A DEFECTIVE SYSTEM

Case analysis of 15 years of Fatal Accident Inquiries after deaths in prison

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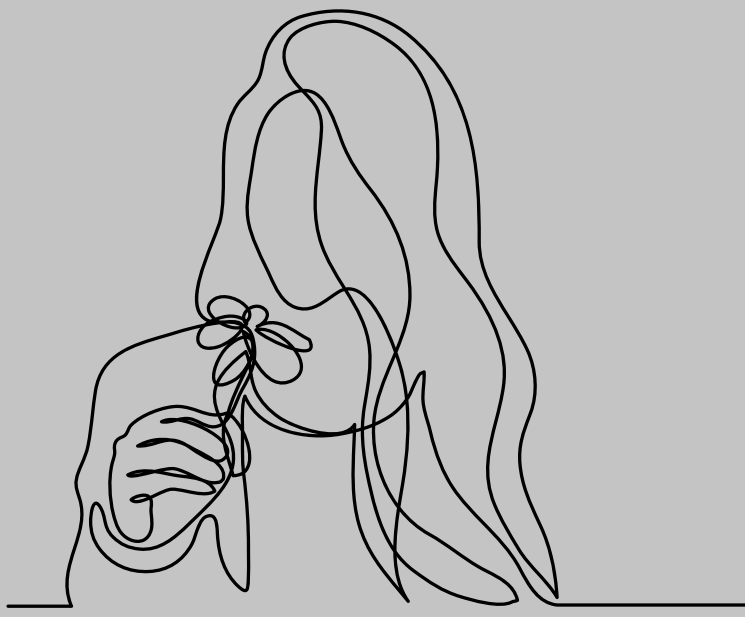
STATEMENT

This document contains information about deaths in prison custody in Scotland, and we understand that this is a distressing topic, especially for those who have been directly affected.



We pay our respects to those who have been affected by a death in custody.

At the end of this briefing is a list of resources that can offer support to those affected.

We have thought carefully about use of names and identifying details. On one hand, every Fatal Accident Inquiry (FAI) relates to the end of a life, and we recognise that the use of statistics and legalistic terms such as 'the deceased' could contribute to the dehumanising treatment experienced by people involved in the criminal justice system and FAI process. We recognise the full humanity of every single person who has died. On the other hand, we are conscious that FAI determinations include medical and other intimate details and some people may have experienced Inquiries as intrusive, and we respect their right to privacy. We have developed an ethical stance that involves case by case assessment centring the interests of families and aiming to balance transparency and sensitivity. For this briefing, we have chosen to follow conventions adopted in similar work (Razack 2015) by using a person's initials rather than their full name to minimise further intrusion. The exception is where families have explicitly told us that they would like their loved ones' name to be used, and we have done so.

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EXECUTIVE SUMMARY

Introduction

This briefing complements the statistical analysis of FAIs, highlighting key issues that emerged through reading all 196 published FAIs available between 2005 and 2019.

Most of the FAIs discussed occurred following Lord Cullen's review of the process in 2009 or around the time of legislative reform in 2016.

Statutory provision for fatal accidents

Legal reform in 2016 was guided by the Cullen review in 2009 and aimed to make FAIs 'practical and effective' to secure 'high quality, affordable and accessible justice'.

However, legal provisions often are interpreted narrowly, potentially explaining the low probability of a finding being made. Moreover, evidence of severe and preventable suffering of a person prior to dying is not considered relevant to making a finding or recommendations.

The law also is applied in a case by case way, so that structural issues and patterns of death are not incorporated in the analysis despite strong evidence of such patterns existing.

'Natural causes' deaths

Most deaths in prison are classified as 'natural causes' but review of these cases raise concerns. There appears to be a widespread and blanket assumption about the poor health of prisoners that results in treating death by almost any cause as regrettable but inevitable. Examples include people dying at young ages or of conditions not commonly fatal in the wider population.

Further implications of this logic are the normalisation of early death among people in state care and a reduced expectation of health care for those in prison.

Drugs deaths and drug issues

Case review revealed a common pattern of interpreting the health concerns of people with any history of drug use as 'drug seeking behaviour'. Examples of deaths due to unrelated health issues showed concerning interactions based on mistaken assumptions about drug use.

Where drug use was occurring, further concerns arise around management of withdrawal and a moral tone in FAIs both of which appear inconsistent with Scotland's public health approach to addiction.

Self-inflicted deaths

FAIs involving self-inflicted deaths reveal multiple issues. Failures to conduct mental health assessments or to initiate suicide prevention management strategies were common.

Decisions often flowed from mistaken assumptions and judgments about what health care is practical in a custodial setting. They were also the result of a common view among staff and accepted by Sheriffs that the prison's suicide prevention strategy is itself likely to worsen suicidal feelings.

Communication and sharing of crucial information regarding a person's mental health are commonly criticised in these FAIs. Information, when it is shared, often is discounted, particularly when it is provided by other prisoners.

The deaths of young people are a particular concern, given that most of their deaths are self-inflicted, often while they are on remand. They also are marked by more significant delays than other FAIs.

FAI 'successes'?

Review of FAIs that have made findings of defect or precaution show that even 'successful' FAIs have limited impact. Such findings often narrowly address an individual circumstance that is not clearly connected to structural improvements in care.

The exceptionally forceful and critical FAI in the death of Allan Marshall produced several recommendations. However, there is no mechanism for enforcing or monitoring implementation of these nor of challenging the rejection of accepting recommendations.

Timing and delay

Years long delays to FAIs and the drawn-out nature of FAI hearings once they have begun has substantial financial, emotional and other impacts on families.

