NOTHING TO SEE HERE?

Statistical briefing on 15 years of FAIs into deaths in custody

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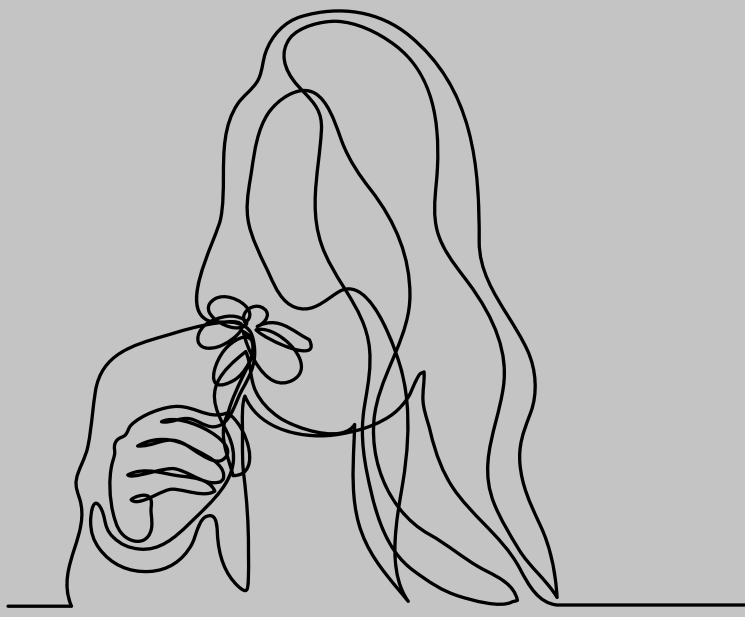
STATEMENT

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 made the decision in this briefing not to identify particular people who have died, though it might be possible to determine their identity from details provided. We have made this choice for this briefing out of the desire not to cause further distress to families who have lost a loved one. At the same time, we recognise the importance of not treating people only as numbers, and not including names can have the effect of erasing individual humanity and stories. We have developed an ethical stance around the naming of people that involves case by case assessment. In other disseminations, where we have space to talk about the contexts and background of individual situations we may include names. This also will reflect our understanding of what families in particular situations want.

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EXECUTIVE SUMMARY

INTRODUCTION

- This briefing presents information from a review of 15 years of Fatal Accident Inquiries, covering 196 deaths in custody (mainly prison) in Scotland between 2005 - 2019.
- The aim of this review was to identify patterns in FAI processes and outcomes to better understand what FAIs achieve, and plan research.
- This briefing also explores how legal reform in 2016 has affected FAIs for deaths in custody.

DEATHS IN CUSTODY ARE ON THE RISE

- The death rate in prison in Scotland increased 44% over the 15-year period.
- This includes rises in the rate of suicides and drug-related deaths.

FAIS TAKE YEARS TO COMPLETE

- 40% of inquiries require three years or more to conclude.
- Fewer than one-quarter of deaths in custody are investigated within one year.

TO FIND NOTHING CAN BE DONE

- Sheriffs are required to make findings identifying precautions, defects and recommendations aimed at preventing future deaths where evidence establishes this.
- In 91% of FAIs, no reasonable precaution was identified.
- In 96%, no defect was found.
- In 94%, no recommendations were made.

IMPACT OF 2016 LAW CHANGE

- Since 2016, FAIs are less likely to make findings, less likely to involve families and are taking longer to complete.
- This assessment is provisional and will change as the outstanding FAIs for deaths between 2016-19 are completed.

FAMILY INVOLVEMENT

- Families frequently are not present (31%), rarely have legal representation (16%) and rarely give evidence at FAIs (17%).
- However, when family are involved in one of these ways, the chance of a finding being made was three times greater than in FAIs with no family involvement.

DIFFERENCES BETWEEN SHERIFFDOMS

- There was marked variation between Sheriffdoms in the rate of making a finding, the time taken to complete an FAI and the length of written determinations.
- The Sheriffdoms taking the longest time to complete FAIs on average took nearly nine more months than those taking the least time to conclude proceedings.

INTRODUCTION

This briefing reports on early findings from academic research exploring the use of Scotland's unique system of investigating deaths in custody, the Fatal Accident Inquiries (FAIs) process; it analyses FAI 'determinations', the written reports by Sheriffs that conclude the inquiry. Sheriffs are required to make findings relating to actions aimed at identifying lapses in care and preventing death where evidence supports this.

The research emerges in a period where the rate of death in prisons in Scotland is rising and concern is growing to prevent avoidable deaths.

Every death in custody has a profound impact – for the family of the person who has died, for the prisoners who cared for or were near to them at death, and for the staff responding to and dealing with mortal emergencies. Each one raises questions about the quality of care and accountability of the state on whom those in custody depend. The present team came together following a roundtable in October 2019 for families affected by a death in custody, in recognition of the need for more research to understand FAIs and their role in safeguarding the lives and wellbeing of people in custody.

The FAI process underwent significant independent review in 2009 (Lord Cullen, 2009), leading to new legislation, The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, replacing the 1976 law[1]. Key changes include mandatory publication of all FAIs (with some aspects of discretion in this), and a requirement that any findings of a Sheriff relating to lapses in care must be responded to in writing (and the response made public). There also has been a thematic review of FAIs by the Inspectorate of Prosecution in Scotland (2016, and follow-up of this in 2019). Among concerns raised in prior reviews were ongoing delays to completing FAIs, which can take several years, as well as the impact of this on grieving families.

However, none of the reviews focused specifically on FAIs into deaths in custody, and there has been scant research activity around Scotland's singular approach to investigating such deaths (c.f. Bird, 2008, 2020; see, Shiels, 2017, for a legal history). What research there has been notes the significant time taken to complete an inquiry (Bird, 2020). Other dimensions of the FAI process, such as its impact on those affected by a death or its effectiveness in changing practice or preventing death, have not been explored.

