrutiny and family engagement when it comes to investigating deaths among people detained for mental health reasons.[13] The Mental Welfare Commission (MWC) began publishing data about deaths in 2023 as part of a wider review and changes to monitoring and investigating deaths of people in this group.

Information about deaths of people detained for mental health reasons comes from the 2022-23 annual statistical monitoring report and direct data provided by the MWC (Table 6). Two earlier reports by the MWC offer further contextualisation and characteristics of people who die in this setting of custody.[14] Data for deaths covers any death of a person subject to compulsory treatment under the Mental Health Act, including those: in the community subject to compulsory order of treatment; in the community where hospital detention had been suspended for a period of time; detained in hospital under a compulsory treatment order; detained under a short-term detention certificate; detained under and emergency detention certificate.[15]

Table 6 Deaths of people detained under the Mental Health Act (and % of all orders)

Year	Deaths	% of orders
2013-14	78	1.0%
2014-15	95	1.1%
2015-16	99	1.1%
2016-17	105	1.1%
2017-18	117	1.2%
2018-19	126	1.2%
2019-20	111	1.1%
2020-21	149	1.3%
2021-22	143	1.2%
2022-23	144	1.2%

Source: MWC.

The data show a large increase in the number of people dying while detained under Mental Health Act powers between 2013 and 2023. However, the third column, which quantifies these deaths as a proportion of all the people subject to an order, shows deaths remaining fairly constant for the ten-year period. Instead, what has increased is the number of compulsory orders issued. The MWC has raised two concerns about the rising number of orders. First, detention orders are more

[12] MWC (2019) Death in detention monitoring report (analysing deaths in 2012-13), p. 7.
[13] SHRC (2022) Consultation response: investigating the deaths of people subject to compulsory treatment under mental health legislation in Scotland, p. 2.
[14] MWC (2019) ; MWC (2020) The use of the Mental Health (Care and Treatment) (Scotland) Act 2003 during Covid-19 .
[15] In future reports we will aim to confirm the categories covered in reporting.

commonly issued for people in the most deprived areas of Scotland, and the rise in the number of such orders therefore reflects disproportionately greater detention of people coming from backgrounds of deprivation, suggesting there ought to be consideration of 'the causes of why compulsion is more common in these areas'.[16] Second, each year fewer emergency detention certificates are issued with the consent of a mental health officer: 'MHO consent in 2022-23 was the lowest we have seen over the last 10 years at 36.6%'.[17] This raises concern about the scrutiny and triaging of care provided for people being taken into state custody under the Mental Health Act.

The 2019 MWC review into deaths during 2012-13 found that the mortality rates of people 'in the mental health population' was significantly higher than that of the general population but that the subset of those who died while detained on mental health grounds did not have a statistically different mortality rate from people generally experiencing MH issues.[18] They conclude from this that it is mental health rather than detention which explains the difference in mortality. We would caution that using one year of data to arrive at this finding may not offer a robust enough basis to make this conclusion and also may not capture the way people with mental health conditions can move in and out of compulsory forms of care; in other words, separating out detention-experienced people from those with mental health conditions who have never been detained would better isolate the role of detention in mortality.

Causes

Causes of death are not yet provided in the MWC statistical monitoring report. These are shown in the 2019 review of 2012-13 deaths (Table 7) and the 2020 review of deaths before and during Covid (Table 8), offering a sense of how these are distributed.[19]

Table 7 Causes of death in mental health detention 2012-13 (MWC, 2019)

Category of cause	Under 65	65 and over	Total
Expected, natural causes	11	28	39
Sudden, natural causes	8	6	14
Sudden, unexplained or related to mental illness/learning disability	4	2	6
Suicide	11	0	11
Delirium as reason for detention	3	0	3
Insufficient information available	2	3	5
Total			78

Source: Death in Detention Monitoring (2019), p. 6

[16] MWC (2023) Mental Health Act monitoring report 2022-23 Statistical monitoring, p. 60.
[17] MWC (2023) Annual report 2022-23, p. 28
[18] MWC (2019) Death in detention monitoring, p. 7
[19] See Tomczak and Mulgrew, 2023, for critical discussion of how deaths in prison are labelled, https://journals.sagepub.com/doi/full/10.1177/26326663231160344

Table 8 Causes of death in mental health detention in 2020 (screenshot)

Cause of death	Number
Covid-19	8
Non-Covid-19	41
Suicide or probable suicide	11
Total	60

Source: MWC (2020), Partial year – March to August 2020

Age, gender and ethnicity

The December 2020 review of deaths in mental health detention during Covid-19 provides information about age, gender and ethnicity of those who died for several years preceding the pandemic (2015-2020) (Table 9).[20]

More men than women died in all years but the disproportion varies considerably year to year; overall, for the years 2015-2020, just over two-thirds of deaths were among men (68%).

Most people who died were 65 years or older (172 of the 321 deaths during 2015-2020, or 54%). Those between 45 and 64 years old accounted for 30% (94 deaths); people 44 years old and younger made up 16% (54) of all deaths between 2015-2020.

Table 9 Individual characteristics of those dying (screenshot)

Tale B11. Individual characteristics of deaths, by year (n)

	2015	2016	2017	2018	2019	2020
Age						
<44 years	10	11	11	13	*	7
45-64 years	15	12	16	15	13	23
65-84 years	17	20	25	32	21	20
85+ years	6	5	6	5	5	10
Gender						
Female	13	15	20	18	8	28
Male	35	33	38	47	34	32
Ethnicity						
Black, Caribbean, Other Black; Asian[1]	*	*	*	*	*	*
White Other British and White Other	6	*	5	*	*	*
White - Scottish	26	34	34	47	27	38
Not Provided	4	*	*	8	0	4
Missing	11	7	15	5	11	14

[1]The number of individuals in these groups were very small and were therefore merged into one category
*n<5

Source: MWC (2020), Partial year – March to August 2020

'White Scottish' is the most common ethnicity of those dying, however, ethnicity data was missing or not provided for one-quarter (81) of all deaths between 2015-2020. Moreover, the various categories of 'White' occlude important distinctions of ethnic or religious background and

[20] It is not clear why the totals in the table do not match the totals for the same years in the data from MWC reported in 2023. We did not have time to reconcile all figures and it is our intention in future years of reporting to clarify these discrepancies.

their intersections with health inequalities.[21] A 2022 report by the MWC on performance of the mental health sector in relation to racial equality found differences in the ways the Mental Health Act was applied when people from ethnic minorities were detained for care and treatment compared with white Scottish people. Hence, data provided about ethnicity is essential to working against inequality, but appears not yet to have been embedded as a priority for data collection.

Investigations

In 2009, Lord Cullen recommended a mandatory fatal accident inquiry into the death of any person subject to compulsory detention, which the Scottish Government declined to do as 'unnecessary'.[22] In 2018, the Government convened a review group that examined arrangements for investigating deaths of people hospitalised for mental health reasons; deaths by suicide of people under suspended detention orders; and deaths of people in the community under compulsory mental health order.[23] It found that deaths of people in these groups were not being investigated consistently or 'in a way that could be guaranteed to be independent' as required by ECHR Article 2.[24] In 2022, the MWC, following a public consultation, proposed a new process with stages of escalation to more formal levels of review.[25] This process is currently being implemented.[26]

From the MWC website, we found six published investigation reports published between 2010 and 2023 concerning deaths occurring between 2007-2019. We did not thoroughly review the investigation reports, nor verify that these are the only investigations which have been published.

The summary data for the reports we found is as follows:

- Published death investigations: 6
- Deaths in detention or under compulsory order 2013-2019: 731
- Time taken from death to publication of investigation report: average of 3.4 years; fastest time was 2.5 years; longest time was 5 years.
- Critical findings about a person's treatment and about the communication, care and coordination among professionals involved were raised in all the investigations.

It is notable that like Fatal Accident Inquiries (covered in Part II), investigations take multiple years to complete, during which there are dozens of deaths annually in mental health detention.

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[21] E.g. https://www.publichealthscotland.scot/our-blog/2022/june/health-inequalities-in-the-gypsy-roma-and-traveller-community-how-we-are-making-change-happen/ ; https://www.euppublishing.com/doi/abs/10.3366/scot.2004.0015?journalCode=scot ; https://www.sciencedirect.com/science/article/pii/S0277953600002008 ; https://www.sciencedirect.com/science/article/pii/S0033350617302032; https://academic.oup.com/ije/article/38/5/1215/663256

[22] MWC (2019) Death in detention monitoring, p. 8

[23] Scottish Government (2018) Review of the arrangements for investigating the deaths of patients being treated for mental disorder (December).

[24] MWC (2022) Investigating Deaths Occurring during Compulsory Care and Treatment under Mental Health Legislation in Scotland – Final Report (March), p. 11.

[25] https://www.mwcscot.org.uk/sites/default/files/2021-12/InvestigatingDeathsDuringCompulsoryCare-ConsultationDoc-07Dec2021_0.pdf (December 2021).

[26] MWC, Annual Report, 2022-23, p. 30.

The MWC emphasises human rights in its purpose statement appearing at the start of every report: 'We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions'. Only two of the investigation reports mention the rights of the person who died. One found a violation of the right against degrading treatment; the other contained extended discussion of balancing rights and risks. A further report makes no mention of the individual's rights but noted their family had a statutory right to support which was not met.

Under the reformed proposals of investigating MH detention deaths, the MWC, like the Crown and the PIRC for police contact incidents, retains discretion in determining which deaths will be investigated fully. Fully escalated investigations, and publication of these, seems to be prioritised where the MWC believes there are learning opportunities at a national level, that is where practice might be improved beyond the individual case and local providers involved. For example, in its latest annual report, 2022-23, the MWC notes, its investigative 'work will not routinely lead to published reports' with 'outcomes and learning' the 'critically important' role of these.[27] This may be an important aspect for preventing deaths in similar circumstances, but this criterion alone does not serve the human rights aims of the MWC nor fully address the concerns expressed by the SHRC about the need for independence and public scrutiny of investigation decisions and processes.[28] The 2022-23 annual report of the MWC, for example, quotes glowing feedback from a family member in relation to one death review, but it is not clear if this reflects the general view of all the families who have lost a member to a death in mental health detention. The decision to feature only one, and a strongly positive view of a family, does not automatically strengthen confidence in the independence of the review process.