Delays also mean witnesses may become unavailable or forget crucial details. Additionally, Sheriffs have been hampered by claims of improvements being made in the years between the death and the FAI hearing. Despite such claims, similar deaths have occurred in the interim or following the publication of the FAI.

Conclusion

The isolated, narrow way deaths in custody have been assessed in FAIs, alongside a rising prison death rate, show the FAI process has a limited impact on improving structures of care in custody. Determinations also evidence a pattern of accepting poor health outcomes of those in custody.

The central role of the Procurator Fiscal, which generally invites the Sheriff to make no findings tied to improving care will be a focus of the next phase of research.

The experience of families through the FAI also will be a focus of research. The analysis of FAIs reveals mostly their absence or partial presence. Given the significant impact of family involvement on the outcomes of FAIs, and the potential of the process to retraumatise them, this is an urgent priority for research and policy.

INTRODUCTION AND METHOD

This briefing reports on early findings from academic research into Fatal Accident Inquiries (FAIs) into deaths in custody in Scotland. It is designed to be read alongside the statistical briefing *Nothing to see here?* (2021), which provides an overview of the project and our statistical analysis of all published FAI determinations over 15 years.

The research team has spent two years reading all publicly available determinations (N=196) into deaths in prison custody between 2005 and 2019, and we have developed a coding approach to inform future research. In this paper we present key themes and examples from individual cases, which have been chosen to illustrate the points in the statistical analysis. It is evident from this initial analysis that there are a series of issues that are not being adequately addressed by the FAI system. In what follows we discuss topics arising from our analysis of so-called 'natural' causes, drug-related, and self-inflicted deaths.

We also discuss some of the issues arising from the legal provision for making findings following a death, and the issue of delays to these processes. Most of the case examples have been selected from inquiries conducted after Lord Cullen's review in 2009, and indeed mainly in the years surrounding legislative change in 2016. We suggest that the themes raised in the discussion below indicate the failure of previous efforts to improve FAIs.

STATUTORY PROVISION FOR MAKING FINDINGS IN AN FAI

The purpose of an inquiry under the 2016 Act is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

The FAIs examined here were governed by two pieces of legislation: the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, enacted in 2017[1] and therefore governed Inquiries that were initiated from this year onwards (i.e. the 2016 law may have been applied to deaths that occurred from as early as 2014); and the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, which was superseded by this later legislation.[2] Only since 2017 has it been mandatory to publish proceedings, and these determinations can vary from as short as 230 words to as long as 100 pages.

In the Policy Memorandum prepared for the 2016 (then) Bill, it is noted that reform is part of a wider 'Making Justice Work' programme to 'to secure high quality, affordable and accessible justice for people in Scotland'.[3] The Memorandum further cites the remit of the FAI review undertaken by Lord Cullen (in 2008-09) to **'ensure that Scotland has an effective and practical system of public inquiry into deaths which is fit for the 21 century'**.[4]

Under both the 1976 and 2016 Acts, the Sheriff presiding is required to make findings, which includes time, date, place and cause of death but *also* whether the death resulted from **defects in any system** involved in a person's care, and whether any **reasonable precautions taken could have prevented** the death.[5] Important issues are sometimes discussed within the determinations outwith these two types of findings. The Sheriff also has the power to note formally other facts that are relevant to the death and to make recommendations. Recommendations are rare, occurring in a small minority of determinations. In what follows, we focus on findings reflecting defects in systems and any reasonable precaution that could have been taken.

1. The 2016 Act and the court rules (2017/103 Act of Sederunt (Fatal Accident Inquiry Rules) 2017), came into force on 15 June 2017.
2. Some reforms of the FAI system occurred prior to the passage of legislation following Lord Cullen's review in 2009; for example a dedicated unit within COPFS, the Scottish Fatalities Investigation Unit (SFIU) had already been established by the time a reformed FAI Bill (SP Bill 63) had been introduced.
3. INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC. (SCOTLAND) BILL – Policy Memorandum, para. 6.https://archive2021.parliament.scot/S4_Bills/Fatal%20Accidents%20(Scotland)%20Bill/b63s4-introd-pm.pdf
4. Id., para. 19.
5. These findings are in addition to determining time, date, place and cause of death. The 1976 Act states the Sheriff 'shall make' (Section 6(1)) and the 2016 Act states the Sheriff 'must make' (Section 26(1)) findings including defects, precautions and recommendations following evidence and submissions to the inquiry.

Having read the 196 FAI determinations, we note that the legal provisions of both 1976 and 2016 Acts typically are interpreted narrowly: the decision to make findings is focused on those factors where evidence has been led that establish that these were immediately causally related to the death.[6] The FAI therefore often becomes a forensic reconstruction of events leading up to a death, and with the mapping of these facts onto legislative details. There are several consequences to analysing deaths narrowly and specifically through existing legal provision, which we discuss in more detail by reference to the case examples.

Here, we note some general issues. One is that the FAIs consider each case in isolation from other cases, so it is difficult to see them in the aggregate. We note below, for example, that this makes the system incapable of recognising or addressing an increase in the rate of particular kinds of deaths or issues of concern. Another is that we found several instances in which the Sheriff identifies a problem, but this does not result in a formal defects or precautions finding, because there had not been evidence led at the Inquiry that this specifically would have prevented the death. It is notable that the law provides for findings to be made only about the prevention of death rather than anything that might ease suffering. This raises important questions about the ability of the FAI process to protect the rights of prisoners to, for example, palliative care, or dignity in death.