1. The law became came into force in June 2017. Given the time lag between the date of death and publication of FAIs, this means that not all deaths occurring in this period will have had a published FAI at the point of our analysis. As of February 2021, there were 33 deaths occurring in custody between 2017 and 2019 that had yet to complete an FAI.

The present research brings together health and criminology academics including those with direct experience of a child's death in prison.

The motivation of the overall study is to understand, quite simply, what FAIs are for, and what they achieve specifically in the case of deaths in custody. This motivation underlies our aim to produce high quality information and analysis about deaths in custody in Scotland to support efforts of preventing death and ensuring transparency and accountability of those charged with caring for those in custody as well as of the process for investigating their deaths.

This aim will be pursued through multiple lines of inquiry. In this briefing, which is helping to scope further planned research, a statistical analysis of all published FAIs over 15 years is presented. **It focuses on issues flagged up in prior reviews, and has three immediate objectives:**

1. To produce statistical evidence that can help assess progress on problems identified in previous reviews of FAIs;
2. To identify other dimensions of the FAIs specifically for deaths in custody that merit further research; and
3. To support efforts to educate and raise awareness about an important and public process for achieving justice.

It includes, as far as we are aware, the largest sample analysed of death in custody inquiries in Scotland, covering 15 years. Alongside this report is a companion briefing exploring qualitative dimensions of FAIs. This separate report is complementary in providing examples from different cases and circumstances of death that can begin to offer a picture of how and why some of these statistical patterns arise.

METHOD

The analysis is based on FAIs published as of mid-February 2021 by the Scottish Courts and Tribunal Service covering determinations for people who died in custody between 2005-2019, inclusive.[2]

This amounts to:
Deaths in prison 359[3]
Published FAIs from these 196[4]

Therefore, the size of the dataset for most of the analysis that follows is N=196.

To supplement FAI determinations, further information was collected about deaths from the Scottish Prison Service website and the National Records of Scotland. This included additional detail on aspects such as cause of death. We also conducted internet searches (mainly producing media reports) that helped with occasional instances of missing information.

We entered variables into an Excel worksheet including: dates (of death, timings of FAI stages), causes of death, parties involved, formal findings made, word counts of determinations, family involvement, parties' legal representation and Sheriffdom information.

Simple descriptive quantitative information could be generated from this as well as some basic cross-tabulations, and these form the core of this analysis.

We are preparing a technical appendix to include information on the statistical significance of findings presented herein. The size of the dataset is relatively small for statistical analysis, and this can mean that statistical significance cannot be determined in some areas. However, this does not mean that variation is due to chance; it only means that a statistical analysis cannot tell us this. This is why the qualitative analysis, as provided in the companion briefing, is crucial to understanding how FAIs work.

Members of the team therefore also read the content of all of the written FAI determinations covering the research period. This flagged up early themes (addressed in the companion briefing) and lays the groundwork for our planned research in which these determinations will be thoroughly qualitatively analysed. The reading of FAI determinations also assisted developing the direction of and interpreting the quantitative analysis.

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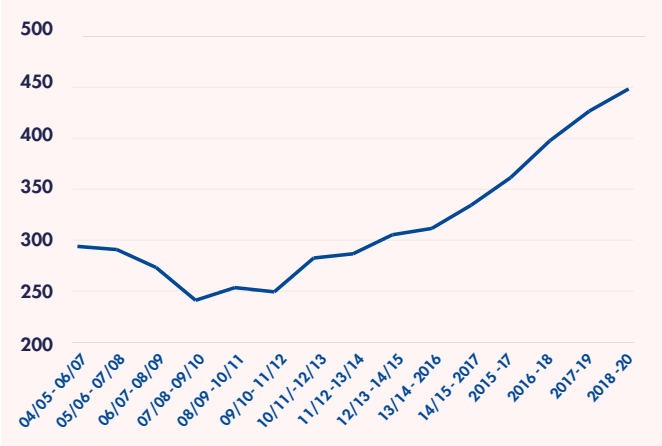
2. Given the time lag between the date of death and publication of FAIs, this means that not all deaths occurring in this period will have had a published FAI at the point of our analysis. There were 33 deaths occurring in custody between 2017 and 2019 that had yet to complete an FAI at the time of this analysis.
3. Nearly all these FAIs relate to deaths in prison custody but there are a small number of FAIs where a person who died had been in police and prison custody around the time of dying. Unlike deaths in prison, there is no centralised, public source of information about deaths in police custody, though one member of the team is working to build such a database.
4. This refers to 196 deaths in prison in Scotland between 2005 and 2019. One FAI addressed the deaths of two prisoners that took place in the same prison within a short period, so technically there are 195 FAI determinations covering 196 deaths.

DEATHS ARE RISING IN SCOTTISH PRISONS

An increasing rate of death in prison provides an important context for this research, and over the past decade both the absolute number and rate of deaths have been rising steadily.

Between 2005 and 2019, an average of 24 people died annually in prison in Scotland, but the annual average for most recent four years pre-Covid-19 (2016-19) was 32.[5] A rolling three-year average rate of deaths (per 100,000 prisoners) from all causes, covering this period, was calculated using Scottish Prison Service and Scottish Government data.[6] This shows that the rate (that is deaths relative to the size of the prison population) is rising.

Figure 1.
Death rate (per 100,000) in Scottish prisons, three-year rolling average, 2005-2020



Source: compiled based on data published by the Scottish Prison Service and Scottish Government.

