Independent Review of the Response to Deaths in Prison Custody:

Responses from Families

November 2021

This document was coordinated by Families Outside to further the voice of families who have experienced the death of a family member in custody in Scotland.

The Co-Chairs of the Independent Review of the Response to Deaths in Prison Custody would like to thank all of the families who contributed to this Review.

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A central focus of the Independent Review was the experience of the families of people who had died in prison custody. The co-chairs agreed at the outset that families' perspectives were key to whether the response to a death in custody could be deemed effective, humane, and compassionate.

This paper summarises very rich and detailed accounts of families' experiences and concerns they raised with the Review team, including their views about what may have prevented their family member's death and recommendations for change.

Methods

As the co-chairs did not have contact details for the families who had experienced a death, the Crown Office wrote to all 63 families who had been involved in a Fatal Accident Inquiry regarding a death in prison custody over a two-year period (1 April 2018 – 31 March 2020. The co-chairs also put out a call on social media for any family that had experienced a death in prison custody in Scotland to take part if they wished. In response, 23 people from 17 families – about a quarter of those who had been through a Fatal Accident Inquiry (FAI) in the relevant time period, plus one family that had not yet been through an FAI - came forward to take part in the Review.

The Review team arranged to speak with families individually but also asked families to volunteer to take part in a Family Advisory Group if they wished. The Advisory Group informed the work of the Review throughout, suggesting and commenting on the questions for families, staff, and people held in prison alike as well as on the information produced for families and the aims and methods of the review team. The Family Advisory Group met monthly for the duration of the Review. In total, 12 people from 8 of these families agreed to participate in the Family Advisory Group, with family members acting as Chair and Vice-Chair. Ten of these people (7 families) have met monthly to share their views and to inform the work of the Review.

Restrictions in contact were in place throughout the Review period due to the COVID-19 pandemic. The review team delayed the interviews with families as long as possible in the hope that restrictions would be lifted in time to conduct such difficult conversations in person. However, the Family Advisory Group assured the Review team that interviews by video link or telephone would be acceptable in the circumstances. In the end, the Review team spoke with 20 people from 14 families (a fifth of all families that had been through an FAI, plus one additional family). Of the remainder, one withdrew due to being too upset about the death and felt unable to speak about it at this time; one only wanted to speak face-to-face as part of a group, which was not possible in pandemic conditions; and one stopped communicating and could not be reached again following initial contact.

A semi-structured interview schedule was developed in collaboration with the Family Advisory Group. The interview schedule ensured that families were all asked the same questions while leaving room for them to elaborate on the issues important to them or to add additional information where needed. All interviews were recorded and transcribed, with thorough notes also taken at the time of the interview.

In addition to the direct interviews and discussions with families, the Helpline team from Families Outside collated inquiries from families from 1 January 2019 – 1 January 2020 regarding concern for someone in prison.

Circumstances of the death

Most of the families who came forward had experienced deaths other than suicide: only three of the deaths were due to suicide. Six cases were the deaths from long-term or underlying health conditions, though in two cases these underlying conditions were not known before the death. In four cases, the families queried the official cause of death, namely where the person in prison had previously been fit and healthy with no cause for concern.

Prior discussion with the prison and involvement in care

Most of the families had not had any discussions with the prison about the health and wellbeing of their family member when they entered prison. The reasons for this varied, either because they did not feel they had a reason to worry or, more frequently, because they recognised their family member as an adult who had their own responsibilities for their health and wellbeing and did not wish to interfere. One mum spoke of deliberately stepping back so that her son did not feel she was interfering. This also included any discussion about care planning or input to case conferences during their time in prison.

This was not to say the families did not have concerns about the person in prison, some of whom had long-standing serious mental and physical health issues. In most cases, they did not contact the prison themselves but encouraged their family members in prison to seek help. Only two families spoke about alerting the prison to their concerns, one starting with alerting the police at the point of arrest and following this up with contact with prison staff early on in the sentence. The other family became concerned during the course of the sentence but said they could not get information or response from the prison other than that "he [their family member] was fine". In two cases, the families heard from other people held in prison that their family member was not well, but they did not hear from the prison staff in this regard.

Two families raised compassionate release as an issue. These families said they were not told that compassionate release might be an option, or they had this request denied.