Here are two extracts from FAI determinations (also discussed below) in which prisoners were found to have lacked treatment for medical issues:

In the case of AH, a man in his 50s who died of acute peritonitis: *"Obtaining medical assistance or taking him to hospital at that time would have made no difference to the outcome. But it could have saved [AH] a great deal of suffering".*

In the case of GC, a man in his 70s who had received no cancer treatment for six months: *"The absence of timeous diagnosis resulted in [GC] losing two opportunities. The first was access to treatment for his cancer, though any such treatment could only have been palliative and would not have extended his life […] though it might have improved his quality of life. The second was the chance of being considered for compassionate release…"*

Despite noting this unnecessary suffering, in neither of these cases were any findings of defects or precautions made. These examples show how existing legislation is interpreted as excluding any issue of care and wellbeing not entirely and directly tied to death. Moreover, in some Inquiries, medical experts have contested claims around suffering as not being related to death. In AH's death, the inquiry also accepted evidence that at points staff laughed at and disbelieved AH while he was contorted in pain as he lay dying. Contrary to the implication of these findings, events such as this do seem in-fact directly related to the wider aim of the FAI to serve the public interest in justice.

6. There also appears to be divergence, including among FAI determinations made under the 2016 Act of what the standard of proof is in establishing causality. This will be further explored in our ongoing research.

‘NATURAL’ CAUSES DEATHS

So-called ‘natural causes’ deaths, the most common classification used by the Prison Service prior to 2019[7], at first pass may seem the least controversial. However, our analysis reveals some troubling issues. Firstly, the people dying from ‘natural’ deaths in prison are not at all old, as might be expected from the term ‘natural’. In fact, the average age of a ‘natural causes’ death in prison between 2005-2019 was only 51 years old[8] which is much younger than the average age of death in the general population from common causes such as heart disease or cancer.

Why is this? The answer is not simple as there is a dearth of accurate health needs, health care provision and health outcomes data for custodial settings in Scotland.[9] Many of the case examples discussed in this briefing raise particular issues around the appropriate provision of care to those with (for example) mental health or substance abuse issues.

However, we note that blanket statements about the poor health of prisoners as a homogeneous population serve as a substitution for a true understanding of the current pressures and needs in existing provision, and demonstrates an acceptance of inevitability.[10]

7. Prior to 2019, SPS published data on deaths in prison were recorded in four categories: Natural causes; Suicide; Homicide; Event of Undetermined Intent (used for drug related deaths). Since this time, data has instead used death certificate information. The term ‘natural causes’ continues to appear in some contexts, for example Fatal Accident Inquiries: follow up review (Inspectorate of Prosecution, 2019).
8. This figure includes all deaths in prison 2005-19 and excludes drug overdoses, suicides and homicides.
9. See Scottish Directors of Public Health and NHS Health Scotland (2017) Response to the Scottish Parliament Health and Sport Committee Call for Evidence regarding Healthcare in Prisons https://archive2021.parliament.scot/S5_HealthandSportCommittee/Inquiries/HCP012_NHS_Health_Scotland.pdf
10. For example, a recent report on the social care needs of people in prison described many people in prison as subject to ‘accelerated ageing’ so that someone who is 50 years old in prison is similar to someone who is 60 who is not in prison (Alma Economics, 2021: 2). A model of social care need is then produced based on the ‘literature on accelerated ageing of people in custody’ using this differential; the only evidence cited to support this was an analysis by the Scottish Prison Service. A separate literature on accelerated ageing in people with substance misuse issues is cited and then applied to cover all people in prison. A further article cited in this report actually concluded the literature on older people in prison was under developed.

This assumption that prisoners are straightforwardly an 'unhealthy' population frequently crops up within the FAIs, and in this context serves to circumvent any scrutiny of the role of the prison environment, NHS or broader structural factors in contributing to health problems.

The 'natural' deaths subject to FAIs are processed through the fatal accident inquiry system in a more perfunctory way. They are less likely to attract formal defects or precautions findings: of 98 deaths not caused by drugs, suicide or homicide, only 7 (i.e. 7%) made any finding of defect, precaution or recommendation; this compares to a higher rate of findings made in FAIs into drug (27%) and self-inflicted (23%) deaths. They also tend to be highly medicalised. But a closer look at some of these cases raises questions about the possible impacts the prison environment itself can have on health outcomes. Significant concerns include the delivery of appropriate healthcare and the impacts of isolation, stress and loss of autonomy on wellbeing. **Here are some examples.**

KD died in his early 50s from a coronary artery atheroma in prison in the mid-2010s. *The FAI involved only two witnesses and resulted in a 4-page determination that stated that he was sentenced to life imprisonment at the age of 16, and had spent the last 35 years in prison. The determination describes a post-mortem report that indicated he "could have died at any time". It is clear from the few details available that KD was in poor health, but it is also the case that he had been in prison for his entire adult life. When a person dies so young, who has known only prison life, what could this reveal about the quality of care and lifestyle management in prisons?*

This case raises these bigger questions but the FAI left completely unexplored. Cases such as these raise questions about the assertion that the early deaths of prisoners are simply because prisoners 'import' health issues into prisons with them, and suggest a more complex reality that is not being scrutinised by the FAI process.

Care delivered in a prison setting should not be substantively different to care delivered in the community: prisoners have the same rights to healthcare access and quality as anybody else. It is disturbing, then, to find that the Crown and Prison Service repeatedly argue that the prison setting necessitates differences in treatment and care.