All the investigations made critical findings and recommendations. It is not clear what the pathway from criticism to change is, nor of the processes for evaluating the impact and effectiveness of making findings. An example of an investigation having some impact was one case mentioned in the Government's paper setting out review of arrangements for investigating deaths of people subject to mental health orders. Though it is early days into the new approach for examining the deaths of people detained under mental health law, the numbers of deaths among people detained on mental health grounds has been rising, accelerating in the pandemic and against a backdrop of increasing and disproportionate use of compulsory orders among the least privileged.[29]

[27] MWC Annual report 2022-23, p. 31.
[28] SHRC (2022) Consultation response: investigating the deaths of people subject to compulsory treatment under mental health legislation in Scotland.
[29] MWC (2020) The use of the Mental Health (Care and Treatment) (Scotland) Act 2003 during Covid-19 .

C. Migration detention and asylum accommodation

Scotland has one migration detention facility – the Dungavel immigration removal centre (IRC). Although immigration is a UK government reserved issue, and Dungavel is privately contracted by the UK Government, it would not be accurate to say that the Scottish Government has no responsibility for those held there. Health and other services are provided through NHS Scotland, and some oversight falls under Scottish powers such as when someone dies, public investigation into this is at the discretion of the Scottish Crown Office.

In addition to facilities formally designated as detention, people in the asylum process who are accommodated in places like hotels or docked ships experience conditions virtually indistinguishable from detention. People in these settings may not be able to come and go freely, have meals provided as in institutions, are at constant risk of official detention, and report isolation levels that are similar to those of institutional settings like prison.[30] Moreover, people can move from asylum accommodation to IRCs and back again, which was the case for one person who died by suicide whilst in asylum accommodation but who had self-harmed during detention in Dungavel.[31]

Unlike in England and Wales where the Prison and Probation Ombudsman investigates every death in migration detention, in Scotland a Fatal Accident Inquiry over death in migration detention occurs at the discretion of the Crown Office.[32] In no part of the UK are deaths of people in asylum accommodation consistently investigated by the Government.

Data on deaths comes from Home Office statistics, fatal accident inquiry determinations, third sector organisation reports, FOIs and media investigations.

Table 10 Deaths in migration detention and asylum accommodation

	Migration detention (2017-22)[33]	Asylum accommodation (2016-2023)[34]	Most recent full year total (2022)
UK	11	180	46
Scotland	1	16	4[35]

The number of deaths among people in asylum accommodation saw a sharp rise especially since 2020: 85% of the 180 deaths across the UK occurred during 2020-23.

[30] Andrew Burridge (2023) Towards a hotel geopolitics of detention: Hidden spaces and landscapes of carcerality; Zoe O'Reilly (2018) 'Living Liminality': everyday experiences of asylum seekers in the 'Direct Provision' system in Ireland.
[31] Karin Goodwin (2022) Escalating asylum seeker deaths prompt calls for inquiry. (24 June).
[32] Medical Justice (2016) Deaths in Migration Detention 2000-2015, p. 2.
[33] Home Office (2023) Immigration system statistics data tables, online.
[34] Liberty Investigates (2023) Suicides Of Asylum Seekers In Home Office Accommodation Double In Last Four Years. (21 December); Karin Goodwin (2022), op cit.
[35] https://www.asylumseekermemorial.co.uk/

Cause

Suicide amongst those in immigration detention and asylum accommodation is higher than for the general population. Of those dying in Scotland, the investigative journalism body The Ferret identified several suicides among those in asylum accommodation between 2016 and 2022. The Asylum Memorial searches for records of death and includes causes where possible. Of the records for four people dying in Scottish asylum accommodation in 2022, two were babies, one born prematurely and another a newborn with a health condition identified prenatally. Of the two adults dying, one is recorded dying in hospital due to 'expected' causes; the other person's death was recorded as heart disease/heart attack. As noted in the introduction the language of 'expected' or 'natural' death may foreclose interest in further investigation even though there are numerous stories identifying conditions which worsened or prevented treatment of conditions that became terminal.

Age, gender and ethnicity

The Ferret's review of asylum deaths 2016-22 reported all of the 11 deaths in Scotland were among people aged younger than 60 years. Of those dying in 2022, according to the Asylum Memorial, all were under 60 years old. As noted, two were babies and of the adults, one person was in their 30s and one in their 50s. Three of the four who died were female, and the remaining death male. Two people came from African countries, two from middle eastern countries.

Investigation

We are not aware of any Scottish investigations of the deaths of those in asylum accommodation. The death recorded at Dungavel was investigated through a discretionary FAI that is discussed in Part II. In this case, the person's death was the result of a heart condition but in the FAI the Sheriff made numerous criticisms finding that quality of and access to care contributed to this so-called 'natural' death.

D. Young people and children in care

Scotland has one of the highest mortality rates for children generally in Western Europe.[36] Care experienced children have a higher mortality rate again, with a major study reporting in 2022 that the share of deaths in this group exceeded that of deaths among non-care experienced children by a factor of more than five.[37] New arrangements setting up a National Hub for Reviewing and Learning from the Deaths of Children and Young People in Scotland came into force on 1 October (child death review hub) 2021, but is not yet reporting on numbers of deaths among looked after youth.[38] 'Looked after' includes children who are under some form of state care order, including: looked after at home, in kinship care, foster care or adoptive placement, residential or secure accommodation, or supported accommodation. Young people aged 18 up to 26 years may receive some after care or through care support and this is noted when being included in figures. Data in this section comes mainly from an FOI request made in 2021, contextualised with a Care Inspectorate 2020 review of deaths and the CHiCS research study on care experienced children.[39]

In an eight-year period (2014-2021), 111 children and young people in some form of care (including through and after care) died (Table11). In 2021 (January-September, the most recent published information), 14 children and young people died. This contrasts with a total of 286 deaths among all children and young people in Scotland in 2021-22.[40]

Table 11 Number of deaths of looked after children and young people, 2014-2021

Year	looked after	continuing care	thru/after care	Total
2014	8	0	0	8
2015	3	0	1	4
2016	5	0	6	11
2017	8	0	7	15
2018	9	1	4	14
2019	6	3	12	21
2020	7	2	15	24
*2021	4	2	8	14
Total	**50**	**8**	**53**	**111**

Source: FOI to Directorate of Children and Families (2021). *January to September.

[36] National Hub for Reviewing and Learning from the Deaths of Children and Young People; Karin Goodwin (2021) A record number of young people in care died last year (24 October), The Ferret.
[37] The Children's Health in Care Scotland (CHiCS) study found: between 2009-2016, 0.11% of children in the general population of Scotland died, compared with 0.56% of care experienced children (Table 2) in Mirjam Allik et al. (2022) CHiCS – Main Findings from population-wide research report.
[38] Care Inspectorate; Healthcare Improvement Scotland.
[39] FOI to Directorate of Children and Families (2021) FOI Reference: 202100236654; Karin Goodwin (2021) A record number of young people in care died last year.
[40] National Hub for Reviewing and Learning from the Deaths of Children and Young People (2023) Overview Report: Year 1: 01 October - 30 September 2022. This includes deaths among 18-26 year olds meeting certain criteria, presumably in after or through care.

Causes

FOI data did not include information about causes of death. Other sources of data show that suicide is a leading cause of death among care experienced children, the CHiCS research showed this accounted for 29% of deaths among care experienced children 2009-2016, in contrast to 16% of non-care experienced children.[41] The Care Inspectorate identified 42 deaths of looked after children young people between 2012 and 2018 with the cause for 26 (62%) due to 'unexplained', 'unexpected misadventure' or 'risk taking behaviours'. Against this were 16 deaths 'expected due to life shortening condition or terminal illness'.[42]

Age, gender, race/ethnicity

Information about ethnicity could not be found for any looked after children and young people who died in Scotland. This is not only a barrier to understanding inequalities among children in Scotland, but the CHiCS study authors also point to estimates of around 5 unaccompanied minors arriving in Scotland each month. Little is known about their care and health outcomes, including deaths.

The majority of deaths in care are among boys and young men. In the 2012-2018 period, two-thirds of the 42 deaths of those aged 0-18 were among males and one-third among females. The Care Inspectorate also recorded 19 deaths between 2015-18 of young people aged 18-26, received after or through care. The gender difference is more concentrated in this group with nearly 80% (15 deaths) being among the young men.

[41] Mirjam Allik, et al. (2022) CHiCS – Main Findings from population-wide research report, Table 2.
[42]Table 4 in, Care Inspectorate (2020) A report on the deaths of looked after children in Scotland 2012-2018.

E. People with learning disabilities and autistic people

Information about the deaths of people with learning disabilities and autistic people held in institutional facilities like hospitals, care homes, police cells and prison is not routinely published. This is unlike England and Wales, where there is comprehensive data provided about the lives and deaths of people in this group, via the LeDeR project and funded by NHS England.[43]

In response to a parliamentary request[44], Public Health Scotland (PHS) produced a one-off report in 2022 focused on deaths of people in NHS facilities but including contracted out care. It used data on deaths based on required notifications of death included in the dataset Scottish Morbidity Record 04 (SMR04), which is:

> *'every episode of inpatient or day case care in a mental health specialty in a psychiatric hospital or unit, or in a facility treating people with learning disabilities, in NHS Scotland. In addition, if the NHS contracts out psychiatric or learning disability treatment or care to a private care home or hospital, an SMR04 record should be generated for each inpatient or day case episode'.*[45]

Information about deaths included only those people admitted to hospital/treatment between 2015-2021 (Table 12). People who were admitted before this period who subsequently died during 2015/16-2021/22 therefore may not be counted in this dataset; we did not have time to clarify this.

Table 12 Number of deaths of psychiatrically hospitalised people with learning disabilities and autistic people 2015/16-2021/22 (screenshot)

Financial year	Number of patients
2015/16	2
2016/17	5
2017/18	3
2018/19	0
2019/20	1
2020/21	0
2021/22[2]	3
All patients	**14**

Source: Public Health Scotland (2022), page 9.

[43] Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR), its latest annual report (2021/22) is over 100 pages long: https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/ and https://www.kcl.ac.uk/research/leder

[44] Helen McArdle (2022) Death toll of autism and learning disability patients revealed. (18 May), The Herald.

[45] Public Health Scotland (2022) Psychiatric care inpatient deaths for patients with learning disabilities and autism Financial years 2015/16 – 2021/22, p. 5.