Interestingly, families who had had experience of someone in a secure health care setting said that the NHS notified them about their family member being taken into their care, providing contact details for the family if they had any concerns. Where someone was in hospital, families said they were able to communicate with the hospital staff or even (though not consistently) the contracted prison escort staff, which they found helpful.

Prior concerns

For most of the families, the death came as a real shock. Sometimes the person in prison was shortly due for release or had been in good health prior to the death, so they had felt no pressing reason to express concern. For others, concern about the person in prison was a normal state of affairs – "a lifetime of concern" or long-standing health issues that would not change due to their engagement with the prison.

There were, however, notable exceptions to this. In one case, a family had noticed a change in behaviour in their family member, going from regular communication to none. The family contacted the prison to express their concern, as a similar change in behaviour had preceded a suicide attempt in the past. Another family said they had also made regular contact with the prison – at least eight times - to express concern but that they felt their efforts were not being taken seriously.

Some families also queried what would trigger contact from the prison. One family said a Governor had told them that protocol was only to contact the Next of Kin in a 'life or death' situation but that their family member had been taken to hospital (including being "blue lighted" out) without informing them.

Perceptions of care

One questions families asked to have included was their view of whether prison health care staff have the necessary and properly functioning equipment, experience, and training needed to support people held in prison. With so many families contacting us following a death other than suicide, their concern about the care provided in prison was not surprising. The issues they raised included:

- Nurses who were unable to operate equipment, or equipment that was not charged enough to function
- Not having the right equipment or medication to revive people
- Nurses who were reported to have been giggling (not an unusual response to a stressful situation) and appeared to be young and inexperienced
- Medical staff not being given access to help people who were being restrained, or not being given information about what had happened
- Apparent lack of information from community-based GPs about medication, or a lack of communication with the family about medication
- Perceptions of "dispassionate" treatment, with people being given paracetamol and sent back to their cells rather than being taken more seriously

- Long waiting periods for appointments
- Difficulty accessing doctors, while nurses give out medication and cope as well as they can

While some of the concerns about health care had come from their family members in prison prior to their death, information also came out during the course of the Fatal Accident Inquiry or from other people held in prison at the time.

Concerns about care extended beyond prison-based health care staff to include questions about why people who were terminally ill and unable to move needed to be handcuffed to their hospital beds, on some occasions against the recommendations and requests of the hospital staff.

Raising concerns

Despite such concerns, none of the families said they knew whom to contact to share these concerns. Two families said they had contacted Families Outside for help, one of whom knew about this service through her work as a mental health and drug worker, and the other through doing their own research. The latter also learned about and contacted the prison's Family Contact Officers, mental health nurses, prison officers, and solicitors but said they received conflicting information and that, even for their family member, they were basically "navigating a foreign system". A third family said they had simply rung "the prison" but did not have a specific point of contact, while others said their only point of contact was their family member in prison.

Even knowing whom to contact did not always help: one mum said that she assumed she could contact the Governor but that she "wouldn't have dared to do that" because of her son's request not to interfere.

One family again highlighted the contrast between their experience with prison and their experience with secure mental health facilities such as the State Hospital. In that case, the Next of Kin received a letter and contact details, though even then, communication was not always consistent:

> *I was his Next of Kin in Carstairs. They kept in touch for about a year. I don't know how many years he was in there. I know he got put back in there because he ran at a wall and bashed his head deliberately. He was sent back, then [I] got a letter to say he was being moved back to Saughton [HMP Edinburgh] in two months or something. I feel some part of sympathy for him, because if things had happened earlier… everything is maybes and should've. He obviously couldn't live with it, and now he's at peace. He told me on the phone he was having bad thoughts.*

Families universally expressed a desire for information such as a point of contact or information sheet. This included a need for information and communication once someone had been transferred to hospital, for example regarding how to transfer their money or belongings to the hospital or how to get their clothes cleaned. One person said that, while some of the contracted prison escort staff were very helpful with this in hospital, one in particular (in his experience) he alleged was deliberately obstructive and that it took 43 requests for his brother's belongings to be sent from the prison.