One example is the case of MR, a death classified as suicide but which raises other issues about the care of people with medical and drug needs. *MR was a woman in her mid 40s who hung herself in prison in the mid-2010s after 'suffering withdrawal symptoms which resulted in her vomiting, sweating, shaking and having difficulty walking and standing'. It was two days before a nurse administered one injection to help with the withdrawal, but there was no response to her subsequent requests for help. An expert witness, a retired Consultant Psychiatrist whose experience of treating patients with significant mental health problems suffering drug and alcohol withdrawal was accepted by the Sheriff, argued that she should have been transferred to a hospital, and that someone in the community suffering from the same extent of withdrawal would have been hospitalised.*

The Sheriff dismissed this aspect of the expert evidence, recording in the determination:

" [The Consultant Psychiatrist] had been critical of [MR's] care while within HMP Edinburgh in a number of respects … Although [she] had expressed the opinion that [MR's] withdrawal symptoms merited her transfer to a hospital setting, she had not been able to specify in what way [MR's] care would have been managed more effectively in that setting. […] It was also fairly conceded on behalf of the Crown that the way in which care is delivered within a busy prison setting will be different to the provision of care in the community. [The Consultant Psychiatrist] has limited experience of care within prisons. "

MR's case is just one example that raises questions over whether the constraints of the prison environment compromises the medical care received by prisoners. There are many others: arguments made within FAIs tend to rely and refer only to the usual practice within prisons, rather than the care somebody would have received in the community. Examples include the constraints of the environment appearing to delay referral to hospital, outpatient care or to access emergency care (see the discussion of the case of AH, below). The case example above also evidences the narrow and extremely limited way that expertise is used or dismissed within Inquiries. The expert witness evidence was here rejected for a lack of sufficient knowledge of the prison's suicide prevention strategy. Through being accepted by Sheriffs, this idea of 'care within prisons' is being institutionalised and normalised through these Inquiries despite having no actual legal basis.

Another woman in her mid 40s, SH, died of peritonitis and sepsis due to colon cancer in the early 2010s. *She had had symptoms over the course of several months and years including vomiting, pain and weight loss but the cancer was not discovered until she was transferred to hospital. At the FAI the family lawyer argued that the Sheriff should find relevant facts, which were that there was a delay in SH's referral to hospital after her symptoms arose, and that she had been handcuffed to a Reliance officer at the time of her death. The Sheriff dismissed these arguments and made no such findings.*

On the subject of the handcuffing the Sheriff wrote:

" I heard no evidence from the Reliance officers on duty at the time of [SH]'s death and who would have undertaken the relevant risk assessment. While clearly [SH] was gravely ill, it would be unwise and inappropriate to comment on or make recommendations on such operational matters in the absence of evidence. Accordingly, I decline to do so. "

As noted above, this extract points towards the limitations of FAIs for protecting dignity in death for prisoners, where due to a lack of evidence the Sheriff is unable to make any comment on somebody dying while handcuffed to an escort officer.

Other 'natural' deaths that have attracted no formal findings of reasonable precautions or defects include:

LC, a woman in her early 30s who died in the mid 2010s of deep vein thrombosis and cervicitis. *She was suffering from such severe vaginal bleeding that she needed a blood transfusion ten days before her death. The prison doctor made a note, saying that if she had any medical complaint to send her straight to hospital, but this was missed. When an ambulance was eventually called, it was not a 'blue light' one, but one that takes longer to arrive.*

GC, a man in his late 70s who went without cancer treatment and died in the early 2010s. *An ultrasound scan of his liver revealed a mass likely to be cancerous, and he was referred for further scans to confirm the diagnosis. Due to communication failures no further follow up scans happened. Six months after the detection of the mass, he died of a stroke, having been eventually diagnosed with metastatic cancer of the liver and lung just 24 hours before his death.*

DRUG DEATHS AND DRUG ISSUES

Our analysis has raised serious concerns about the treatment of prisoners with drug issues. Evidence of witnesses at FAIs reveals that there is a common view among prison and health staff, and accepted by the Crown and Sheriffs, that people with present or past drug issues have a tendency to lie, and that concerns or distress should be dismissed as 'drug-seeking behaviour'.

Here are some examples:

AS, a man in his 40s who died of meningitis in the late 2000s. *This man told multiple staff he was dying of meningitis but he was disbelieved. Instead, they ordered drug tests and administered multiple rounds of Narcan in the belief he had misused drugs. He was shackled and finally put in an ambulance after he'd been observed to be unconscious for 8-10 hours. The Sheriff found one reasonable precaution: if the nurse had conducted a follow up assessment within two hours of the initial one, this might have got him treatment.*

MK, a man in his early twenties who hung himself in the late 2000s while going through withdrawal from heroin. *On the night of his death he had repeatedly pressed his emergency bell and when officers attended his cell he asked for a strong painkiller, dihydrocodeine, and to be seen by a nurse. The determination records: "When both these things were refused [MK] became annoyed […] It was clear that there was an impasse and the officers decided to leave taking the view that while [MK] was annoyed he was not vulnerable enough for them to take any further action." In several previous incidents MK had either attempted suicide in custody, or said he intended to do so, including one where he was arrested 'for his own safety'. The Sheriff found that a reasonable precaution would have been for officers to have had access to this information about evidence of suicidal tendencies.*

AH, a man in his 50s who died of peritonitis in the mid 2010s after spending time in both police and prison custody. *The evidence demonstrated that this man had experienced 29-30 hours of agonising pain, but his complaints were dismissed by both police staff and the doctor, and viewed as 'drug-seeking behaviour'. As noted above, despite noting the 'unnecessary suffering', the Sheriff concluded that she could make no findings of defects or precautions, because it couldn't be conclusively demonstrated that quicker or more attentive treatment would have prevented the death or been practical.*

The extracts above exemplify a further issue, inconsistent with Government policy and public health strategy: the problematic framing of drug issues as a personal, individualised or moral failure. In one case the Sheriff mused that a reasonable precaution would have been for the person who died not to have taken drugs. In general we observed within the FAIs a lack of scrutiny of the possibilities for providing proper support of people with drug issues within the prison environment.