Causes

No information is provided about causes of death. The report states (p.8): 'Cause of death is not available within the SMR04 dataset and is therefore not reported here, and it should be noted that the patient's diagnosis of or treatment for learning disabilities or autism may have no bearing on the patient's cause of death.' Whilst this may be true, it is also impossible to exclude this as a possibility in explaining their death. As with other categories in this report, an initial label of 'natural causes' has been applied to deaths of people with learning disabilities that, following an investigation, found serious failings in care as primary contributors to death.[46] Moreover, given the length of stays reported by media, deaths apparently due to the natural causes of aging deflect from focusing on the detention of people in the first place, and the way they can become stuck in institutional settings.

Length of stay

All but one of the deaths occurred among people who had been held for at least three months, and six people had been inpatients for a year or longer when they died (Table 13).

Table 13 Lengths of stay of people with learning disabilities and autistic people who died in care (2015/16-2021/22) (screenshot)

Length of stay	Number of patients	% of patients
< 30 days	1	7
30 - 90 days	0	0
91 - 365 days	7	50
Over 365 days	6	43
All patients	**14**	**100**

Source: Public Health Scotland (2022), page 12.

Given media coverage highlighting the issue of people with a learning disability and autistic people being detained for years and in some cases decades, further breakdown of the 'over 365 days' group seems warranted. A BBC investigation found through freedom of information requests that as of 2022, 129 people had been detained in hospital for more than one year, 40 people for more than a decade, and 15 people had been living in hospitals for more than 20 years.[47] A Scottish Government strategy for reducing inappropriate stays in hospital, called Coming Home, reported in 2022, but we could find no further published reports on progress since then.[48] An FOI in November 2023 sought an update, though the Government offered no information on outcomes or updated statistics on long stays or deaths.[49]

[46] https://www.judiciary.uk/wp-content/uploads/2021/05/Laura-Booth-2021-0137-Redacted.pdf
[47] https://www.bbc.co.uk/news/uk-scotland-62477095
[48] https://www.gov.scot/publications/coming-home-implementation-report-working-group-complex-care-delayed-discharge/ (February 2022)
[49] https://www.gov.scot/publications/breakdown-of-the-progress-of-the-coming-home-implementation-report-from-february-2022-foi-release/

Age, gender and ethnicity

No information in the PHS data on deaths between 2015/16-2021/22 is provided about ethnicity; this is unfortunate in light of known health inequalities. Of the 14 deaths, 5 (36%) were among women and 9 (64%) were of men. Eight people (57%) were under the age of 65 (including one person aged less than 45), six (43%) were 65 years or older.

Investigations

In the limited time of this project, we did not find published reports or fully clarify a distinct process (e.g. compared to the existing process for death in a health care setting) for investigating deaths of people with learning disabilities or autism held in hospitals and care homes. Unlike in England where there have been coroner's inquests, we could not find any fatal accident inquiries into deaths among people in this group. Media reports seems to be the main way of raising awareness of the deaths of people with learning disabilities and autistic people held long-term in hospital and care homes.[50]

[50] https://news.stv.tv/scotland/families-of-people-with-complex-needs-locked-in-secure-hospitals-for-several-years-protest-at-holyrood#:~:text=Families%20of%20young%20adults%20who,lack%20of%20carers%20and%20accommodation.

F. Prison

Deaths in prison are on the rise in Scotland. Since the 2010s there has been a steady increase in the mortality rate in prison,[51] with a sharper rise from around 2016-17 and then another spike in the Covid-19 pandemic. The rate of prison death in 2021-23 is 155% higher than in 2008-10, a period in which the prison population was seen as in crisis and the work of the Scottish Prisons Commission meant to bring it down.

Figure 1 Deaths (per 100,000) in Scottish prisons 2008-2023 (three-year moving average)

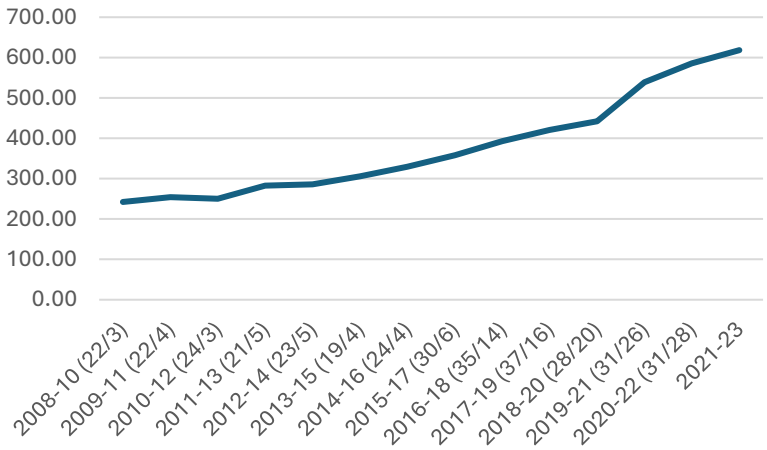
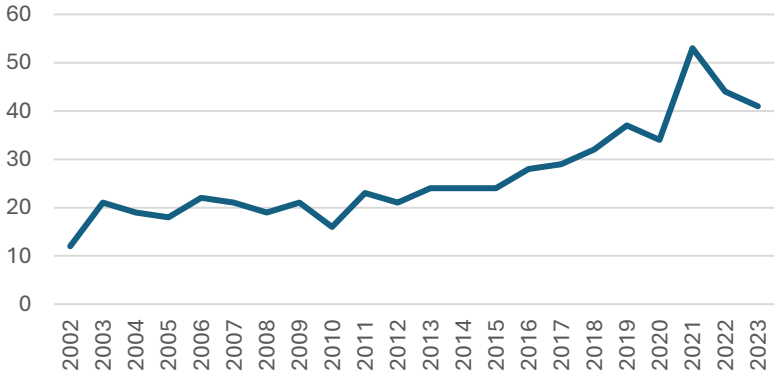


Figure 2 Number of Deaths in Scottish prisons 2002-2023



[51] The death rate is the number of deaths per 100,000 prisoners, a standard means of controlling for the size of the prison population (e.g. Fazel et al. 2017). Grouped years and a moving average are used to smooth out year to year fluctuations, which can provide a misleading picture of the overall trend given baseline annual numbers.

We offer more detailed analysis of prison deaths in this section. It analyses deaths over the previous year from October 2022 to September 2023, contextualising this in places for a longer-term review of the trends in Scottish prison deaths. All data on prison deaths comes from two sources, from which researchers constructed tables and figures: the Scottish Prison Service which publishes datasets on deaths, and the Scottish Government, which provides data on prison populations. In addition, we make a comparison with England and Wales for suicide and drug deaths, and with Europe and Australia for drug deaths. Data sources are provided in these sections.

Deaths in 2022-23

In the 12 months to 30 September 2023, 38 people died in prison in Scotland in an average daily population (ADP) of 7,426.[52] This is fewer than number of who died in prison in the same 12-month period October 2021 to September 2022 (48). However, the death *rate* (deaths proportional to the population in prison) remains high and on an upward trend: death from all causes in 2023 was 552 per 100,000 compared to a rate of 453 in 2019. The figure above shows the rate through a moving average, which helps smooth year to year fluctuations.

Age, gender and ethnicity

The average age of people dying in prison over the past year was 49.5 years. There was one woman among those who died, in her late 30s. (Non-binary gender is not reported.) The average age at death of all 23 women who have died in prison since 2004 is 37 years; for men, the overall average since 2004 is 46. Ethnicity data is not consistently labelled: ethnicity was entered for all people who died in the past year, using the following terms 'White Scottish', 'White', 'White British', and 'British/Scottish'.

Remand vs. convicted

Over 40% of prison deaths in 2022-23 occurred within 6 months of a person being admitted to prison (16). Most of these deaths were due to drugs or suicide. It is well known that people on remand are more at risk of dying, and that these deaths occur sooner after prison admission than for sentenced prisoners. In 2022-23, 29 people who died were convicted and serving a sentence, 9 were on remand. Those on remand died on average within 45 days (and a median of 7 days) of admission to prison, compared to convicted people dying on average 1,715 days (or 4.7 years; median time to death was 944 days or 2.6 years). Between 2008 and 2022, 110 people on remand died in Scottish prisons, and the average time to death was 138 days (63 of these deaths were by suicide). The high use of remand in Scotland, driven by its continued use for crimes such as bail offences and common assault as well as by continuing court backlogs that lengthened in and since the pandemic, therefore raises particular concern.

[52] Average daily population comes from Scottish Government, https://www.gov.scot/collections/scottish-prison-population-statistics/

Cause of death

Table 14 Causes of death in Scottish prisons, 2022-2023

Prison deaths by cause	N	%	Average age at death
Self	6	16%	39.7
Drugs	7	18%	34.0
Pending investigation/suspected drug deaths	5	16%	37.8
Health condition or incident[53]	18	45%	61.7
Homicide	-	-	-
Covid-19	-	-	-
Undetermined	2	5%	53.0
Total deaths and average age	**38**	**100%**	**49.5**

Deaths from health conditions and incidents

There were 17 (45%) deaths from causes besides suicide and drugs, mainly health conditions, plus two deaths where the cause remains undetermined and there's no reason to suspect suicide or drug overdose.

Deaths from health conditions and incidents predominantly involved cancer or heart and lung problems. The ageing prison population is part of the explanation for increasing deaths in this category over the past decade, and the higher average age of people in this group (62 years) reflects this. But these deaths also can raise questions about quality of and access to health care as well as quality of the general prison environment, particularly where deaths are from conditions usually managed successfully in the community. Part II discusses some FAIs where chronic health conditions leading to deaths that are labelled as due to 'natural causes' included concerns raised about health care and diagnosis.

