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Scottish Government
Riaghaltas na h-Alba

Audrey Nicoll MSP
Convener
Criminal Justice Committee
The Scottish Parliament
EDINBURGH
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30 May 2025

Dear Convener

Independent Review of the Response to Deaths in Prison Custody ("Independent Review") November 2021– Key Recommendation

I write to you to provide an update on the key recommendation of the Independent Review of the Response to Deaths in Prison Custody[1] ("Independent Review"), which was carried out by the Scottish Human Rights Commission, Families Outside and HM Inspectorate of Prisons for Scotland and published on 30 November 2021.

As you know, the Scottish Government was leading the delivery and implementation of the key recommendation which is *"A separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator and the NHS"*.

The Scottish Government accepted that recommendation in principle and led a working group, with representatives from Scottish Prison Service (SPS), NHS, Crown Office and Procurator Fiscal Service (COPFS), Police Scotland, Families Outside and families bereaved by a death in prison custody, which developed a proposal in line with the recommendation. The working group agreed that the proposed new system should be piloted and evaluated to carefully consider the impact on bereaved family members, and to understand whether it could meet the objectives and intentions of the recommendation as set out in the Independent Review, prior to committing to any legislative changes and funding for such a system to be implemented.

His Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) led the pilot exercises, assisted by members of her team plus a Senior Inspector from Healthcare Improvement

[1] Independent Review of the Response to Deaths in Prison Custody
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Scotland (HIS), a representative from Families Outside, as well as a member of the family reference group to bring their lived experience. A Legal Officer from the Scottish Human Rights Commission also observed some of the pilot. Representatives from SPS, NHS, COPFS and Police Scotland participated in the pilot exercises.

Two pilot exercises took place, where investigations were conducted on cases that had already reached an FAI determination. The first pilot exercise in autumn 2023 used a natural cause death to allow an initial test of the process. The second pilot exercise took place in March 2024 using a death with a more complex set of circumstances, in which the cause of death was both drug related and natural cause related.

A thorough evaluation was completed following these two pilot exercises, with all organisations involved in the deaths investigation and the co-authors of the Independent Review contributing to this. The evaluation findings highlighted the following:

a) Whilst it was impossible to mirror exactly how the new investigative process would operate in a 'real time' investigation, the pilot exercises provided enough evidence to assess whether the process could meet the requirements of the key recommendation and sufficiently demonstrate how workable the process would be in practice.

b) Clear evidence was gathered that demonstrated that the new investigative process did not meet the requirement of being truly independent as COPFS were legitimately required to exert a significant degree of influence to preserve the Lord Advocate's constitutional role as head of the systems of criminal prosecution and the investigation of deaths.

c) The pilot exercises were unable to demonstrate that this new investigation could be completed more expeditiously than the FAI. In both pilot exercises, the investigation would not have been able to commence until COPFS were able to rule out criminality to ensure any future criminal proceedings were not prejudiced. The period of time before the investigation could commence, which would vary from case to case, was likely to have been a number of months following the death for both pilot exercises. This did not represent the person-centred approach intended and expected, and would not meet the needs of bereaved families.

d) The new investigation risked becoming a 'mini-FAI', which would likely create confusion for bereaved families. The ability to undertake a thorough investigation was negatively impacted by the investigators lack of control over access to information and lack of freedom to undertake investigations they consider appropriate, within timescales they consider appropriate.

e) There was a clear intention to engage with the bereaved family. However, evidence demonstrated that due to a lack of ownership of information, this communication was not as meaningful as expected. Information requested by the bereaved family could not be conveyed to them as quickly as they would have liked. There was therefore a risk that bereaved families would lose trust in this new investigative process and disengage, which would not deliver the person centred and trauma informed approach envisaged.

The working group, including the co-authors of the Independent Review, concluded that the mechanism used for the pilots would not be able to achieve certain crucial objectives in practice, as detailed above. Therefore, other ways of achieving those objectives would need to be found. The inability of the Independent Review to examine the FAI process was also noted. You may also recall that Gillian Imery, in her oversight role in relation to implementation of the Independent Review, expressed the view that the key recommendation and resources required to implement it would not be required if the FAI process was sufficiently improved.

The Committee will be aware that, following consultation with the Lord Advocate and my statements to Parliament on 23 January and 27 March 2025, I have now commissioned an independent review of the FAI system, with respect to deaths in prison custody. This review will focus on improving the efficiency, effectiveness and trauma-informed nature of investigations into deaths in prison custody, in addition to identifying the specific barriers families face when engaging with the process. This review will further consider and propose concrete solutions to shorten the timescales of the overall FAI process.

The Committee will also be aware that there is no dedicated national oversight body or framework in Scotland in relation to deaths in custody, resulting in a gap in relation to: independent monitoring and scrutiny of FAI recommendations, independent annual reporting, analysis of trends (existing and emerging) and thematic review. The key recommendation envisaged that the new investigative body would address this gap by performing a national oversight role.

The Scottish Government is therefore progressing the establishment of a National Oversight Mechanism (NOM), to support better system wide understanding, learning and action – for example, identifying and highlighting important thematic issues, as well as exploring evidence and trends, in order to inform and support improvement and prevention. The NOM will and must operate independently from Government, reporting to Parliament. In doing so, it will strengthen transparency and accountability and support ongoing systemic improvement in relation to deaths in custody. We will also seek to ensure that it operates with complementarity in relation to existing bodies and their work, for example COPFS and HM Inspectorate of Prisons for Scotland (HMIPS).

The NOM will be underpinned three core principles:

- Accountability – for the bereaved and the people of Scotland, ensuring recommendations are implemented by responsible bodies, with the necessary impact in practice.

- Transparency – increased through reporting, analysis and thus enhanced scrutiny of Government and responsible bodies, in turn increasing public trust and confidence.

- Improvement – driven at the system level, informed by evidence and analysis, responsive to existing and emerging trends.

The Scottish Government are prioritising work to refine the final model, alongside establishing a detailed approach through which it can be implemented. That work will draw on the expertise and insights of a broad group of stakeholders, including the Family Reference Group, to ensure the voices of experts and families are heard and incorporated.

That work will consider key issues such as the body responsible for this work, its scope and remit, functions and powers. Practical issues such as the resources and corporate support required will also be considered.

The experience of bereaved families was at the core of the Independent Review and the key recommendation. I am therefore also pleased to report that work has begun to put in place additional support services for families, through the introduction of a new family advocacy role. Engagement is taking place with families to ensure the approach is shaped by them. This will ensure that families have independent, trauma informed support and guidance following the death of their loved one.

In summary, the Scottish Government accepted in principle the key recommendation of the Independent Review. An approach to implement that recommendation was decided upon by the working group and piloted. The pilot exercises were required to understand how that approach would work in practice. They demonstrated crucial shortcomings of that particular model and highlighted the primacy of the FAI process. The Scottish Government is now progressing a review of the FAI process, the creation of a National Oversight Mechanism and additional family support services. These measures, as part of the wider package of measures I announced on 23 January 2025, will I believe deliver on the objectives underpinning the key recommendation. On that basis, the Scottish Government will not continue to progress the key recommendation.

I hope the Committee find this information useful and I will continue to provide updates to parliament as required.

Yours sincerely,

ANGELA CONSTANCE