We have a particular concern about the ways in which withdrawal is being managed within prisons. The cases of MR and MK discussed above give two examples. A further one is SC, a man in his 40s who hung himself in the mid-2010s. He had been prescribed a highly addictive drug, Zopiclone[11], in one prison, then denied it following transfer to a second prison. SC had a diagnosis of paranoid schizophrenia and a history of being sectioned under the Mental Health Care & Treatment (Scotland) Act. Expert evidence led at the Inquiry highlighted that the prescribing of Zopiclone was not good practice in these circumstances. The Sheriff said the 'main issue is substance abuse' and 'drug induced psychosis', but did not venture to comment about the appropriateness of prescribing an addictive drug to this particular man, and the lack of support for withdrawal.

11. One study cautioned against prescription of this drug especially for those with addiction issues. Stopping use resulted in 'severe anxiety, tremor, palpitations, tachycardia, and seizures' in some. N. Cimolai (2007) Zopiclone: Is it a pharmacological agent for abuse? Canadian Family Physician, vol. 53(12): 2124–2129.

SELF-INFLICTED DEATHS

As discussed in the companion briefing, rates of suicide are much higher in prison than in the general population and are increasing, but FAIs do not problematise this. Rather than revealing serious concerns about the mental wellbeing of prison population, suicides are normalised, and seen as regrettable but inevitable There is a lack of questioning in almost all FAIs of the efficacy, evidence base or utility of the suicide prevention strategy within Scottish prisons.

JP was a young man who hung himself in the early 2010s. *He had gone into a police station agitated and paranoid, with a knife and, suspected of 'banking' drugs, he ended up in prison. Despite being put on constant observations in the police cell after a struggle with officers, upon his arrival to prison he had not received a detailed mental health assessment. Paperwork that gave information about his concerning behaviour in the police station was not passed on. At the FAI his family gave evidence that they had raised concerns with the prison before his death. The family lawyer put forward their suggestion that all new prisoners should undergo an assessment by a qualified mental health nurse or psychiatrist. This was dismissed by the expert witness for the Prison Service as impractical.*

The Sheriff records:

" As to the suggestion that all new prisoners undergo assessment by a psychiatrist upon admission, [the] suicide prevention adviser to the Scottish Prison Service, said in her evidence that that this was not practical. It may be that the rate of suicide in custody is no higher than that in, what [this witness] described as, the most deprived areas. "

The Crown, concurring with this view, requested the Sheriff to make no findings of defect or precaution. However, the Sheriff disagreed and made findings that the death could have been prevented through the reasonable precaution of putting a doctor's letter in JP's file, and passing on information about his need for observations in the police cell.

This exemplifies another problem with the narrow way that FAI investigations are framed. In cases of self-inflicted death the scrutiny seems limited to an assessment of whether or not the SPS's suicide prevention strategies (Act 2 Care/Talk to Me)[12] have been carried out, rather than whether or not the tools are effective. In practice this can mean simply establishing whether the correct assessment form was completed. Yet the assessment tools are not in-depth psychiatric evaluations and appear to over-rely on simply asking prisoners whether they are suicidal. This way of assessing risk may be problematic.

DT was a man in his forties, who hung himself in the early 2010s. *Before his death he had been noted by a doctor doing a community assessment to be psychotic, abusing alcohol, that he had lost five stone and had heard voices telling him to hurt people. His lawyer had been so concerned that he had requested protection housing for his client, although this was never done. When assessed DT denied to prison staff that he was suicidal. This followed a previous experience a month earlier, where he had been placed in a 'safer' cell: this included observations every 15 minutes, 24 hours per day, and he was only permitted to wear anti-ligature clothing.*

The Sheriff commented on this failure of anyone to take account of DT's request for protection:

"DT's Although I do not consider it relevant to the circumstances of Mr T 's subsequent death, nevertheless, it goes too far to hold that the failure to consider his requests [for protective housing] had no effect upon him. It is of concern that none of these requests for protection was considered."

The Sheriff made no findings of precautions or defects. Again, the above extract shows that even where issues of concern are noted, they do not necessarily translate into findings or recommendations.

In another example from the mid 2010s, a man in his forties, AS, hung himself in his cell after 10 days of exhibiting strange and concerning behaviour including: *not eating for several days, not attending for his regular anti-psychotic medication, not speaking, doing 'kung fu' in his cell, banging his head, describing hearing 'not nice' voices to a nurse, and talking to voices in his head. This particular episode followed several previous psychosis diagnoses. An assessment was arranged with a view to transferring him to the state hospital Carstairs, but he hung himself before this assessment could take place.*

At AS's Inquiry the Prison Service and officers' evidence was that there had been no reason for thinking he was at risk of suicide or self-harm. A fellow prisoner presented a different view: he had drafted a petition following the death that118 prisoners signed, apparently in agreement that the death was a tragedy that could have been avoided.

Here is an extract from the determination:

" Those signing [the petition] apparently agreed that the treatment [AS] received was unprofessional, unethical and unacceptable, that he was subject to medical negligence and his tragic death could and should have been avoided if the mental health team and NHS staff had given a due care to his wellbeing and mental health. They considered this was not an isolated incident, referring to this being the third death of this nature in the prison in a few months and there also having been a number of suicide attempts.