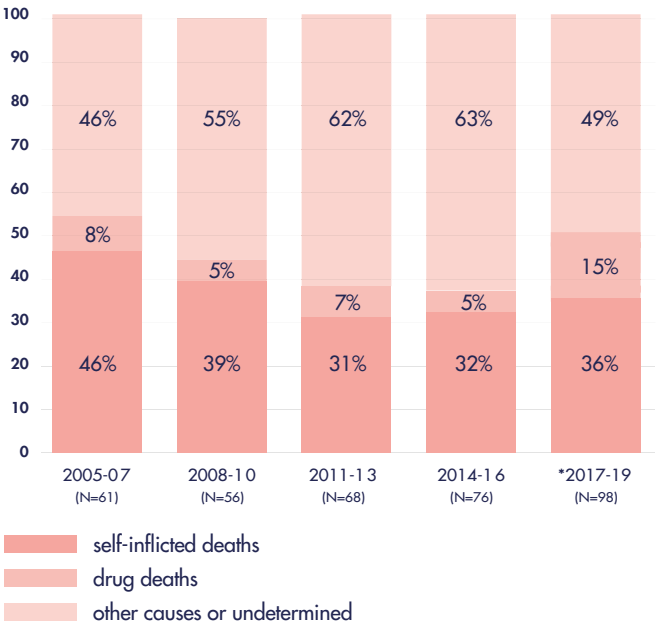
We do not thoroughly analyse the causes of a rising death rate in this document. However, there are relevant factors worth noting. The prison population is aging (due to multiple reasons including increased prosecutions of historical crimes and longer sentences being served), and this is reflected in the profile of those who die in prison. Mortality risk increases with age, and so it may be expected that the rate of death in prison reflects this. There is some evidence to support this theory. The average age of a person dying in prison in 2020 was 49 years; twenty years earlier, in 2000, it was 35 years.

If deaths due to causes associated with aging are rising, one would expect these to make up a growing share of all deaths in prison. This is broadly the case, as shown in the figure below. In the late 1990s self-inflicted causes of death accounted for 64% of all deaths in prison between 1995-97 and 61% of deaths that occurred between 1998-2000.[7] **However, causes besides drugs and suicide (which tend to occur among younger age groups) have accounted for a majority of deaths since 2008.** Figure 2 shows these relationships (all deaths not caused by drugs or suicide are listed as 'other'; this includes mainly deaths attributed to a natural cause, and a small number of homicides).

5. Of significance but outside the scope of the present analysis are the last two years when the prison system was affected by Covid-19. In 2021, for example, 26 people died between January and June, meaning that the average annual total deaths in prison over the past decade had already occurred by the halfway point of the year.
6. To produce the rate, prison deaths per year are divided by the average daily population (ADP) and multiplied by 100,000. Until 2013-14, annual prison population data was reported by the Scottish Government by financial year as deaths are reported by calendar year. From 2015, SPS website prison population data reported by calendar year allowed calculation of death rate using calendar years for both deaths and population. A multi-year rolling average smooths sharp and unrepresentative annual changes.
7. These data were supplied by the SPS via a Freedom of Information request of one of the study team authors.

Figure 2.

Proportion of deaths in Scottish prisons by different causes, 2005-19

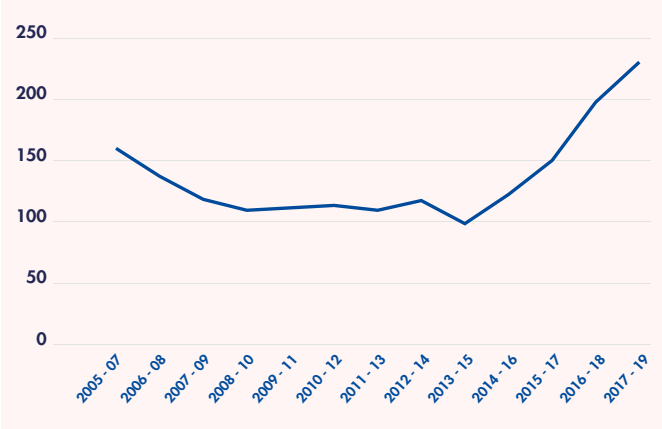


*Note: Source of data is SPS published information supplemented by data from death certificates. There is missing data for the year 2018.

While the figure above shows that deaths labelled as due to natural causes account for the largest percentage of deaths in prison, it is important to note that the rates of suicide and drug deaths also are rising. Self-inflicted deaths had been declining in Scottish prisons in the 2000s and early 2010s, but have been on the rise since the mid-2010s (Armstrong and McGhee, 2019). The rate of those dying due to drugs is growing even more quickly. **The figure shows the increase for these two causes of deaths:**

Figure 3.

Combined self-inflicted and drug death rate (per 100,000) in prison (3-year rolling average), 2005-2019



Note: Source is the same as Figure 2. The missing data for 2018 means the last two points are essentially two year averages.

Even though deaths attributed to natural causes appear to be rising as the prison population ages, this is not automatically reassuring. The Prosecution Inspectorate's follow-up review of FAIs (Inspectorate of Prosecution, 2019) describes a continuum of how long and in-depth investigations will be:

FAIs vary enormously in their nature and complexity. They can range from inquiries into the death of a person in custody by natural causes, where there are no issues of concern, to inquiries involving complex medical matters or technical inquiries into the cause of a helicopter accident.
(Inspectorate of Prosecution, 2019: para 1:16).

In our reading of FAIs we found causes for concern in cases so-called 'routine' deaths (the label applied to most deaths in prison attributed to a natural cause; please see the companion briefing for discussion). Deaths attributed to natural causes, even when they are sudden, tend to involve, though there are important exceptions, shorter, less reflective FAIs (for example, natural cause FAIs are completed 3-5 months faster than those involving drug deaths or suicide). They rarely lead to any findings of defect or precaution (fewer than 10% of FAIs compared to around one in four FAIs involving drug or self-inflicted deaths leading to such findings). Such deaths compete for the time and attention of authorities under pressure to investigate violent, complicated and unexplained deaths. This raises a potential concern that some deaths might too readily be seen as raising no concerns and able to be concluded quickly. The fact that deaths due to natural causes are increasing faster than other kinds of death suggests the need to ensure these are investigated thoroughly.