Immediate aftermath

Notification of the death

In most cases, families learned about the death when the police came to their homes to tell them, consistent with current policy and practice in Scotland. Families' experiences of this process were very mixed, ranging from those who were home on their own to hear the news, who felt the police approach was unsympathetic, or who were told by the same police officer who made the original arrest; to those who found the police to be kind and sympathetic, and one family for whom the police officer was a family friend. More consistent was that notification of the death often took place several hours after the fact – something many of the families queried - and that the police often had few details of what had happened.

Some families learned about the death in other ways. The person notified of the death is the Next of Kin, so other family members found out through other people. Not having a direct role as next of kin can make confirmation of a death problematic:

> *Well, I got a phone call from someone else… to say that she had heard that [son] had been found dead…. I phoned the prison, and the telephonist was obviously not trained in how to handle calls like this, because… I said "I'm just phoning to find out, I've heard that my son has been found dead in his cell, would you be able to confirm or deny that?" And she said "Well, can you hold on?" and she put on music to play. And I phoned back and said: "Can I speak to the Governor?" "Well, can I get him to phone you back?" and I said "No, this is*

urgent. I need to know whether my son is alive or dead". Out of frustration, I hung up. I phoned his solicitor. His solicitor then phoned the prison and then he phoned me back to say that has been confirmed that [son] was found dead in his cell at lunchtime. So that was the shambles that I felt that, and, you know, I still haven't heard from the prison.

Families also raised the issue of having the opportunity to tell other people in their own time. One family wanted to wait to tell their daughter about the death until they knew her partner was available to support her. The death had been reported in the press, however, and the daughter ended up finding out via a friend on Facebook.

Deaths in hospital could also be exceptions to how families found out. Some families were able to be with the person when they died. Others had less positive experiences:

Well this is the bit that I find quite cruel because … I got a call on my work phone … from somebody saying: "Are you so-and-so?" And then, a few minutes later, I got a call from the ward that he was on and basically they just said: "Are you [X], is your [ex-partner] date of birth blah blah blah your husband or whatever?" And I said "Yes" and then all she said was "He's died"… If I could be angry; I'd be angry at her. I am still very angry at her…. she's already made a decision about him because he was a prisoner… I followed it up, you know … all I wanted to know was how he was… and if he'd been OK… as he died, because my understanding at that point was that he'd had nobody with him and just the two prison officers and all she said was, well, he was comfortable, I mean, she wouldn't speak to me, she wouldn't say a word about him.

Only one family said they heard the news of the death directly from the prison (in this case, the prison Governor).

Early information, next steps, and support

Families were unified in saying that they received very little information immediately after the death. Nearly all received contact from a prison chaplain, but this was for support rather than information. Some recall being told that a Fatal Accident Inquiry (FAI) would take place, and all had received a letter from the Crown Office (Procurator Fiscal) to explain this. Those who had lawyers were able to access additional information, but most of this focused on engagement with the Procurator Fiscal (PF) and the FAI process.

In some cases, the police gave the family a telephone number for the prison, and where the death was in hospital, families received a hospital pack about what to do after a death. Information directly from the prison was largely absent, however, nor were any families apparently told about processes such as the DIPLAR or (previously) SIDCAAR or that they could feed in to these processes via the chaplain: only one family had been told about this process, in this case from the police. Consequently, none of the families took part in any investigation or follow-up, other than the small minority (two families) who pursued action on their own or with legal support.

None of the families had received information about where they could go for support following a bereavement for someone in prison, noting that the information the Review team provided about this was the first they had seen. Most families received contact from the prison chaplain, though some turned this down because they weren't 'religious'. Families highlighted support from lawyers, chaplaincy, the police, and sometimes the PF or undertakers / funeral directors as the most helpful to them, though again experiences of this varied widely.

Information about what happened

Information to families to explain what had happened was sparse. Sometimes this was because little information was available, or because the information was simply not shared. Families said they were told when their family member was found rather than when they had died – a distinction they clearly found upsetting and unhelpful – or other questions were left unanswered, such as why their family member had to be handcuffed to their hospital bed when they were clearly not needing to be restrained.

Only one family member said that medical staff in the hospital explained what had happened; others, meanwhile, were told that it was their family member's right not to have involved them. The apparent cause of death might be shared, but families wanted to know the detail, the reasons, and the context – or indeed any information that might provide an explanation and closure. Instead, families almost universally shared the feeling that they were being dismissed.