We noted in last year's review of deaths in custody that investigations into the deaths of people from medical causes during peak Covid years (2020-22) did not mention the pandemic nor consider the access and quality issues in health care that are well recognised during this period.[54]

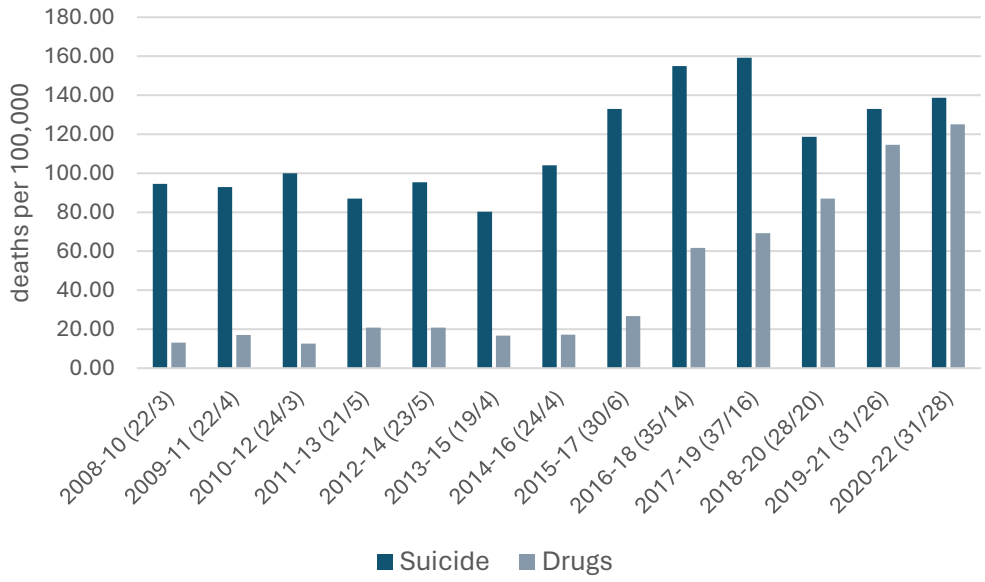
[53] We use the term 'health conditions or incident' to designate deaths with a cause of death related to a chronic health problem or incident such as a heart attack. Our labels are evolving but we intentionally avoid use of 'natural' or 'expected' to refer to these deaths.
[54] S. Armstrong et al. (2022) Still Nothing to See Here? One year update on prison deaths and FAI outcomes, SCCJR.

Suicide and drug deaths

Together, suicide and drug deaths continue to be leading causes of death in Scottish prisons.[55] Six people died by suicide in prison between October 2022 and September 2023; this compares to 14 people dying from this cause over the same period 2021-22. There were 7 drug deaths (plus 6 suspected drug deaths[56] pending lab results) in 2022-23; this compares to 10 drug deaths in 2021-22. Suicide and drug deaths together accounted for between one-third to one-half of all deaths in Scottish prisons in 2022-23 (depending on whether suspected drug deaths are confirmed). In ten years, 2013-2022 inclusive, there were 50 deaths from drugs (including more than half of these occurring since 2020) and 99 suicides.

The figure below shows the prison death rate for suicide and drugs between 2008 and 2022. In brackets next to the years are the number of deaths, respectively, for suicide and drugs in each three-year period.

Figure 3 Deaths from suicide and drugs (per 100,000) in Scottish Prisons

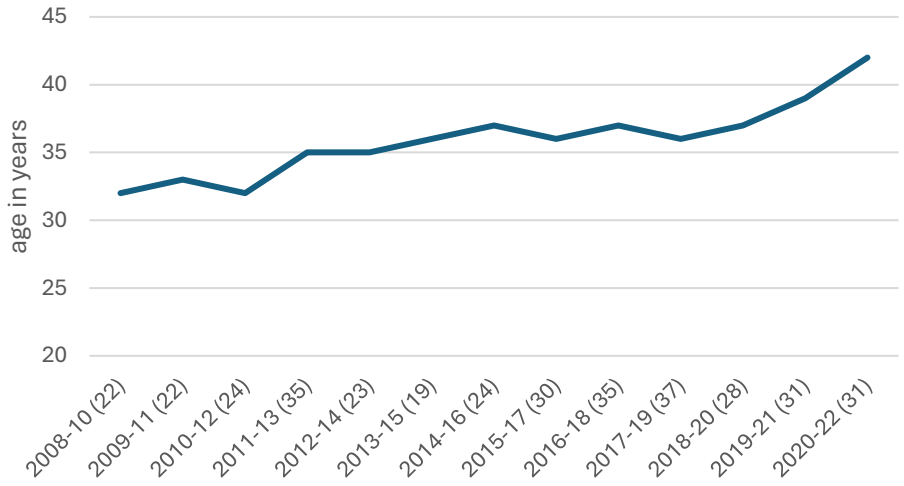


[55] An analysis of prison deaths by the Scottish Government and published in August 2023 refers to drug deaths as 'poisonings', a terminology we have intentionally rejected in our research (https://www.gov.scot/publications/deaths-prison-custody-scotland-2012-2022/). Drug deaths is a familiar and accessible for non-specialist readers, and connects this issue to the way it is framed in other policy settings such as the Scottish Drug Deaths Task Force. However, we note that some deaths include as a cause chronic alcohol or drug use with another health condition being the main cause of death. We classified these deaths as due to health condition or incident rather than as drug deaths, and use the latter term where this was the primary and immediate cause of death, i.e. an overdose.

[56] Deaths listed as 'pending investigations' or 'lab tests pending' often turn out to be drug deaths. The researchers excluded some deaths where lab investigations were pending, selecting suspected drug deaths based on the age, prison and time in prison of the person.

The average age of those dying by suicide in Scottish prisons is rising. In the 1990s, most people who lost their lives in prison to suicide were in their 20s; between 2010 and 2022, this had risen to 37 years old. In 2022-23 the average age of those dying by suicide was 43 years old. Figure 4 shows the average age of those dying by suicide between 2008 and 2022, using moving averages (with the total number of suicide deaths in brackets for each period). Though the data should be read with caution, given the small baseline numbers, a trend emerges showing an increasing average age.

Figure 4 Average age of people dying by suicide (moving 3-year average)



Though rising, the average age of those dying from suicide remains lower than for the average age of those dying from all causes in prison (52 years in 2022-23), and it is important to remember that suicide remains disproportionately higher among younger age groups and those on remand. Between 2008 and 2023, all but two of the 70 deaths among people younger than 30 years old were from suicide or drugs. However, the rising average of suicide overall suggests that more older people are ending their lives, a concerning development which merits investigation.

Looking further into the rising age of those dying by suicide, we calculated the time in prison over three periods before someone died; this produced interesting results (Table 15). Suicide in prison commonly occurs early in a person's sentence or arrival.[57] However, we observed that in the most recent five-year period a greater proportion of suicides is occurring among those who have been in prison for a year or more.

Table 15 Average time in prison of people dying by suicide in three periods

Period	N	Average days	Median days	Number dying after a year or >	% dying after a year or >
2009-13	37	375	23	5	13.5%
2014-18	47	290	64	5	10.6%
2019-2023	50	820	133	15	30.0%

[57] E.g. Daniel Radeloff et al. (2021) Suicide after reception into prison: A case-control study examining differences in early and late events

If this observation about the data represents an actual trend, it could flag concerns about: prison conditions, sentence progression practices, support for people serving longer sentences, loss of hope or deteriorating amount and quality of health, social and other support in prison.

International comparisons

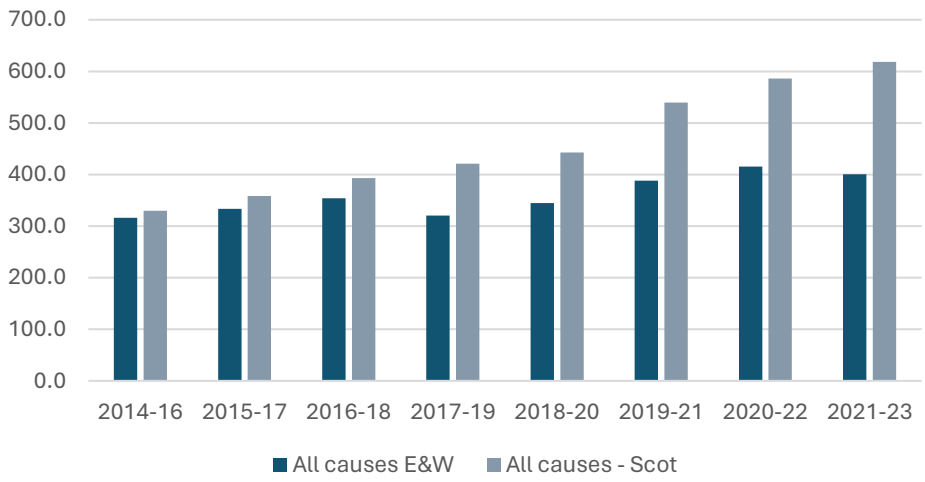
The Scottish national problem of drug deaths is reflected in the high rates of death from this cause in prison. We searched for international data to understand how Scottish prisons compare to other jurisdictions. Given that absolute numbers are small, and data collection suffers from quality issues, comparisons must be interpreted with caution. However, it is striking that Scotland's numbers are so much higher than other places.

England and Wales

Last year we compared death rates in Scottish prisons compared to those in England and Wales. Since then, the Office of National Statistics (ONS) published a data linkage study analysing prisons deaths from suicide and drugs in English and Welsh prisons between 2008 and 2019.[58] This provides a high-quality source of data, supplemented with statistical data on deaths in prison published by the Ministry of Justice for the years 2020-2023, to compare with Scotland. (Refer to the appendix for further tables documenting numbers and rates of death and comparing the age profiles of the two prison systems.)

Comparison of prison deaths between Scotland and England & Wales (using grouped year moving averages) shows that the rate of death in Scottish prisons is higher in all years for all causes. Scotland's higher rate of prison death is even greater for suicides and is most pronounced for drug deaths.

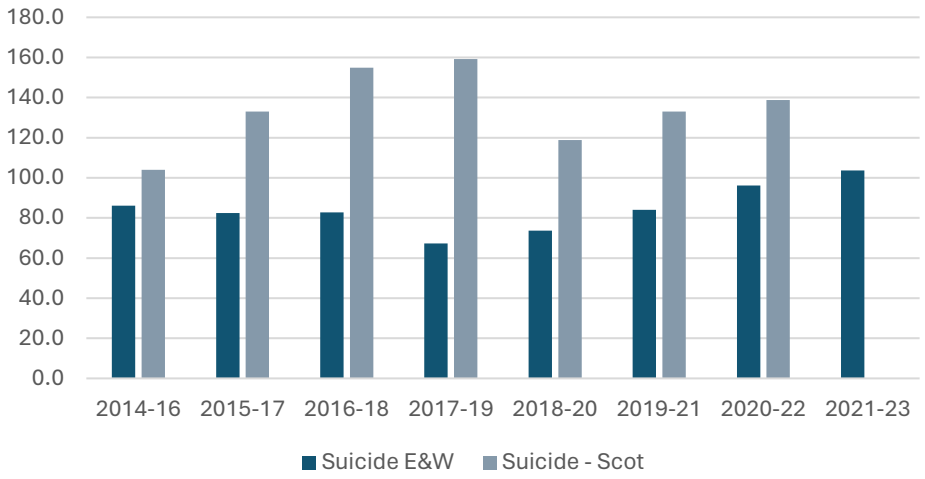
Figure 5 Deaths in prison (per 100,000), Scotland vs. England & Wales



Source: SPS and ONS (2023). Periods containing 2019 undercount E&W deaths.