"I have concluded […] that there was nothing to indicate that [AS] was at risk of self-harm or indeed

12. The current strategy is Talk to Me: The Prevention of Suicide in Prison Strategy. It is operational 2016-21 and superseded the previous strategy which was Act 2 Care, operational 2013-16.

taking his own life at that time and that there was no basis for placing him on the ACT 2 Care regime. It is a sad truth that, had he been placed on that regime, he may not have been successful in taking his own life, but that is to take undue advantage of hindsight, because all the evidence was that there was no basis for doing so and, indeed, the effect of doing so could have been harmful to his mental health."[13]

As the extract shows, the Sheriff dismisses the petition of the fellow prisoners who attempt to raise concerns particularly in light of other deaths in the same prison and accepts the evidence of staff that there 'was nothing to indicate' that the man was at risk of suicide or self-harm. This pattern is repeated in many other self-inflicted deaths.

More than this, the above extract also demonstrates another puzzling argument we found within Inquiry determinations. Evidence on the part of the Prison Service at FAIs involving self-inflicted deaths frequently includes the argument that their own suicide prevention measures are likely to be distressing and actually exacerbate a sense of isolation. This is because, it is argued, the use of 'safer cells', removal of possessions and prevention of contact with others can be actively harmful to someone's wellbeing. This kind of argument reduces the Act 2 Care / Talk to Me protocol as merely entailing the transfer of the prisoner to a 'safer cell'. It is repeated in many Inquiries as a rationale for why somebody was not 'put on' this 'regime'. We have found that this argument is usually accepted by Sheriffs without interrogation. FAIs into self-inflicted deaths frequently include the unchallenged assertion that the prison's own suicide prevention strategy is known to be likely to be harmful to mental health and hence, counterproductive.

However, this is contrary to the actual written strategy, which details that someone thought to be at risk of suicide should be involved in planning their own care and that decisions should not be made without their involvement.

For example, the Act2Care strategy reads:

"[T]o assume a shared responsibility for the care of those at risk of self-harm or suicide. To work together to provide a person centred caring environment based on individual assessed need where prisoners who are in distress can ask for help to avert a crisis. To identify and offer assistance in advance, during and after a crisis."

The Talk to Me strategy reads:

"The care of people in prison who are 'at risk' should involve supportive relationships and regimes and where possible reflect normal routine while allowing for engagement in therapeutic interventions. The use of Safer Cells should be limited to exceptional circumstances."

In the FAI into the self-inflicted death of WH, a man who hung himself less than 36 hours following admission to prison, a Sheriff takes issue with the argument put forward by the Prison Service justifying the lack of Act2Care. Rejecting the recommendation of the Procurator Fiscal to make no findings, the Sheriff found that a reasonable precaution would have been to initiate the Act 2 Care policy.

He noted:

" [T]he SPS ACT2 procedure does not claim to eradicate the occurrence of suicide in custody. It is a risk management strategy and is focused towards providing care and support to those at risk of self-harm and suicide with the aim of reducing its occurrence. […] There are many ways to provide help, support and assistance, the purpose of which is to discourage the prisoner from feeling the only way out is to take his own life."

13. Subsection 26(3) of the 2016 Act, addresses the issue of hindsight in which there had been inconsistent interpretations under the 1976 Act. It provides that 'it does not matter whether' a reasonable precaution or system defect 'was foreseeable' in order for a finding of these to be made. This has not appeared to result in a finding more likely to be made (see companion briefing).

This was an important but rare challenge by a Sheriff to the standard position of the Prison Service. In general the FAI system seems poorly equipped to scrutinise whether or not suicide prevention policies, procedures and practices are fit for purpose.

Within this troubling context of acceptance of suicide as a feature of prison life, the cases of self-inflicted deaths of young people are of particular concern given the higher rate of suicide among this age group in prison, most typically while not yet convicted of any crime. We found few instances of young people who were assessed as being at risk, despite these deaths frequently involving young people who had made previous suicide attempts and/or had previous diagnoses of depression or psychosis. Of 18 available FAIs into the self-inflicted deaths of young people under 25, eight were of people on remand (detained awaiting trial or sentencing).

Despite the significant concerns raised by the deaths of young people, there does not appear to be any greater urgency in progressing their Inquiries. The death by hanging of one young man, RM, at HMPYOI Polmont resulted in an Inquiry that took almost four years to report. In the intervening time there were a further 10 self-inflicted deaths of young people aged 24 or less, including four who were 21 years old or younger, including Katie Allan, who died in 2018 and whose FAI, in turn, is still yet to be held. Another death of a young person, WL, occurred shortly after the publication of the FAI.

FAI 'SUCCESSES'?

While the vast majority of FAIs do not result in findings of any reasonable precautions that could have prevented the death, or defects in any systems, some do.