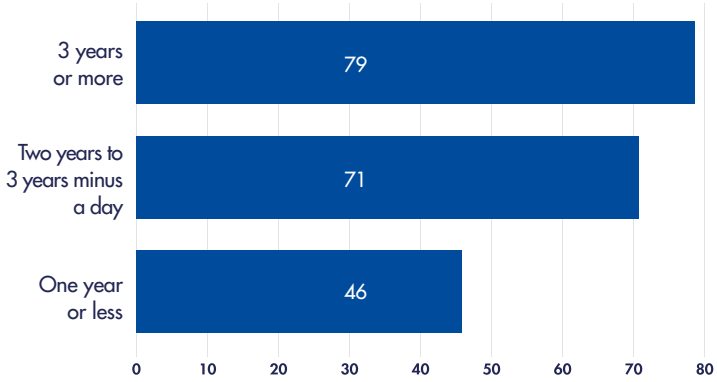
ANALYSIS OF DEATH IN CUSTODY FAIS

FAIs take a long time

The time it takes for a death to be investigated and a Sheriff to make a formal determination has been a consistent issue of concern. We measured how long it took from the date of a person's death to the publication of an FAI determination, that is, when the public and family receive a formal determination of the cause of death and any other issues related to it. Time-frames appear to be increasing.

For all 196 deaths, the average time taken to complete an FAI was nearly two years (720 days). The figure below shows that more than three-quarters (76%, 150 deaths) take two years or more.

Figure 4.
FAIs taking one, two or three or more years, 2005-2019



To find nothing can be done

Legislation requires Sheriffs to make formal findings based on the evidence submitted in the inquiry. This includes a requirement to establish, the time, date, place and cause of death, but also to make findings if there were lapses in care. These latter kind of findings fall under four types: (1) a defect in system(s) involved in the care of a person, (2) a reasonable precaution that, had it been taken, would have prevented death; (3) relevant facts that clarify the context and circumstances of a person's care and death, and (4) formal recommendations directed at those involved in the care of a person. The Act requires that any bodies or individuals addressed by these findings must respond in writing.[8]

Following review of all FAIs, we found that vanishingly few produce any finding raising concerns about a person's care. In the 15 years between 2005 and 2019 covering 196 deaths in custody:

8. Under the the 1976 Act the Sheriff can make a finding (under Section 6(1) subsections (c), (d), (e)) identifying any reasonable precautions that might have avoided the death, a defect of system that may have contributed to death and any other findings of fact relevant to circumstances of death. In the 2016 Act the parallel section is 26(2), subsections (e), (f), (g). Subsection 26(1)(b) provides for the Sheriff making recommendations and Section 28 sets out the requirement to respond to these (though there is no penalty for not doing so).

- **91%** found no reasonable precautions would have prevented death
- **96%** found there were no system defects contributing to death
- **94%** made no recommendations to improve practice

In other words, the vast majority of FAIs in cases of death in custody limit themselves to making findings only as to the time, place and cause of death. While a slightly greater number (22 cases, still only 11%,) make additional findings of fact providing further detail about a death, it is very rare for an FAI to make any finding which triggers or recommends corrective action. Significantly, and although the numbers are small (we could find only six published between 2005-2019), **not a single FAI in the case of a woman dying in prison made a finding identifying any precautions, defects or recommendations.**

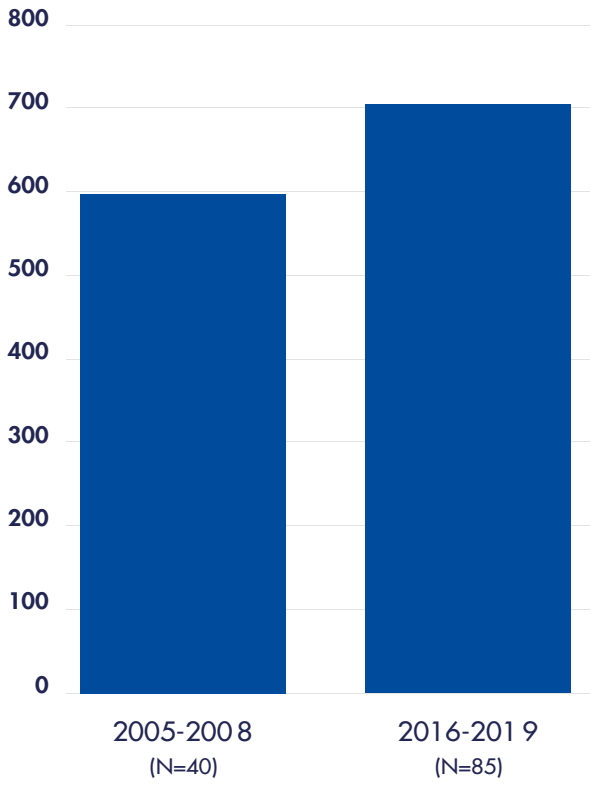
Table 1.
Findings made in FAIs, 2005-2019

Out of 196 FAIs, a finding is made about:	N	% findings made	% no findings
Reasonable precaution	17	9%	91%
System defect	7	4%	96%
Other Fact	22	11%	89%
Recommendations	12	6%	94%
Any finding (precaution, defect, fact or reco)	32	16%	84%

Since a 2016 change in law, FAIs are taking longer and appear less likely to identify problems

To explore trends in FAIs following the 2016 Act, we compared time periods before and from 2016[9]. The next figure compares average times of FAIs, measuring from the time between a person's death and the publication of the FAI:

Figure 5.
Average number of days to FAI publication, 2005 - 8 and 2016 - 19



Between 2005 and 2008 death in custody FAIs took 590 days on average (or slightly more than a year and a half). In the more recent period (2016-2019), FAIs were taking on average 100 days more than this (or over 3 months longer). It is important to note that there remain numerous FAIs yet to be completed for deaths that occurred in this more recent period (there are 33 deaths from 2017-2019 where the FAI had not been done at the point of data collection), and hypothetically, if these had all been completed by September 2021, the average time would be around 750 days. Given that this has not happened, the average time for FAIs concerning deaths in custody between 2016-19 will be substantially longer than is displayed in the figure.[10]

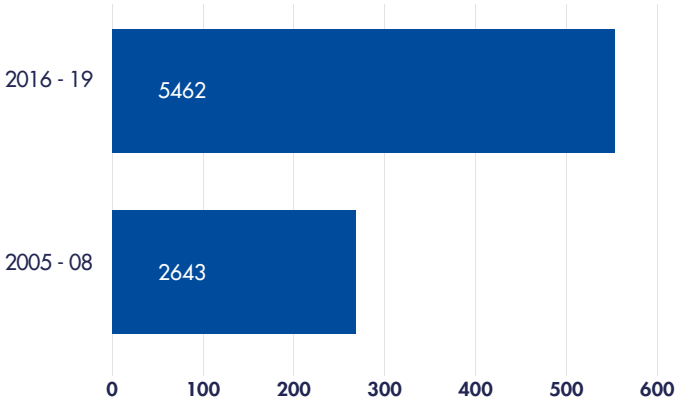
9. Although the 2016 Act did not come into force until 2017, some changes recommended in 2009 had already been implemented and so would be expected to have some impact by 2016.
10. It is also important to note that the Covid-19 pandemic has affected court processing times and will likely extend completion times.

A rising number of deaths in custody might be one reason for the increasing time taken to complete FAIs, as this increases the workloads of all those involved in investigating them. The requirement to publish all FAIs may also add pressure to workloads. Against this, however, there is a higher proportion of FAIs being published since 2016 involving deaths attributed to natural causes. These deaths, as noted above, often are treated as involving less complex and contentious issues than deaths that are self-inflicted, due to violence or otherwise unexpected, and would therefore be predicted to take less time to resolve, thereby bringing down average times.[11] The average time taken for an FAI involving self-inflicted (753 days, 73 FAIs) or drug-related death (836 days, 22 identified FAIs) was indeed higher than for the average time for all FAIs (720 days across all 196 deaths) into deaths in custody; it is unclear, therefore, why a rise in the kinds of cases likely to have shorter completion times would accompany overall rising average times. FAI completion times in all cases remain significant; in England and Wales the analogous system of coroner's inquests has a target of six months for a hearing to begin.

Written determinations are getting longer

Another difference between FAIs completed in the early years of the period compared to more recent ones is the length of FAI determinations themselves. FAI determinations are getting longer, and this is a consistent trend. The average word count for FAIs published across all years we reviewed (2005-19) is about 5,000 words, or approximately10 pages of single-spaced text. However, the average word counts for determinations published in recent years is more than twice as long as that published in the early period of the dataset, as shown in figure 6.

Figure 6.
Average word count of FAI determinations, 2005-08 and 2016-19



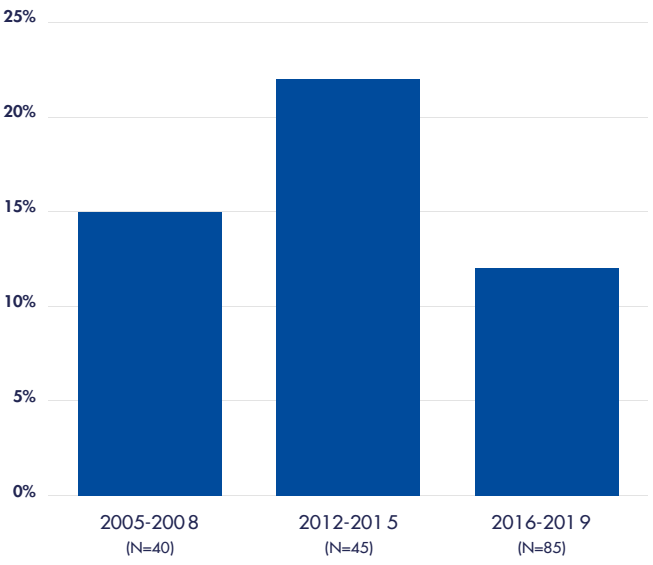
There is no right or wrong length for a written determination, and the interest here is in change over time which can flag up shifts which can be explored qualitatively to understand why. We note that the shortest written determinations in the overall sample of 196 cases often were less than 200 words, barely the length of a paragraph, this includes – though rarely – cases of suicide. Most of these very short determinations fall into the earlier years of the dataset (though this was not always the case: an FAI determination in 2016 was only 157 words long). These short determinations merely state the cause, time and place of death and, if noted at all, confirm that there were no reasonable precautions, system defects or other facts found. Typically, they refer to a joint minute agreed between, most commonly, COPFS and the SPS. Joint minutes are a process for saving court time on issues where there is no dispute and to clarify what evidence will be presented in court. The role of the joint minute, the contents of which are almost never published, is an issue that is intended to be taken up in the next phase of the research as we found numerous cases where these appeared to cover issues disputed in similar cases or where Sheriffs had lamented they might have made a finding but for lack of evidence being led.

11. The Prosecution Inspectorate (2016) makes this point in its thematic review, criticising the FAI into a 'natural causes' death of a person in custody in 2012 as 'unnecessarily protracted' (p. 23).

The likelihood of a finding being made appears to be declining

As reported above, it is rare for an FAI determination to identify any problem (i.e. make findings beyond time, place and cause of death) triggering action. With changes to the law in 2016 that strengthened some aspects of determinations (requiring, for example, publication and a formal response to any finding made), one might expect to see more FAIs where a reasonable precaution, system defect, additional finding of fact or recommendation is made. The figure below compares three sub-periods in the dataset; it shows that this does not appear to be the case. While the likelihood of a finding being made in the middle period (2012-15) peaked at just over one in five FAIs (22%), the data available for 2016-19 shows a considerable drop (to 12%).