Further issues

Families raised other issues in relation to the barriers they faced immediately following a death.

One had not been told that their family member's body needed to be moved to a different hospital following the death, for example. Another had a similar experience, learning that the police had already moved the body for autopsy without telling the family that this was happening. This family had been speaking with a funeral director about getting the body released before learning from the police that this wasn't possible "because he was a prisoner". The family was not even able to get a death certificate until the funeral director arranged for this.

The location of the death could also pose difficulties: the death may have taken place in one prison or hospital, but the body was then moved to another area, the police handling the case were in yet another area, while the family in turn lived in an entirely different part of the country.

> *All we wanted was to have [family member] home. What would have helped at the time is that we could have had [them] home, even to the west of Scotland. Wasn't until we got [the] body back to the undertakers that I felt a bit better.*

Information families wanted

Again, families wanted to know more about how their family member had died – what had led up to the death, what support they had been receiving, and the details of the death (time, place, circumstances). One family spoke about how they had been worried about the person in prison but had struggled to get any information from the prison about their family member's health and wellbeing, only learning after the death that the person had not been washing or eating and was breaking up his cell.

They wanted someone to reach out to them, for example through a specific role in hospital following a bereavement, but especially for someone from the prison to reach out: universally, families did not equate the prison chaplains with contact from the prison. They wanted someone they could take their questions to and to help them understand the sequence of events. Crucially, they wanted to feel heard and to be taken seriously – an experience that only one family reported having.

Overall, families wanted information about their family member and the death to be provided as a matter of course, without them having not only to ask for the information but also having to pursue it again and again.

> *- … after getting [the] body back and in between that and the FAI, I guess, there was nothing between that time and so we felt quite lost…*
>
> *- The worst problem was us having to chase it up constantly. It would have been really nice if they could have kept us up to date with everything that was going on cos we were, obviously, with whatever we were going through… we were trying, not force ourselves but…*
>
> *- Kind of push ourselves to find out things.*
>
> *- Yes, they should really provide families with the information cos they're already going through grieving and just trying to think like 'everyday' as well.*

Support after a death

Immediate aftermath

Few families had an early or immediate opportunity to see their family member after the death. More immediate opportunities were available when the death was in hospital, with some families able to be with their family member when they died. One was able to see their family member through glass, which they described as "horrendous", while another was able to see their son slightly earlier through personal connections (the undertaker was a family friend). Another said their lawyer offered to show them photographs.

Most families however spoke of having to wait at least two weeks after a death until after the post-mortem. This too could vary, however. In one extreme case, the family did not get the body back for six months:

> *[We] wanted to bring him home but couldn't as [the body was] too badly decomposed… we asked for our own [post-mortem after] and he couldn't as [body was] too badly decomposed. Had to go off previous one…. Couldn't even put clothes on him; lassie was in tears saying we can't even put clothes on him as too badly decomposed. His body was leaking in the coffin….*

For some families, seeing the body gave them comfort and closure, and the importance of this should not be underestimated:

> *He looked healthy. Just when I got near, he had a goatee beard, his hair was all brushed nice, and he just looked amazing. And I am so glad I went to see him,*

because he looked like a grown man.

The opportunity to identify the body came out as important to the families as well, not least because this opportunity was not made available to them. Rather, the prison took responsibility for this, which took some families by surprise. Communication between agencies created some additional tensions here. For example, following a death in hospital, one family received a card from the police and said they were told that someone would be in touch for them to identify the body. They rang the number on the card to be told that the body had already been identified and that "*'they'd taken that burden away from you now'…. It was the shock. They just did it*."

Following up

Most (but not all) families said they were offered the opportunity to see where their family member had died or had been with their family member in hospital when it happened. Only one said this had not been offered to them. Not everyone wished to or accepted the offer, with one explaining that they wanted to see where their family member had *lived* rather than where they died. Only two families said the prison staff had invited them proactively, with one invitation including an audience with the Governor. One of the two families declined the offer at first but tried to take up the offer several months later, at which point they were refused. Three others said specifically that they had to push for a visit and for an audience with the Governor, again with mixed success.