[58] ONS (2023) Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019. Ministry of Justice (2023) Prison population figures: 2023; House of Commons Library (2023) UK Prison Population Statistics ; Ministry of Justice Safety in Custody Statistics.

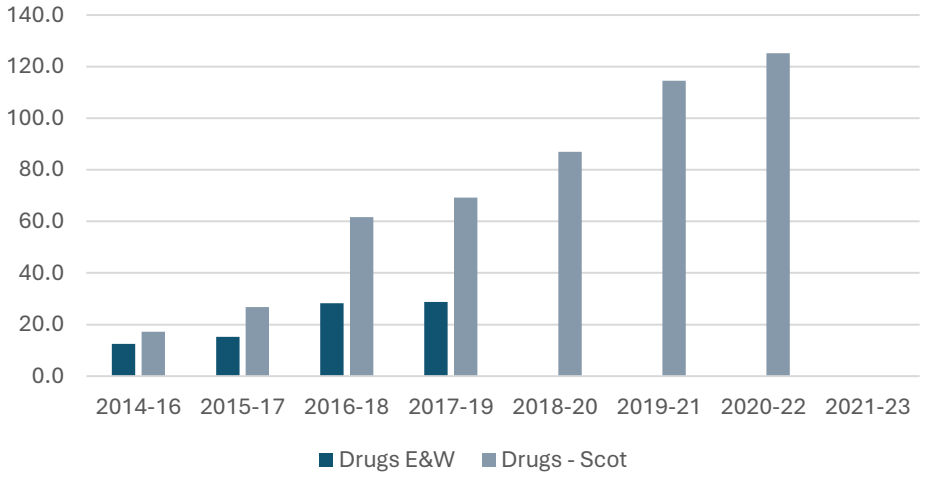
Figure 6 Deaths from suicide (per 100,000), Scotland vs. England & Wales



Source: SPS and ONS (2023). Periods containing 2019 undercount E&W deaths.

The ONS analysis notes that 2019 data for England & Wales is an undercount. Scotland saw highest number suicides 2016, 2017, returning to that level in 2019, 2021 and 2022.

Figure 7 Deaths per 100,000 from drugs, Scotland vs. England & Wales



Source: SPS and ONS (2023). Periods containing 2019 undercount E&W deaths.

Death from drugs shows the biggest difference compared to E&W. In 2022 there were 74 drug deaths in E&W prisons in an average prison population of 80,659. In the same year there were 14 drug deaths in Scottish prisons in 2022, in an average daily population of 7,426. In England and Wales, 74 drug deaths represents nearly a quarter of all deaths in prison that year (304 total). By comparison, Scotland's 14 drug deaths were nearly a third of total deaths (44). The reports from England and Wales note drug deaths are rising, as they are in Scotland.

Europe

The World Health Organisation (WHO) surveyed European countries about prison deaths during 2020.[59] The table below (Table 16) shows an overall drug death rate in prison across EU member states of 24.5 (per 100,000 population) in 2020. This rate is below that in Scottish prisons over the past ten years (Table 17), with the gap growing substantially so that by 2018-21, the Scottish rate (112) was over four times that reported for Europe.

Table 16 Prison deaths by cause in Europe, 2020 (screenshot)

Table 9. Main causes of death in prison (compared to the general community)

Deaths	Number of Member States reporting	Number of cases	Rate/100 000 people in prison	Rate/100 000 people in the community
All causes	36	2598	424.9	1369.2 *(34)*
Suicide	35	626	103.0	39.5 *(34)*
Overdose	27	92	24.5	4.4 *(34)*
COVID-19	33	163	31.2	126.8[a]

Source: WHO, Status report on prison health in the WHO European region 2022

Table 17 Scottish prison deaths from drugs, 2014-2022

Period	Rate per 100,000
2014-17	26
2015-18	46
2016-19	59
2017-20	79
2018-21	112
2019-22	115

Australia

The Australian Government publishes and analyses data on deaths in custody, via The National Deaths in Custody Program, a development from The Royal Commission into Aboriginal Deaths in Custody (1987-91). The most recently published dataset shows that a prison system which is five times larger than that of Scotland has many fewer drug deaths in absolute terms and proportionately fewer deaths overall. In 2022-23, Australia recorded a total of 70 deaths in prisons, where the overall population was around 40,000 ADP.[60] Scotland, with a prison population that is less than one-fifth this size experienced 38 deaths. The two tables below compare annual numbers of deaths from drugs in the two jurisdictions (Tables 18 and 19).

[59] Status report on prison health in the WHO European Region 2022

[60] Australian Government/Australian Institute of Criminology (2023) Deaths in custody in Australia 2022-23 (downloadable dataset and report).

Table 18 Number of prison drug deaths in Australia

Australia - drug deaths in prison (2022 ADP was 40,000)	
Year	**Deaths**
2017–18	0
2018–19	1
2019–20	3
2020–21	2
2021–22	1
2022–23	0

Source: Table C12, Deaths in prison custody, 2022-23, Australian Institute of Criminology.

Table 19 Number of prison drug deaths in Scotland

Scotland - drug deaths in prison (2022-23 ADP was 7400)	
Year	**Deaths**
2017	4
2018	8
2019	4
2020	8
2021	14
2022	6

Conclusion – deaths in custody

This part has compiled an extensive amount of data from a range of sources. It shows that in many areas, deaths are on the rise. Straight comparisons are very difficult, and overall we urge caution in interpreting the aggregate picture. However, information about deaths in a range of settings of care and custody show that: the data shows deaths are increasing in many settings; in many contexts deaths are not routinely reported; that most reviews or investigations of deaths do not report public outcomes. There is heavy use of the labels 'natural' and 'expected' to classify deaths. This may be entirely consistent with the facts of a given death. However, our experience in researching criminal justice deaths shows that these categories have been used in ways that do not reflect the full context and implication for state responsibility. Across multiple contexts of custody, it appears that deaths are higher among men than women, but that women may be dying at younger ages compared to men or counterparts in the general population. This impression requires further investigation to confirm.

It also is clear that mental health problems, drug and alcohol issues and suicide – national problems for Scotland – are fully, and disproportionately reflected among detained people. In official reports, a tone sometimes emerges of deaths being regrettable but inevitable. This is a narrative worth interrogating and confronting, given the absence of investigatory processes and outcomes which clearly evidence this. Problems come across as being individualised as the characteristics of individuals before they come into care or custody. Attention would be worth giving to how these problems intensify or can be exacerbated by settings of detention and responses of state actors. Moreover, in a country that uses prison more than any other in western European, and where police report the majority of instances of death after contact are in relation to non-criminal incidents, reliance on criminal justice to respond to mental health and addiction does not seem an effective choice for Scotland. Numbers from prison data make the case not only that death rates are higher in Scottish prisons, but that drug deaths in prison are significantly more of an issue than for any other country considered.

PART II FATAL ACCIDENT INQUIRIES

FAIs for deaths in custody continue to comprise predominantly deaths in prison, where an FAI is mandatory, but we identified two non-prison custodial deaths, which are included in the analysis. In this part of the report, first we provide statistics covering the past year about the people whose deaths led to an FAI, the time FAIs take, the findings Sheriffs make and family involvement, followed by comparison to longer term trends on these issues. The final section flags up key themes and offers mini-case studies that reflect issues of concern. As we have noted in our prior two annual updates, FAIs rarely make findings that a death could have been prevented or that any procedures were flawed. They rarely involve families in meaningful ways. And they continue to take years to complete, during which time there are further deaths.

Characteristics of FAIs

FAIs over the past year (2022-23)

Between 1 October 2022 and 30 September 2023 we identified a total of 22 FAI determinations into deaths in custody.

Table 20 FAIs by type of detention

Detention type	Number
Prison	20
Police	1
IRC	1

With 38 deaths last year in prison and one in police custody, it remains the case that FAIs are not keeping up with the deaths of those in detention, and the backlog of inquiries continues.

Age, gender and ethnicity

All but one of the 22 FAIs in the past year involved the death of men; the lone woman died in prison. Ethnicity and race information was not mentioned for all but one person; the one case where it was mentioned raises issue of institutional racism as discussed below in our case study and thematic analysis. The average age varied considerably depending on the cause of death, shown in Table 21. It is notable that deaths typically labelled as due to 'natural causes' – those involving health conditions such as heart disease or cancer – had an average age at death of just 56.3 years, younger than the average age of mortality for those in the general population for such conditions.[61]

[61] For example cancer mortality rates rise most steeply from about age 60 for men and 65 for women. https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/age#heading-Zero

Table 21 FAIs by cause of death and age

Main cause	Average age
Drugs	33.4 years
Suicide	38.0 years
Health cond/incident	56.3 years

The time FAIs take

The 22 FAIs in 2022-23 had a similar time profile as we have found in previous years, measured by the time between the date of a person's death and the date the determination concluding the investigation is published. Only one determination was completed within a year. More than three-quarters of all FAIs take more than two years to complete, and more than a third took more than three years (Table 22). We point out once more that coroner's inquests in England and Wales aim to be completed within 6-9 months of a person dying.[62]

Table 22 FAIs by cause of death and age

Time	Number	%
Up to one year	1	5%
Up to two years	5	23%
More than 2 years	17	77%
More than 3 years	8	36%
4 years or longer	3	14%

The shortest inquiry took just under a year and involved the death of a person in their 70s from sepsis and diabetes. The longest inquiry took nearly 6 (5.7) years and related to a death in immigration detention from a heart condition.

Corrective Findings in FAIs

There are two kinds of findings that can come out of an FAI. What the Crown commonly refers to as formal findings are those that confirm the time, date, place and cause of a person's death. As we noted in our 2022 update, this information appears in a death certificate and is usually available within eight days of a person dying. The second kind of finding is where the Sheriff identifies an issue, fact or improvement that could help prevent future deaths. The Sheriff is required by law to make additional findings where the evidence supports this. There are four kinds of such findings:

1. A 'reasonable precaution' that, had it been taken, could have prevented the death; the Sheriff can use hindsight to identify this, that is, he can find there was a precaution even if a person in the situation testifies they did not foresee it at the time;

2. A 'defect of system', which is a procedure or policy that was flawed and therefore contributed to practices which could put lives at risk';

3. A 'recommendation' aimed at improving working, ultimately to prevent death; and,

[62] https://coronerscourtssupportservice.org.uk/wp-content/uploads/2018/11/CCSS-EL_Inquest_Factsheet_Final29317221_3.pdf

4. ‘Any other facts relevant’ to the death of a person that helps understand the circumstances but is not a direct cause of their death.[63]

We focus on the first three, which are directly related to preventing a death, referring to them as ‘corrective findings’, whilst the fourth type of finding is more about establishing context, and often used to identify issues raised as concerns which the Sheriff nevertheless concludes did not contribute to a death. Other facts often raise concerning issues, but it is not clear what they actually achieve as there is no requirement that a concern be acted on by anyone.