Figure 7.
Percentage of FAIs where any corrective finding was made, 2005-08, 2012-15 and 2016-19



Because many FAIs for the most recent period remain to be completed, this figure should be read with caution. However, in order for the 2016-19 period to achieve a level of findings equal to that observed in 2012-15, nearly half of all yet to be completed FAIs[12] would need to make at least one finding, a findings rate of 48%. This is highly improbable, as the average findings rate across all years is only 16%; put another way, of the FAIs of deaths between 2017-19 yet to be completed, Sheriffs would need to triple their rate of making a finding to reach the level seen in 2012-15.

What happens when families are involved in FAIs?

A key concern raised about Fatal Accident Inquiries is how families are engaged in and affected by the process. This is a focus of the planned research, and we explored the statistical data to document trends in how often, how deeply and with what effect families take part in fatal accident inquiries.

First, it is notable that families rarely are involved at all. In reading all published FAIs of 196 deaths between 2005-2019, it appeared that:

- **Family are not present in most FAIs** (absent in 69%)
- **Family rarely have legal representation** (no lawyer mentioned in 84%)
- **Families rarely give evidence** (no family evidence cited in 83%)

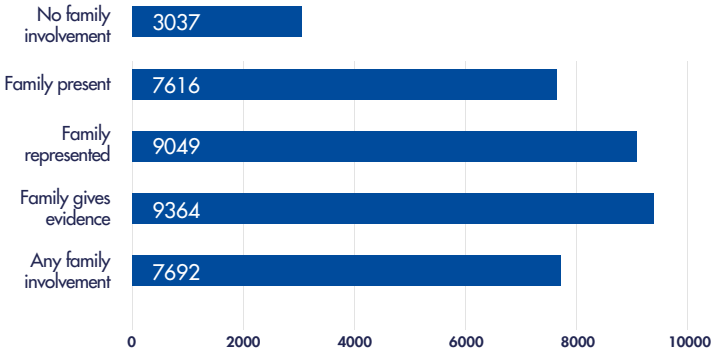
Even in the FAIs where family attendance has been noted, this may be partial: we found a number of FAIs where families were present only at the preliminary hearing or a small number of days of the full hearing. Why this happens will be explored in future research.

Second, when families do take part, FAI determinations show marked differences compared to those where they have not. Figure 8 shows that cases where a family gives evidence or is legally represented, result in determinations that are, on average, three times as long as hearings where there is no family involvement, and this difference is statistically significant.

12. I.e., for the 33 deaths occurring in 2017, 2018 or 2019 where the FAI was still pending at the time of our data collection.

Figure 8.

Word count of FAI determinations when families are involved, 2005-19



Note: Individual columns do not sum to 196 because it is possible for multiple aspects of family involvement to occur in the same case (i.e. be present, have legal representation and give evidence).

Initial qualitative comparison highlights potential explanations of why family involved in FAIs might produce longer reports; for example, when families are legally represented, questions are more likely to be posed to expert witnesses and additional evidence submitted.

Family involvement also is associated with FAIs that take longer, roughly 100 days more on average compared to FAIs where there is no family involvement. The table shows average time to FAI publication when family are involved in various ways.

Table 2.

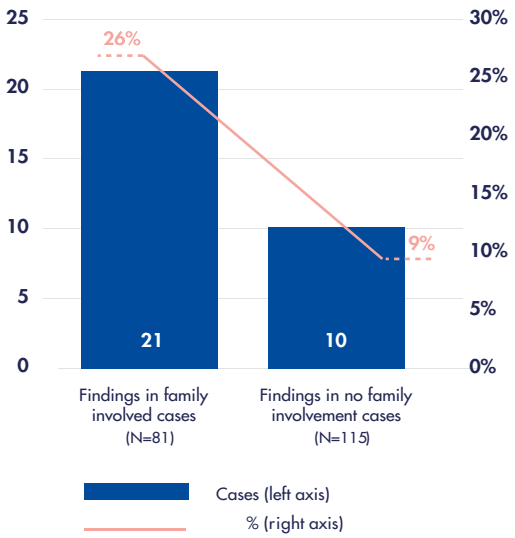
Average time for completing FAIs where families are involved, 2005-2019

	Cases	% all FAIs	Average Time (Days)
Family legally represented	45	23%	807
Family gives evidence	34	17%	825
Family present	60	31%	807
All published FAIs 2005-2019	196	100%	720

Family involvement also was associated with a greater chance of a Sheriff making a finding. Figure 9 shows that **findings are made in three times as many cases in FAIs where family have been involved (27%, 21 cases) than in those where they have not (9%, 10 cases)**; this is a statistically significant result.

Figure 9.

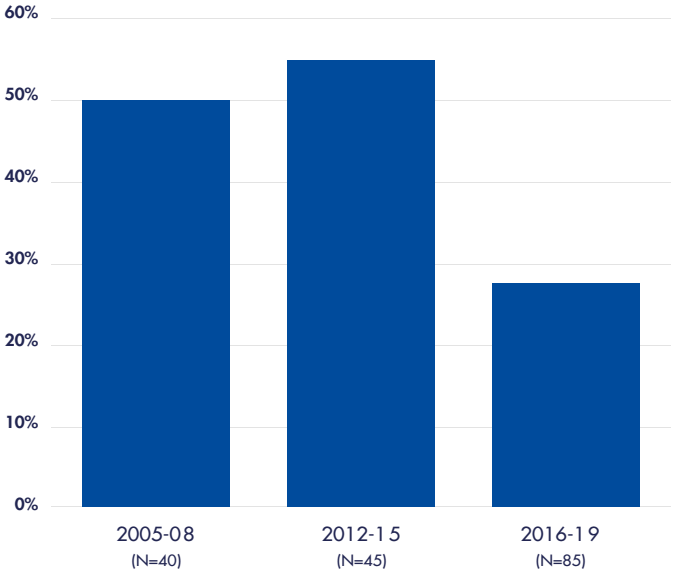
Chance of findings being made when family are involved or not involved in an FAI, 2005-19



The next figure compares how family involvement has changed over time, in three time periods. This mirrors the same trend above in relation to how the chance of a finding being made has changed over time, showing that family involvement rose in the middle period and fell in the most recent period, and to a lower level than seen in 2005-08.