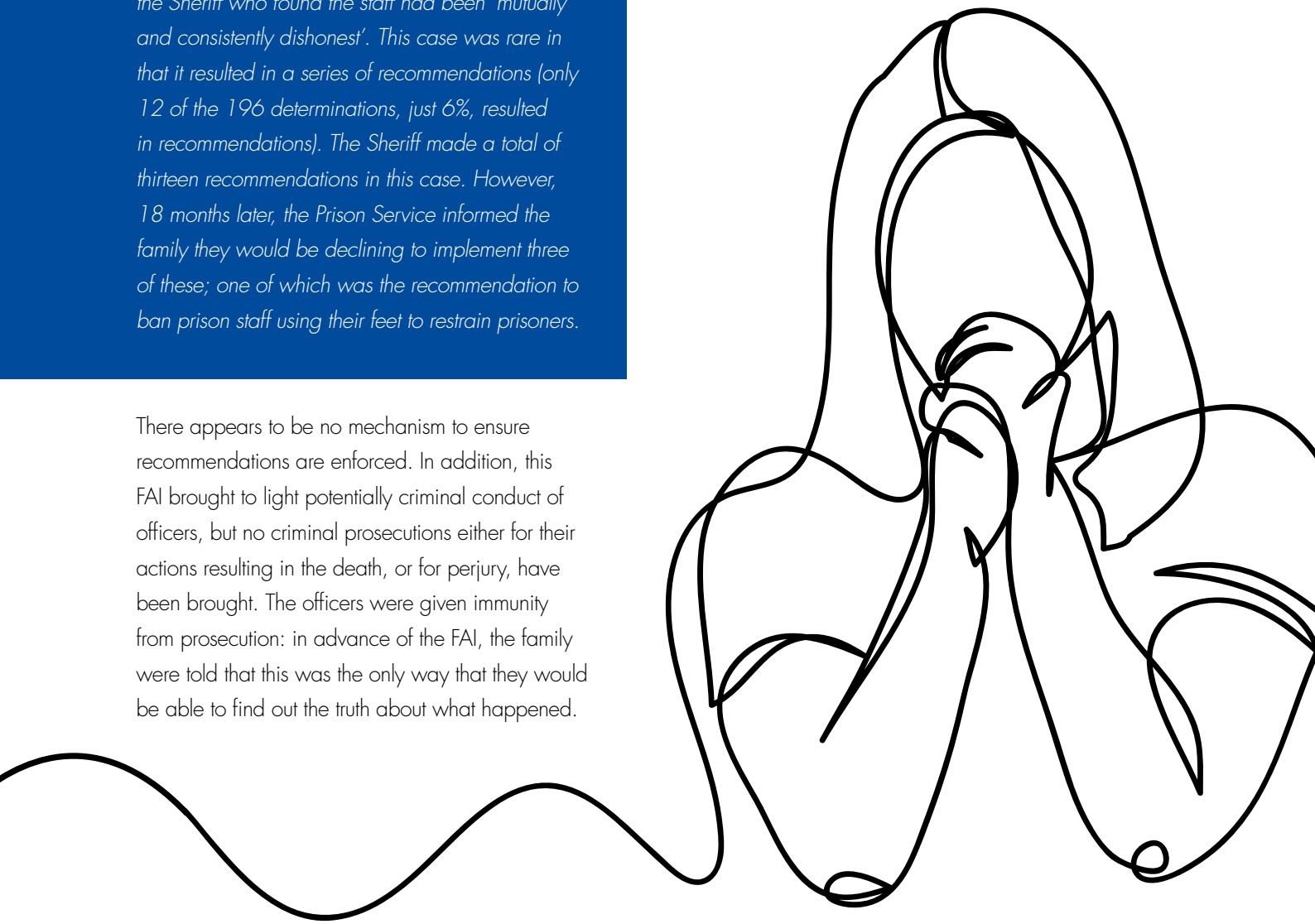
We might consider these 'successful' FAIs, in terms of formally identifying areas of practices where improvement might prevent deaths, and we might expect that they give examples of scrutiny of the systems and processes that are implicated in deaths and deliver accountability for any wrongdoing. However, a closer look at FAIs where defects or precautions are found, show that even these raise questions about their ability to support structural change capable of preventing further deaths.

For example, in a case classified as 'natural causes', AH was a man in his twenties who died in the mid-2010s of a heart attack of 12-24 hours in duration. *An important issue at the Inquiry was the fact that an Electrocardiogram (ECG) that could have revealed the heart attack was not taken by nurses at the prison. The Sheriff found that a defect in the system was that the ECG machine had run out of paper, there was no available key to the stationery cupboard, and therefore the nurses could not use the ECG machine. The reasonable precautions identified by the Sheriff included that the ECG could have been completed, and the nurses could have been advised by the prison doctor to take further action, including calling an ambulance earlier. What does not come through in these findings is the fact that a heart attack of such duration in a young man could and should have raised more concern or questioned whether in a non-prison setting access to emergency medical care would have been much more straightforward.*

Again, this example points towards the underlying problem outlined above, which is that findings are restricted to narrowly specific factors that can be directly causally linked to the death. This elides wider and structural factors from view and leaves broader arrangements and processes that contribute to these unchallenged. So, in the example above, the lack of a key to the stationery cupboard was the defect, rather than the overall ways in which healthcare is delivered in prisons – where a person complaining over several hours of chest pains did not have an urgent ambulance called – that creates barriers to accessing emergency care, in this case fatally.

The inquiry into the death after restraint of 30-year old Allan Marshall in HMP Edinburgh in 2015 stands out as highly unusual in its criticism of the actions of prison staff. *Yet even in this case, it is not clear what the FAI achieved in terms of accountability and justice. The Sheriff found that Allan had been subjected to a lengthy restraint face down on the floor that included officers using their feet on him, and concluded that his death was 'entirely preventable'. Evidence by staff involved in the restraint and senior management was contradicted by CCTV footage, and disbelieved by the Sheriff who found the staff had been 'mutually and consistently dishonest'. This case was rare in that it resulted in a series of recommendations (only 12 of the 196 determinations, just 6%, resulted in recommendations). The Sheriff made a total of thirteen recommendations in this case. However, 18 months later, the Prison Service informed the family they would be declining to implement three of these; one of which was the recommendation to ban prison staff using their feet to restrain prisoners.*

There appears to be no mechanism to ensure recommendations are enforced. In addition, this FAI brought to light potentially criminal conduct of officers, but no criminal prosecutions either for their actions resulting in the death, or for perjury, have been brought. The officers were given immunity from prosecution: in advance of the FAI, the family were told that this was the only way that they would be able to find out the truth about what happened.



TIMING AND DELAY

One issue raised by several cases discussed above is the duration of the FAI process, which has the potential to have a substantial and traumatic impact on the families of those who have died.