In 2022-23, there were only four FAIs out of the 22 where the Sheriff identified a precaution, defect or recommendation (Table 23). Of the four cases of suicide (Table 26, below) in the past year of FAIs, none made a corrective finding.

Table 23 FAIs making a corrective finding in 2022-23

Finding	Number	% finding	% no finding
Precaution	2	9%	91%
Defect	2	9%	91%
Recommendation	4	18%	82%

The numbers are small, and so percentages should be read with caution, though they follow the pattern of what we have seen over 23 years and over 220 prison death FAIs, as presented below. In fact, if one were to remove the police and IRC FAIs, so that we were analysing only prison FAIs as in previous years, the numbers drop: only one prison death FAI over the year identified a precaution, and only one identified a defect.

Family involvement and legal representation

Alienation, confusion, poor treatment, disregard of relevant knowledge and lack of access to good legal representation are all concerns raised by families after a death in custody and expressed in prior reviews of post-death processes.[64]

Table 24 Family involvement in FAIs during 2022-23

Involvement	Number	% yes	% no
Present at FAI	9	41%	59%
Have lawyer	7	32%	68%
Gave evidence	3	14%	86%

The table above (Table 24) shows that over the past year, families continued to have low levels of involvement in FAIs measured in three ways: attending some or all of the inquiry; having legal representation; and giving evidence at the inquiry. There were three FAIs where families were present but had no legal representation (and one FAI where family legal representation was noted but it was not clear if the family attended). Prison death FAIs had worse levels of family participation than the others. Legal representation was more likely where the death involved a suicide (lawyers were present in four of the six FAIs involving suicide).

The table below (Table 25) compares the legal representation of families to that of other parties and key providers of evidence to an FAI. Looking at these figures helps one understand the sense

[63] See Sections 26(1) and (2), https://www.legislation.gov.uk/asp/2016/2/contents/enacted

[64] E.g. The Independent Review of the Response to Deaths in Prison Custody (2021).

of disadvantage the families may feel in the FAI but the imbalance between themselves and the others in the courtroom: typically there will be multiple lawyers representing staff unions and statutory agencies, and a single lawyer, if any, for the family. This can have, aside from the optics of fairness, an intimidating feel to those attending the FAI in person.

Table 25 Comparison of legal representation among parties in FAIs 2022-23

Party (& number of cases where attending or party)[65]	FAIs with lawyer	% of FAIs
SPS (20)	20	100%
NHSS (21)	15	68%
POA (20)	10	50%
Police Scotland (13)	3	23%
Family (22)	7	32%

How FAIs vary by cause of death

There are marked differences in FAIs depending on the type of death involved. Table 26 shows that FAIs involving death by suicide or drugs take longer, produce longer written determinations and are more likely to see families attending than other FAIs. The time that FAIs take for deaths involving health conditions is skewed somewhat by one hearing which took nearly six years to complete; excluding this would reduce the average time by 100 days, and also the average word count of these FAIs.

Table 26 Differences in FAIs by cause of death

Cause of death	N	Days (avg)	Word count (avg)	Age	Findings	% with finding	% w family invlvmt
Self	4	1032	12,126	38	0	0%	60%
Drugs	4	1201	7,904	33.5	2	50%	75%
Health condition	14	939	6,736	54.6	2	14%	23%

FAIs over the long-term (2005-2022)

We found 227 FAIs into deaths in prison, covering deaths up to the year 2020, published through September 2022. This section presents characteristics of these FAIs to help contextualise those that were published over the past year. We also present some breakdowns to compare FAIs completed before a major reform to the law was implemented in 2017.

[65] Scottish Prison Service (SPS); National Health Service of Scotland (NHSS); Prison Officers Association (POA). The denominator is the number of cases where an entity is named as a party or gives evidence. For example, SPS is a named party in all prison deaths, and Police Scotland would be a party in all police custody deaths. There is overlap in that, e.g., NHS is involved in almost all kinds of custody settings, and police officers may give evidence or be a party in prison deaths.

The time FAIs take

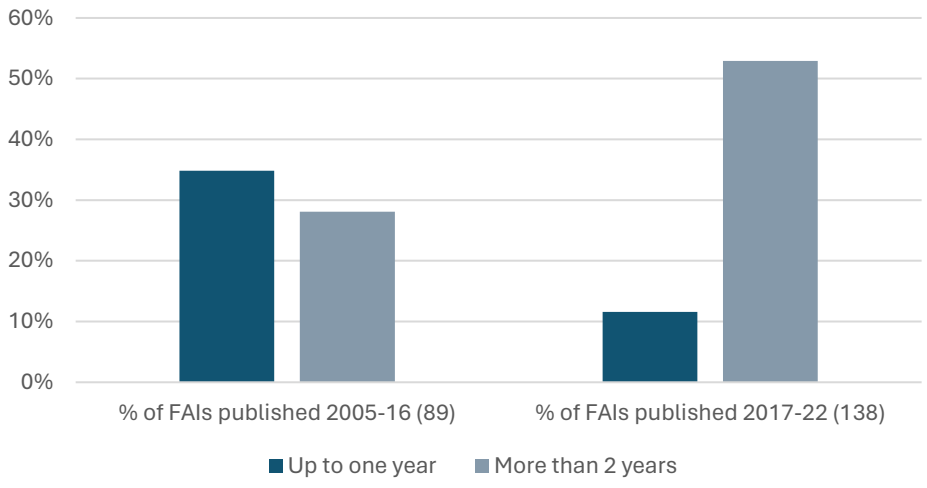
Overall, the median time of FAIs for deaths occurring 2005-2020 was 655 days from the date someone died and the date the FAI determination was published (Table 27). Most FAIs took more than two years to complete (66%), and nearly a fifth took four years or more. The fastest FAI took little more than 4 months (126 days) involving a suicide in 2005; the longest FAI in this period took over nine years and involved a homicide (criminal proceedings will take precedence over the FAI).

Table 27 Completion time of FAIs 2005-2020

	N	Average Days	Median Days
All FAIs	227	735	655
	N	**%**	
Up to one year	47	21%	
Up to two years	129	57%	
More than 2 years	98	43%	
More than 3 years	12	5%	
4 years or longer	41	18%	

Reform of the Inquiries into Sudden and Fatal Accident Act in 2016, was substantially motivated by criticisms over the lengthy times FAIs take. However, breaking down FAIs by those published before and since the law came into effect, shows FAIs taking more than two years has (Figure 8, with total number of FAIs in each period in brackets).[66]

Figure 8 Publication times of FAIs before and since legal reform



Two factors may be affecting the time FAIs take: the 2016 Act requires that all deaths in custody are now subject to an FAI, increasing the workload of the Crown and Courts. In addition, Covid-19 had a massive impact on court processing times, creating a significant backlog of cases.

[66] This figure shows the number of FAIs published in the two periods regardless of when death occurred, so the latter period is FAIs published 2017-2022 may include deaths occurring before 2017.

However, the increase in FAIs taking longer than two years has nearly doubled (from 28% of FAIs prior to 2017 to 53% since 2017), and it is not clear that these factors explain all of this change.

Corrective findings

Overall, FAIs into prison deaths between 2005-2020 made a corrective finding 15% of the time; that is, out of 227 published in this time, 34 identified a precaution, defect, and/or made a recommendation. Findings by type are shown below.

Table 28 FAIs making a finding by type, 2005-2020

Type of finding	2005-2020	%
Precaution	19	8%
Defect	9	4%
Recommendation	13	6%
FAIs making any finding[67]	34	

However, if one divides the FAIs into those published before 2017 and those published from this year, it can be seen that the more recent ones are less likely to make corrective findings since the reformed law governing FAIs came into effect.

Table 29 FAIs with findings before and since 2017

	Number of FAIs	N with findings	% findings
2005-2016	133	25	19%
2017-2020	94	9	10%
All FAIs 2005-2020	227	34	15%

This might be expected since, from 2017 onwards, *all* deaths in prison are subject to a mandatory FAI, where before 2017 an FAI was discretionary. Hence, the kinds of deaths that in the past might not have led to an FAI because they were determined not to raise any issues of concern, such as death by natural causes, must now undergo one. However, we analysed findings by cause of death and found that the increase in the number of FAIs being published into 'routine' deaths – such as those due to a health condition or incident – does not explain the overall decline. The table below shows that the chance of an FAI making a finding declined for *all* causes of death, including those seen as the least likely to raise an issue of concern.

Table 30 Findings in FAIs before and after 2017, by cause of death

	2005-2016	2017-2020	Difference
Suicide	24%	17%	-7%
Drugs	29%	14%	-14%
Health condition or incident	10%	4%	-6%

[67] The total number of FAIs making any finding includes FAIs where multiple findings are made. Hence summing the numbers above this would be greater than 34.

Another possibility is that in the past, an FAI would be published only where it was felt necessary to do so in the public interest, and this is more likely to be the case where the court has made a corrective finding. But in more than 80% of the FAIs published prior to 2017, no findings were made.

Finally, one might argue that the FAIs which make findings tend to take longer, and so we might expect that FAIs for deaths in the more recent period, which have not yet been completed, are more likely to make findings. There are 15 deaths between 2017-2020 which are yet to complete an FAI, some of these inquiries are taking place now. If one assumes that a high share of these eventually do make findings, on a generous estimate let us say more than half do – 8. This would only increase the corrective findings rate of 2017-2020 FAIs to 16% still lower than the findings rate for FAIs into deaths 2005 to 2016.

Family involvement

Families are not involved in any way in most FAIs, and their involvement was lower in the more recent period than before legal reform (Table 31).