Figure 10.

Comparisons of family involvement in FAIs across time, 2005-08, 2012-15 and 2016-19



To explain the lower level of family involvement in the most recent period, one might conjecture that family are more likely to attend or seek involvement in proceedings involving a death that is complex or where there are significant concerns about care. We might then argue that the FAIs yet to be done are more likely to be such cases as these take longer to complete. However, the case analysis of all 196 FAIs produced many cases involving deaths with complex and contentious elements where no family were present as well as cases involving 'natural deaths' where they were. There also was no clear pattern or correlation in family attendance of deaths that were self-inflicted compared to those that were not; family appear to attend these at similar(ly low) rates.

Review of cases showed there were also numerous instances in which family may have attended a preliminary hearing and even part of the main hearing but gradually stopped attending. Further investigation is required on this issue, but minimal and declining engagement of families will be a focus in planned research.

Again, because of missing data for the 2016-19 period, it is necessary to read this figure with particular caution. However, it will be impossible for the level of family involvement in 2016-19 to reach the level seen in 2012-2015, as this would require that families were involved in 47 cases, when there are only 33 FAIs remaining to be done.[13]

While families rarely were involved in FAIs, prisoners are even less commonly included. **Only 26 FAI determinations, or 13% of all published reports in 15 years mentioned oral evidence given by a prisoner.** Prisoners, like prison hall staff and health staff, are most likely to have personally observed the deceased in the days, weeks and months leading up to their death, and even to have been eyewitnesses to the death itself. However, they are rarely called to give evidence to the formal inquiry into such deaths. More typically, where the observations of prisoners are noted, it is through prison staff testimony at FAIs or prisoners may be interviewed as part of the COPFS investigation (and their words occasionally indirectly taken account of in this way). We found two FAIs where prisoners sought to submit evidence at an FAI. In one case the Sheriff declined to hear from a prisoner in a recognised relationship with the deceased and who claimed to be next of kin and have relevant information about the death. In another case, a remarkable petition signed by over 100 prisoners raising concerns about a person's wellbeing and care was noted but not considered in the Sheriff's determination (see companion briefing).

There are big differences between Sheriffdoms

Another area of focus in Lord Cullen's review related to the inconsistency and difference in style between determinations. We explored this issue by comparing patterns between judicial regions, or Sheriffdoms, by these variables: the time taken to complete an FAI, the word count of FAI determinations, and the rate of making findings. In each of these areas, there were substantial regional differences.

In terms of time taken to complete an FAI,cases in Glasgow & Strathkelvin took the least amount of time while those in North Strathclyde (all parts combined) took the longest, differing by nearly nine months or 43% longer.

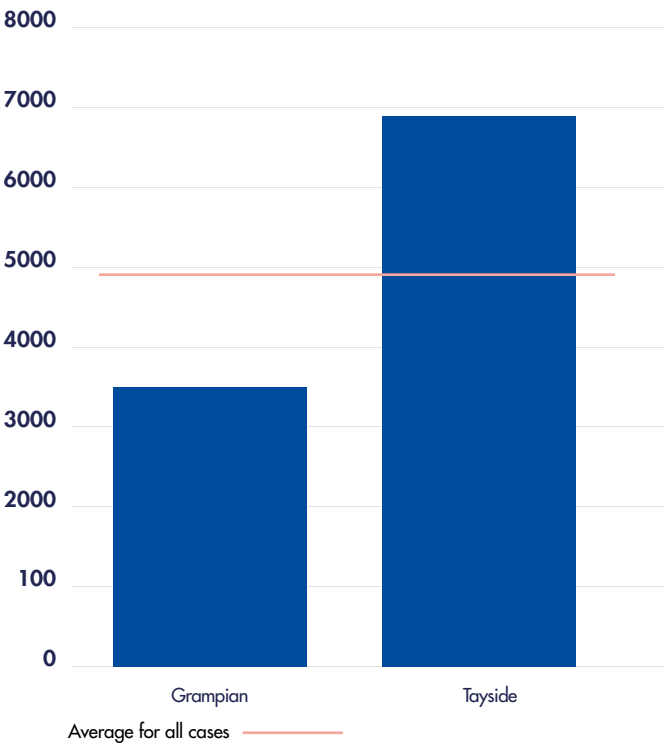
Table 3.
Number and average time of FAIs by Sheriffdom, 2005-2019

Sheriffdom	Average days	FAIs
Glasgow	606	47
Grampian	626	27
South Strathclyde	628	10
Lothian	753	41
Tayside	811	53
North Strathclyde	867	18
All Sheriffdoms	720	196

13. I.e., it would require the impossibility of families being involved in 142% of remaining cases.

The second difference is in the length of FAI reports. The average length of determinations for the entire sample 2005-2019, as noted above, is about 5000 words. The Sheriffdoms of Glasgow & Strathkelvin and North Strathclyde (Greenock, Kilmarnock and Paisley courts combined) produce reports roughly of this length. Those of Lothian & Borders are shorter (averaging 4000 words). The figure below shows the stark difference between Grampian, Highland & Islands (averaging 3300 words) and Tayside Central & Fife (averaging 6700 words), which produce the shortest and longest determinations, respectively (with the overall average of 4900 words marked by the line):