This is especially the case in inquiries with a substantial number of oral witness testimonies, in which court hearings tend to occur in sets of a few days at a time but sometimes over many months. The most drawn-out Inquiry we found was into the death of JP, a young remand prisoner who hung himself in the early 2010s. There were just ten days in total of evidence hearings but these were spread out over an entire year, beginning in late 2015, and eventually concluding in late 2016. The FAI determination was eventually published six months later. A timescale organised around the schedule of legal officials and courts rather than bereaved families exacerbates and prolongs their suffering; families seeking to learn what happened to their loved one are subsequently forced to engage with this process.

Inquiries take place years after the incident, and this may mean that key witnesses are unavailable to give evidence or cannot recall details. The Sheriff frequently records of a particular witness that they 'had only a vague recollection'. We have also noted several occasions when, by the time the Inquiry gets underway, important documentary evidence appears to have been lost. Examples include the missing paperwork from a suicide risk assessment in the case of DK, a young woman who hung herself in the mid 2010s; and a destroyed code blue alert message requesting medical assistance and missing CCTV evidence in the case of Allan Marshall, whose death after he was subjected to restraint by officers in 2015 has been classified by the Prison Service as due to natural causes.

Sheriffs find themselves unable to make recommendations if they are told that systems have already been improved to address a problem in the time between a death occurring and the FAI finally taking place. There are many examples within the determinations of problems that are identified but the Inquiry is assured that it could not happen again due to changes that have been made since.

However, the increasing rate of deaths in prison (as evidenced in the statistical companion briefing) flatly refutes these numerous claims of improvements and updates. In a determination from one FAI that took over 5 years to complete, the self-inflicted death of WH in the mid 2010s, the Sheriff took the opportunity to comment:

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

WH was a man who had been arrested covered in petrol and carrying a lighter, with a noose around his neck. He was assessed by reception staff as being at

risk, but then by a mental health nurse who didn't see any of his paperwork and assessed him as not at risk of suicide. He was found hanging less than 26 hours following admission. Rejecting the arguments made by the Procurator Fiscal who invited him to make findings only about the place, date, time and cause of death, the Sheriff found that a reasonable precaution would have been to initiate Act 2 Care. In the time it took to complete WH's Inquiry, there were two further self-inflicted deaths at the same prison.

CONCLUSION

One of the overarching problems with the existing system is that FAIs consider each case solely in isolation, leaving wider structures and processes unchallenged.

The problem is made particularly stark given that the reformed FAI process is coinciding with a rising rate of deaths in prison: the current system is unable to grapple with systemic issues. As the preceding discussion and examples indicate, there is a tendency to treat death, pain and suffering of prisoners as regrettable but inevitable. In most of these cases there has been no official finding of any concerns in how people are cared for in confinement. Far from providing scrutiny and challenge to practices of institutional neglect, the routine way that these deaths are processed through the FAI system works to normalise suffering and death in prison. There are some exceptions. We have noted above several cases in which Sheriffs have strongly criticised agencies. However, even on the rare occasions that FAIs result in recommendations, although agencies are obliged to respond there is apparently no mechanism to actually enforce them. Potential criminal conduct is not further investigated, let alone prosecuted.

Several of the examples discussed above touch on other issues that we plan to explore in more depth in the ongoing research. One issue is the role of the Procurator Fiscal, who acts on behalf of the Crown and whose stated role is to represent the public interest. We have found that where there is scrutiny of the prison as an institution, this is introduced by the Sheriff, and not by the Procurator Fiscal. In fact, on the occasions that the Sheriff has made findings of defects or precautions, usually this was contrary to the arguments of the Procurator Fiscal; generally, the Procurator Fiscal invites the Sheriff to make no findings beyond time, date, place and cause of death and the reasons for this systematic practice are unclear. In our companion briefing we note that there is a relationship between whether or not the family is represented at an FAI, the length of the determination and also chances of a finding being made. We also highlight possible inconsistencies between Sheriffdoms. Together, these issues raise serious questions about the role played by the Crown in providing adequate scrutiny of these deaths.

Finally, several cases and extracts included above point towards what FAIs are like for families. Lord Cullen (2009) recommended that relatives of the deceased should not have to justify the reasonableness of the granting of legal aid and the limit should be increased for legal aid in FAIs. This was not taken forward by Government. Existing rules on legal aid result in many families having no access to legal representation.

As noted in the companion statistical briefing, the majority of FAIs do not include the participation of loved ones at all. We also noted several FAIs where family members attended at the beginning but were

not present by the end. The emotional and practical impact of attending hearings that can be far from home, and often are a stop-start process over several months should be underlined here. We have also found little evidence of prisoners being meaningfully supported on the rare occasions that they participate. For these and other reasons, inquiries could be extremely triggering or retraumatising events. The experiences of people who loved and miss the people who died, who find themselves going through one of the Inquiry processes discussed here, is one of the issues centrally important to any system claiming to offer 'high quality, affordable and accessible justice'.

In this briefing, we have highlighted cases which help shed light on resistance within the FAI law and process to making defects or precautions findings, even where there is evidence of avoidable suffering and death. A system that seems largely incapable of seeing and rectifying problems, or delivering accountability and justice to those who have lost loved ones, may itself be a defective system.

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SUPPORT RESOURCES

Samaritans, 116 123 (24 hours), *https://www.samaritans.org/?nation=scotland*

Cruse Bereavement Care, 0808 802 6161, *http://www.crusescotland.org.uk*

Breathing Space, 0800 83 85 87, *https://breathingspace.scot*

Petal (supporting those with grief and trauma from suicide and murder), 01698 324 502, *http://www.petalsupport.com*

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