Table 31 Family involvement in FAIs 2005-2020

Type of involvement	2005-2020	%	2005-2016	%	2017-2020	%
Present	68	30%	49	37%	19	20%
Represented	53	23%	37	28%	16	17%
Gave evidence	37	16%	29	22%	8	9%
Total FAIs	**227**		**133**		**94**	

We counted involvement where the FAI determination stated that a family member was present (even if only for part of an inquiry), where there was mention of their legal representation, or where family evidence was referred to. Especially in the earlier part of the time period, there is inconsistency in how Sheriffs format their determinations, and where it is not clear whether families attended, had a lawyer or gave evidence, we coded this as 'not noted'.

Breaking down FAIs by cause of death shows that families are more likely to be involved in cases of suicide or drug overdose; these deaths also tend to occur among younger people, where parents more likely than spouses would attend. The table below shows family involvement in different kinds FAIs (with the total number of FAIs for a given cause of death in brackets).

Table 32 Family involvement in different kinds of FAIs 2005-2020

	2005-2020		2005-2016		2017-2020	
	N	%	N	%	N	%
Suicide	47(83)	57%	35(54)	65%	12(29)	41%
Drugs	14(28)	50%	10(14)	71%	4(14)	29%
Health condition	27(111)	24%	17(61)	28%	10(50)	20%

Again, separating FAIs into those covering deaths before or after legal reform shows family involvement is dropping, even for deaths that families were most likely to attend in the past. The same qualification should be made here that there are FAIs for deaths occurring between 2017 and 2020 which have not yet been completed and so the rate of family involvement might increase.

Case analysis of FAIs

This section moves from statistics to specific examples. FAI determinations range from a couple paragraphs of text to hundreds of pages. They contain a huge amount of information that sheds light not only on the content of decisions, but about who is included and attends FAIs, how different parties and witnesses are treated and the kinds of evidence that underpins the making of findings, or not. In the case of prison deaths, they also contain information about a person's conviction and criminal history. Some of the people who have died have committed very serious crimes, inflicting the most profound kinds of harm. Others may be people not yet convicted of any crime, or who have been convicted of less serious offences. We do not make any distinctions in identifying issues of concern in FAIs based on a person's offending. Regardless of whatever reason a person may be detained by the state, they have an equal right to be kept safe, and to have appropriate support and care provided.

In previous reports we identified several themes of concern in FAI determinations (2005-2020):

- **Inappropriate care of those with drug issues**: Suicides by people experiencing drugs withdrawal, including by people who had requested help with addiction; a tendency for staff to dismiss health complaints as 'drug-seeking behaviour'.
- **Dismissal of suicide risk by non-mental health experts**: Over-reliance on superficial assessments of making eye contact or appearing well by prison staff that people are not at risk of suicide; ignoring medical history and medical records when assessing suicide risk; default interpretation of suicide prevention policy as simply moving a person to a safer cell, rather than offering support and consulting the person on their needs.
- **Access to medical care and dignity in treatment**: Avoidable or early deaths from treatable causes; delays to medical treatment, sometimes unexplained; lack of consideration of prisoners' (and families') rights to dignified end-of-life care.
- **Ineffectual or unimplemented FAI findings**: Sheriffs declining to make corrective findings when assured changes have been made since a death; lack of an enforcement or even monitoring mechanism after significant issues are identified after a death; where findings are made to a narrow individual circumstance and struggle to address systemic issues.

In the following examples, we identify concerns arising from recently completed FAIs, those published from 1 October 2022 to 30 September 2023. As noted there were 22 completed determinations, most reporting on prison deaths (20). Where the cases led to corrective findings by the Sheriff, this is indicated in brackets; most did not. As explained above, we use the term 'corrective findings' to mean those findings specified in law that have the aim of preventing future death: a 'reasonable precaution' that if taken might have prevented a death; a 'defect of system', meaning operating procedure or policy, that has been found to have contributed to death; or a recommendation that is made to improve the chances of preventing another death. A fourth possible finding allowed in law is noting other relevant facts. In several cases there were observations in FAI determinations made under 'other facts': these referred to issues that added context to a death and in some cases raised a concern but one determined not to have had caused death.

Care of people with drug issues

The consumption of drugs can render people vulnerable to acute health crisis. Our review raises concerns about the treatment and care of people who use drugs, making clear the tragic consequences of a punitive criminal justice approach to drugs rather than a public health approach. In the case examples below show opportunities to offer medical care earlier. We are concerned that FAIs are normalising the deaths of drug users as inevitable, instead of questioning the appropriateness of custodial and punitive settings for people in various forms of drug-implicated crisis.

SS [No findings]. SS was in his 30s when he died of diabetes complications in prison after consuming drugs, impairing his ability to manage blood sugar. On the day of his death, fellow prisoners and SS's friends tried to conceal his intoxicated state, apparently trying to protect him from punishment, although prison officers had noticed he was seeming unwell. By the time they raised the alarm in the early evening it was too late and he died in a holding cell awaiting transfer to hospital. Expert witness evidence was that if he had received earlier medical attention, he could have been saved. A prison officer on shift that morning gave 'vague and evasive' evidence, he said he thought another officer was going to contact healthcare. Fear among prisoners about disclosing someone's drug use conveys the prison environment as one which has not adopted Scotland's claimed public health and harm reduction approach to drug use.

JMA [Recommendation, finding of 'other facts']. JMA was a young man who died of a drugs overdose. After consuming drugs he became aggressive and agitated and his mum eventually called the police. He was arrested then held for nearly two hours in a holding area outside the police station, apparently forgotten about by custody staff. The officers monitoring him became distracted and one scrolled his phone, while he was able to access drugs from his clothing, which had not been discovered through searching. Arresting officers had failed to tell custody staff about his consumption of drugs. He was taken to hospital but collapsed and died 10 days later. The Sheriff observed that communication and monitoring 'could have been better'.

Mental health and suicide risk

As noted, there were four suicides investigated by FAI in 2022-23; none resulted in any corrective finding. We have concerns about the ways that mental health and suicide risk is being approached in prison environments, and more generally about the use of prison to house people with serious mental health issues. 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 staff, including prison officers, 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, recent changes in life or behaviour and refusal of medication. We have serious concerns about the care of people with issues such as trauma and psychoses, and have found that FAIs have a tendency to view mental health as an individual or medical issue, rather than considering the nature and impact of custodial settings on people in acute mental distress.

JWA [No findings]. JWA was in his 30s when he died by hanging. On the evening before his death, JWA made several 999 calls while experiencing a traumatic flashback. Emergency service call handlers were concerned and attempted to contact the prison, trying for nearly an hour and half with no one at the prison picking up the phone. When they eventually made contact, they requested a welfare check, but this was not noted as a welfare check. Prison officers gave evidence that they had been told of a prisoner making "nuisance calls" to 999, and went to the cell and confiscated his phone. The following night he hanged himself. JWA had previously requested support form addiction services and to be put on methadone, which was not done. At

the FAI, when asked about his interactions with JWA, one officer insisted that although he appeared 'disgruntled', it was 'commonplace to complain' about medication, and 'quite normal in a jail setting'.

RA [Finding of 'other facts']. RA was in his 30s when died from a drug overdose of prescribed medication. RA was a remand prisoner living with psychosis; after a deterioration in his mental state he committed two violent assaults. He presented as 'floridly unwell', expressed delusions and was known to be not taking his medication. He spent three months in a segregation unit; a transfer to the state psychiatric hospital was requested but did not take place. He was put on a high dose of anti-psychotics in an effort to bring symptoms under control, then died of a lethal dose of this medication, apparently stockpiled in his cell. The Sheriff was critical of the lack of medical documentation and cell searches, but did not explore the possible impact of spending several months isolated in the segregation unit or whether prison was an appropriate place for him in the first place.

JB [No findings]. JB, 30s, died from hanging. He was serving a short, four-month sentence when he experienced a decline in his mental health. He had a history of borderline bipolar, schizophrenia, drug use and not taking medication. He had referred himself twice to the mental health team and mental health staff had made urgent referrals based on their concerns in the days before his death, but died before seeing psychiatrist. Concerns about his wellbeing rose to the level that he was removed from association and put into a single cell. The Sheriff found all care and treatment he received at the prison was appropriate.

Access and quality of healthcare

In previous reports we have noted a tendency in prison of homogenising the prison population as 'unhealthy', sidelining scrutiny of healthcare quality and access within custody. Several cases raised questions about the possible impacts that incarceration can have on health outcomes, including poor communication between prisons and hospitals, missed health appointments and scans. We also note that FAIs do not seek to understand the underlying factors that could be driving poor health in prison, even despite the deaths of people dying relatively young of lifestyle-related conditions after spending most of their adult lives in prison.

WC [Finding of 'other facts']. WC died in his 50s of heart disease. A scan of his heart had been recommended but never took place, and a recommended increase of medication to prevent heart attacks was never implemented by prison healthcare. The Sheriff did not find the missed treatments to have been causally related to WC's death, but noted that it was 'unsatisfactory', noting the missed scan under other facts.

JD [No findings]. JD died in his 50s of lung disease. Several hospital appointments to receive care from a specialist were missed after a referral letter to the prison health centre went astray, and transport to hospital wasn't booked for JD on multiple occasions. The medical expert witness speculated that the treatment options that might have been offered to JD may not have been well tolerated by him, so Sheriff concluded there was no causal connection between missed appointments and JD's death, and made no findings.

JMN [No findings]. JMN was in his 70s when he died of lung cancer. He had been in prison for over six years. No information is provided about his diagnosis or treatment, and the determination was the shortest one in almost the entire sample of 20 years we have read, at 270 words.

Prison unlock and lock-up procedures

Guidance introduced by the SPS in 2016 requiring officers to get a verbal response from prisoners when they are being locked into their cells at night and unlocked in the morning: this is to 'reduce the risk of suicide and also identify someone with a deteriorating health condition.'[68] This guidance was itself issued in response to several previous FAIs in which Sheriffs had found that procedures were not being followed.

It therefore is a matter of concern that recent FAIs are still finding the non-compliance with these guidelines, with an apparently routine practice among officers of merely looking in on prisoners in a cursory way. In two recent FAIs, Sheriffs identified non-compliance with the procedure: AH, who died aged in his 50s of heart disease, and GR, who died in his 30s of an accidental drugs overdose (see below). Officers have sometimes claimed they are at risk of being assaulted rousing prisoners from sleep (AH). We also noted cases where the death of a person was discovered by another prisoner, including where officers unlocking in the morning had not noticed someone had died overnight (GC).