Families generally valued the opportunity to speak with people who knew their family member and valued the support they received from them. They spoke of receiving cards and other contact from other people held in prison alongside their family member; contact from prison chaplains who had a relationship with their family member; memorial services or commemorative football matches held in the prison; and in one case, the Open Estate providing buses for people held in prison to attend a service in the community, with staff attending from three prisons. Families were understandably touched when staff and other prisoners had good things to say, and some still kept in touch and received letters from people in other prisons who had known their family member.

Again, only two families said the prison Governor had reached out to them and invited them to the prison. One family said the Governor contacted them to express condolences, and in this case, the prison chaplain got in touch the same day. Importantly, very few families equated contact from the prison chaplain as contact from the prison. This is a crucial point, as families universally believed that the prison should have reached out to them but did not recognise this as happening through the chaplaincy. One described contact from the chaplain as a comfort but that they were "*not the person to ask things of*."

Further, families did not find all contact from the prison to be positive:

- We kind of thought the [Family Contact Officers] were supporting us, but they weren't.

- They were trying to pacify us. It became very clear that we were asking questions…

- … they were giving us a quick answer to shut us up.

A further problem was, again, communication between agencies. One family noted the lack of communication between the hospital, the prison, and the family, for example with no explanation or understanding as to why the body had been moved from one hospital to another after a death. Particularly distressing was families who were contacted after the death regarding their family member's whereabouts: one family said the prison rang them to say their family member was missing and to ask whether they knew where he was, and several weeks later, the police also rang to ask why their family member had not turned up for his court date. More than one family reported this experience which, understandably, they found exceptionally upsetting.

Another sensitive issue was collecting their family member's belongings after the death. For some, the prison chaplain or social worker brought these to the family within a few days. For others, the return was delayed until after the post-mortem, with some retained for considerable periods as evidence, and one noting that they had to wait several months, eventually receiving the items in a clear polythene bag. For families, the collection of belongings amplified the pain they were already feeling, especially if they "*got the runaround from the prison*" in trying to collect these – for example, when a family member went up to the prison to collect the belongings and was told they weren't there so had to turn around and leave – or for more personal reasons: "*I remember that [their] belongings smelt of the prison, and I hated that*." Of note was the high proportion of families who

said that items were missing, such as watches, rings, or rosary beads. Families said that items removed from those who died in hospital were taken back to the prison or to a 'production store' at the police station rather than given directly to the family, and at least five families claimed that items were still missing.

Needless to say, the experiences families had stuck with them. Some were still receiving medical support to cope, with at least one formally diagnosed with Post-Traumatic Stress. A few expressed empathy for the prison staff who find someone who has died, recognising the impact a death must have on staff as well. Another family member noted that the death "*released me*" of a lot of things but that, given the choice, she "*wouldn't have wanted it that way*" – in other words, she didn't want the death to be what made her own life easier.

What was helpful

Families' experiences of support and what was helpful varied considerably. Many simply said they received no support. Three mentioned support from chaplains, one of whom came from outside the prison.

> *100% [the prison chaplain]… he's the one that sticks in my mind with being so kind…. He was just this big, bold character and he made me feel like a person because he spoke so fondly of [family member], and then he done the service for him… [when I asked] he said 'I'd be honoured'…. all that's sticking in my mind was him [family member], as a person.*

Those who were able to go to the prison and speak to people who knew their family member, on occasion attending a memorial service there, expressed having a much more positive experience overall. Individual families spoke about support from the Procurator Fiscal; from their lawyer; or from Families Outside – in the latter case saying that more families should be aware that such support is available.

The support families wanted was equally varied but generally included a desire for more information and contact from the prison. They spoke of wanting someone to tell them what was happening *("Just the truth!"*), someone to tell them about next steps, and to have the opportunity to ask questions. They mentioned a need for compassion, even by phone or letter, and to feel they were not being ignored and that someone was taking them seriously.