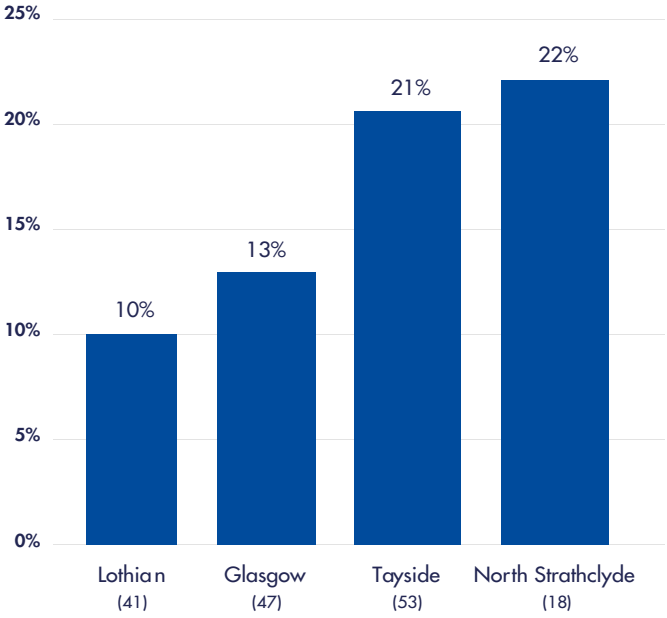
Figure 11.
Longest and shortest FAI word counts by Sheriffdom, 2005-2019



Word counts are a crude measure and do not distinguish different kinds of content, for example, lengthy extracts from legislation, appendices and annexes compared to core text presenting the analysis supporting a particular finding being reached. A full qualitative analysis of these differences is needed to assess this. At this stage, we can report that there do seem to be significant differences around issues such as providing detail about the context of a person's death and the amount of space given to evaluating the evidence about any concerns around this. For example, some FAIs provide the context only of a day or two surrounding a death, while others provide information about a person's condition and situation in the months or even years leading up to this. The shortest FAIs, as noted above, merely list parties and details of time, place and cause of death. These quantitative differences in word count therefore can suggest significant qualitative issues for further study. The systematic difference between Sheriffdoms in terms of length of determinations, therefore, is of interest.

Finally, and perhaps most important, Sheriffdoms differ markedly in the likelihood of issuing a finding (relating to a precaution, defect, finding fact or recommendation). Overall, across the 196 FAIs between 2005 and 2019, only 16% (32 FAIs) contained any such finding (that is, combining all possible finding categories). The figure below compares the Sheriffdoms most and least likely to make a corrective finding (with total number of published FAIs in brackets):

Figure 12.
Sheriffdoms with highest and lowest rates of making corrective findings, 2005-2019



It is more than twice as likely that a death in custody in Tayside, Fife & Central or North Strathclyde (all courts) will lead to a corrective finding than one investigated in Lothian & Borders. On the face of it, it appears improbable that these differences reflect substantive categorical differences in the nature of death between areas of Scotland or a systematic difference in the quality of care that can account for all, or even most, of this difference. The numbers here are too small to assess statistical significance and therefore qualitative investigation will be a priority of future research.

CONCLUSIONS AND NEXT STEPS

The Inspectorate of Prosecution stated in its 2019 follow-up review that "The FAI is a powerful vehicle to expose systematic failings and unsafe working practices and to ensure there are systems to safeguard and protect those in held in legal custody" (p.4). This briefing has presented numerical analysis of 15 years of FAIs covering deaths of those in custody finding that in over 90% of cases Sheriffs make no determination as to defects, or precautions, or recommendations. Over the same period, the rate of death in custody has increased, and this increase cannot be explained entirely by an aging prison population.

Lord Cullen stated in his 2009 review the aim of facilitating a system 'for inquiry into fatalities that is effective, efficient and fair' (Lord Cullen, 2009: v). Over a decade since he wrote these words, and in the five years since legal reform was enacted to support this aim, FAIs are taking longer, are less likely to produce an actionable finding, and are less likely to engage families. We also found large differences between Sheriffdoms in the likelihood that a determination would be made.

The published FAIs we analysed represent 196 people who died in a setting where no one wants to die. They died while entirely dependent on the state for their life and wellbeing. They died away from those who loved them and from the comforts of a home. They died of heart attacks and epileptic seizures. Some were murdered, many hanged themselves. Each of these deaths, taking place while in the legal custody of the state, requires a thorough review. The research we are undertaking provides an opportunity to do this and to explore across cases patterns and practices that can explain the initial results of our review.

The published FAIs we analysed represent 196 people who died in a setting where no one wants to die. They died while entirely dependent on the state for their life and wellbeing.

REFERENCES

Armstrong and McGhee (2019) *Mental Health and Wellbeing of Young People in Custody: Evidence Review for the HM Chief Inspector of Prisons Scotland, Glasgow: SCCJR.*

Bird (2008) Fatal accident inquiries into 97 deaths in prison custody in Scotland (1999 to 2003). *Howard Journal of Criminal Justice, vol. 47(4): 343-370.*

Bird (2020) Fatal accident inquiries into 83 deaths in Scottish prison custody: 2010–2013, BJPsychOpen, vol 6(6), e132, pp. 1-7.

Lord Cullen of Whitekirk (2009) *Review of Fatal Accident Inquiry Legislation – The Report, Edinburgh: The Scottish Government.*

Inspectorate of Prosecution (2016) *Thematic Review of Fatal Accident Inquiries, Edinburgh: The Scottish Government.*

Inspectorate of Prosecution (2019) *Follow-up Review of Fatal Accident Inquiries, Edinburgh: The Scottish Government.*

Shiels (2017) The origins of the fatal accident inquiry, *Scots Law Times*, 2017, 12, 47-53.

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, www.petalsupport.com

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