GR [Findings of precautions and recommendations]. Died aged 34 of an accidental overdose. CCTV showed GR moving in a way that displayed unwellness. At lock-up, prison officers did not get a verbal response, as required, from GR. Other prisoners believed to be intoxicated were monitored overnight but GR was not, therefore he got no medical attention when his condition deteriorated. The Crown argued against making any criticism of the prison staff because it would be 'speculative' to consider whether the death could have been prevented by eliciting a verbal response. The Sheriff rejected this and found that a reasonable precaution would have been for staff to follow their own policy. He noted the similarity to a death two years previously in the same prison where officers also didn't get a verbal response from someone who died of an overdose. He said that it was a 'significant concern… to note there has been a continued non-adherence to the… Lock-up procedures across the prison estate' despite repeated Inquiry findings of the same issue.

Failures of a "successful" FAI?

It is mandatory to hold a FAI into a death in custodial settings in Scotland, but they can also be held on a discretionary basis where the death occurs in circumstances giving rise to serious public concern. This Inquiry concerned the death of XBH, a Chinese man in his 50s who died of heart disease in Dungavel. The 147-page FAI determination is unusual in its criticism of the treatment of XBH, and identified a number of defects in systems and reasonable precautions that could have prevented the death, namely, that he wasn't given proper medical care. The Sheriff made 14 recommendations about delivering medical care and using interpreters.

XBH had been detained by immigration officers in England and despite his family connections there was transferred to Dungavel detention centre in Dumfries. On arrival his name and language were incorrectly recorded. His language being listed as Mandarin, of which he had no knowledge as a Taishanese speaker. No interpreting assistance was sought by medical staff, and he spoke no English so he never had an opportunity to explain to them his symptoms of chest pain. When he approached nursing staff asking for help, they dispensed cold and heartburn medications. Medical evidence at the FAI was that he had most likely suffered two separate heart attacks and had been experiencing a cardiac event at all times he presented to medical staff. He was eventually found unresponsive by his roommate after he had sought help from medical staff on

[68] Scottish Prison Service Governors & Managers Action of 28 March 2016, "Revised requirements during Locking and Unlocking Periods" Reference 016A/16.

ten separate occasions. The Sheriff found several failures by the nurses: they had failed to examine him, failed to use the consulting room and instead interacted at a 'hatch', failed to utilise the telephone interpreting service and failed to keep proper records.

Even despite the detailed and critical exploration of these issues, the case does not explore wider factors of the workplace culture at Dungavel nor the possibility of institutional racism facilitating this culture and the conditions for someone in acute health need to be dismissed so readily and repeatedly. Racism is not mentioned in the entirety of the determination, despite XBH's demeaning treatment. There is ample evidence supporting such a deeper inquiry: the systematic abuse of detainees including denial of healthcare has been documented across the UK detention estate by Parliamentary Inquiries, as well as the Prisons Inspectorate in England and Wales and others.[69] There are disturbing similarities with a previous death in Dungavel in 2004 of a Vietnamese man, TQT, who hung himself aged 35 after not being able to communicate with his doctor or solicitor. TQT's health screening wrongly noted he spoke Chinese. The Sheriff at this FAI also recommended the use of interpretation services by medical staff.[70]

Family involvement

We have concerns about the ways that families may be experiencing and treated at FAIs. In several cases, families have brought concerns about the treatment of their loved one to the attention of authorities, only to have them dismissed as irrelevant or being exposed to judgmental speculations.

JB's (above, who died by suicide) sister brought a suicide note to court with her and recounted that she had tried to raise her concerns about her brother's potential suicidality with the authorities. SPS claimed to have no record of her call and lawyers at the hearing seemed to focus on the timing of a call and the potential of the sister being confused. The Sheriff did not probe this discrepancy further, but did venture to list parental issues with alcohol as in some way providing explanation for JB's problems. No findings.

RJ [No findings]. RJ died of brain cancer in his 40s. His family had raised concerns about his care and communication with them including that he had been handcuffed to a bed and that the family had not been provided with adequate information, but the Crown had decided that these matters were not relevant to the Inquiry.

'Public' inquiry? Joint minutes in FAIs

The FAI is Scotland's only statutory system for the public investigation of deaths. It therefore acts as a central means of establishing Scotland's compliance with its legal obligations under human rights law, of which independence and transparency are key values. All FAIs make use of 'joint minutes' a legal tool claimed to save court time by allowing parties to agree uncontested matters in a proceeding, such as the name and date of birth of a person. However, given the low level of family involvement in FAIs, particularly the low number who are legally represented, most 'joint' minutes are agreed where the only parties with lawyers to review this technical document are the bodies responsible for the care of the person who died, the NHS, Scottish Prison Service and

[69] https://medicaljustice.org.uk/research/death-in-immigration-detention/#:~:text=In%202016%20Medical%20Justice%20decided,under%20immigration%20powers%20in%20prison ;
https://www.bbc.co.uk/news/uk-england-sussex-66846891
https://www.opendemocracy.net/en/shine-a-light/inquest-jury-finds-failures-in-detainee-healthcare/
[70] See FAI determination https://www.scotcourts.gov.uk/search-judgments/judgment?id=d59b87a6-8980-69d2-b500-ff0000d74aa7

Police Scotland (and occasionally staff unions of these bodies). The joint minute is not usually included in the FAI determination so there is little public awareness or scrutiny of what has been agreed to be an uncontested fact.

Numerous FAIs are concluded where the joint minute constitutes the only evidence considered. This somewhat obviates the need of a public hearing to determine if a death reflects any issues in care, since all issues have been pre-agreed by the deliverers of care not to raise such concerns. An example in the FAIs we analysed this year (where more than one relied on the joint minute as the sole source of evidence) includes that of JMN (who died of cancer after six years in prison, see above), the shortest determination, in which the Sheriff's only substantive comment is 'the joint minute of agreement forms the entirety of the evidence before the Inquiry. It details the circumstances of Mr McGrogan's death and his care and treatment'. This FAI exemplifies the concern we have about how meaningful the FAI is as a system for ensuring accountability. The fact that FAIs, run by the Crown Officer Procurator Fiscal Service according to court rules governing other court proceedings, take vastly more time than in the coronial approach to investigation in England and Wales, belies the claimed efficiency of this tool. From experience of following FAIs, we note that discussions over the contents of the joint minute take a considerable amount of time and may play some role in delays to hearings proper commencing.

Conclusion - FAIs

Review of FAIs shows that over the past year, the trend continues of rarely finding anything went wrong in contributing to a death. With more FAIs being published since legal change, it was possible to compare FAIs before and since reform. This showed that FAIs now are less likely to make findings, less likely to involve families, all whilst taking more time. The pandemic and new requirement that all deaths in custody must hold and publish an FAI certainly have had an impact on time scales. But these trends raise worries that the problems identified in the past have not been addressed. Perhaps most important, by comparing trends in prison deaths (Part I), it is notable that despite legal reform to FAIs there has been no correlation with decline of those dying in prison. In fact, we have observed the opposite.

The case analysis of FAIs raises a number of concerns and running through these is a sense, not in all but certainly in most, of deference to and complacency about the stories presented by agencies responsible for the care of a person. FAIs are a unique Scottish arrangement for investigating deaths, and there are questions to be asked about the independence and effectiveness of this system, when it takes so long to find so little.

Final thoughts

The title of this report series – *Nothing to see here?* – comes from our original review in 2021 of hundreds of deaths in prison and nearly 200 inquiries into them. There is a jarring contrast between the bulk of FAI reports, which almost never identify any failing of the state, and the increasing number of people dying in prison. Across the much wider range of custody forms covered in this year's report, there are important differences but also many continuities. One of these is that deaths in custody in Scotland occur regularly but mostly go unnoticed by the public. We produce this report out of an interest in raising awareness. We believe it is important that information about deaths in custody should be readily and publicly available. One might argue that it is part of a state's duty to provide clear information about deaths in its care, and what it is doing to investigate and prevent these; and that this is an issue too important to depend on a small group of researchers working with limited resources. It is also important that data and the analysis of it are produced in an independent manner.

Whilst this report is concerned with death, this is only one, and the most extreme, outcome for those dependent on the state for their lives. An avoidable death is a tragedy in its own right, but also may be a marker of wider conditions in which people are not able to flourish, and indeed may experience severe physical and mental unwellness without this ever rising to a level of concern and review. Analysis of FAIs in particular shows how factors that may not have contributed immediately and directly to death nevertheless reveal a wider environment that actively undermines wellbeing of potentially thousands of people.

Contact

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Appendix: Deaths in prison, England & Wales and Scotland

England & Wales - numbers	ONS data												MOJ Safety in Custody Statistics			
	2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	***2019**	**2020**	**2021**	**2022**	**2023**
All causes	161	166	193	187	186	204	235	243	333	281	285	240	318	371	301	304
Suicide	39	51	47	41	52	57	65	69	87	56	67	46	67	88	74	92
Drugs	5	6	6	11	5	8	7	9	16	14	41	17	unk	unk	unk	unk

**ONS data for 2019 is an undercount*

Prison Deaths Scotland - numbers	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Total - all causes	19	21	16	23	21	24	24	24	28	29	32	37	34	53	44	40
Self	6	6	10	6	8	7	8	4	12	14	9	14	5	12	14	
Drugs	1	2	0	2	1	2	2	0	2	4	8	4	8	14	6	

E&W death rates per 100,000 - moving average	ONS data										MOJ data			
	2008-10	**2009-11**	**2010-12**	**2011-13**	**2012-14**	**2013-15**	**2014-16**	**2015-17**	**2016-18**	***2017-19**	***2018-20**	***2019-21**	**2020-22**	**2021-23**
All causes	206.5	215.1	220.7	226.2	244.8	266.7	316.0	333.4	354.2	320.6	344.8	387.9	415.6	400.2
Suicide	54.4	54.8	54.6	58.8	68.1	74.7	86.1	82.5	82.8	67.3	73.6	84.1	96.1	103.7
Drugs	6.8	9.0	8.6	9.4	7.8	9.4	12.5	15.2	28.2	28.8				

**ONS data for 2019 is an undercount*

Scotland Rates per 100,000 - moving average	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20	2019-21	2020-22	2021-23
All causes	242.3	254.0	250.2	282.5	286.2	305.6	329.4	358.1	393.1	420.8	442.4	539.3	585.9	618.4
Suicide	94.5	92.9	99.9	87.0	95.3	80.2	104.1	133.0	154.9	159.2	118.8	133.0	138.8	
Drugs	13.0	17.0	12.6	20.8	20.8	16.7	17.2	26.7	61.7	69.2	87.0	114.5	125.2	