> *I just wanted somebody like to sit with us or sit with me and go, like [prison chaplain] did… support like, this is what happens next. 'Can we come and see him? Do you want to see where he died? Do you want to see his wee cell?' … I just didn't know things were like that were possible…. I just feel I would have liked somebody just to give us that support to say 'this is what would happen next'.*

Some spoke more specifically about a desire to have been told beforehand that their family member was struggling, or to be told about standard procedures such as the body being moved to a different hospital after the death. Even one who was a registered carer for her family member prior to the imprisonment due to his mental health spoke of receiving no information from the prison. The struggle for information was a recurring theme for nearly all of the families.

> *It was a big shock for us, and I think we dealt with it by kind of fighting to get information. Instead of fighting, it would have been, I don't know I guess – humane - to get a bit of – not sympathy, but just a bit of information, I guess. Just information.*

Earlier sight of their family member's body was also a contentious issue, with almost all families unable to have sight of the body until weeks (and sometimes months) after the death.

> *It would have been helpful to have actually seen [family member's] body within a couple of days. I know it wouldn't have been possible before then. But, you know, until we saw him 3 weeks later, the reality of the fact that he was dead was moot…. I would have liked to have seen him when he was still [my son] and not a corpse. By the time we saw him, he was a cadaver.*

In sum, families needed information, explanation, communication, and closure.

Fatal Accident Inquiries

Communication prior to the FAI

Families again shared mixed experiences about the time between the death and the Fatal Accident Inquiry (FAI). The only universal experience was that this was "a long time", whether this were five months or five years (and in one case, still waiting). Families received letters from the Crown Office annually to keep them informed, so some relied on personal contacts

(e.g. friend who worked for the Crown Office) to explain processes, and what to expect.

Those who had lawyers depended on the lawyer to explain what was happening. Others depended entirely on communication with the Procurator Fiscal from the Crown Office. Some reported very positive experiences with this, while others had considerable difficulties:

> *I felt very informed and well informed and treated as a human being rather than as you know, just somebody, you know who was… I felt like I had been tarred with the same brush as him. So all the emails were very informative and tactful and, you know, open-ended, so, you know, it was they were happy to talk more or clarify more or anything like that. It was absolutely fine.*

> *… she seemed as if she wanted to hear our side of the story, what was he like and things like that. So, I think she was like on his side, if you like.*

> *We got [family member's] post-mortem result… report emailed to us… after [that] we asked the Crown Office to send everything to [lawyer]… we just couldn't cope with that any more. Can you imagine reading a report about your child's body being dissected?*

> *… we had a meeting with the [Procurator Fiscal]…, she came to Glasgow to come and meet with us, and then she was taken off it – we don't know why, and then another PF… but he wasn't answering any calls or emails even from lawyer, and didn't – even at the FAI – didn't speak to us once, [not even] good morning, he didnae even acknowledge us. [Family member] was quite angry about that.*

Involvement in the FAI

Most of the families attended the FAIs. For them, "being in court was my voice". For others, other circumstances prevented them from attending (e.g. deaths of other family members or serious ill health), with one person avoiding the court due to fear of media exposure. One family member said, in hindsight, that she wished someone had encouraged her to attend, despite the fact that deaths by natural causes were more straightforward. Regardless, attendance at an FAI could engender mixed feelings for families:

> *… part of me wished I was there to say my bit for him because that was my bit [to] sort of [fight] his wee corner, let everybody ken he was a decent man… and then part of me was like I'm glad I never. Because I'd have probably been in bits listening to all this cos I thought he was all right in prison. I thought he was well-liked and looked after and things like that and it just sounded to [family member] that he wasnae.*

None of the families gave evidence themselves, with any views they had expressed on their behalf via lawyers or the Procurator Fiscal. Only one family member said she had been offered the opportunity to speak (an opportunity she missed due to the death of her mother on the court date).

Support during the FAI

A number of families mentioned that legal representation was suggested to them, though only one said they were encouraged to apply for Legal Aid, and only two said they had received it. Some families decided against legal representation on the grounds that they didn't think they needed it or that they couldn't afford it. One mum spoke about her efforts to get a lawyer but said that no one would take the case, telling her that this would be a waste of time as an 'open and shut' case (a drug-related death). In this case, the Sherriff proved to be a useful advocate:

> *The judge just wanted kinda like a timeline on everything, and a lot of stuff in …and so on for like maybe a year because the judge wasn't happy with certain things that [the prison] was presenting … [so] He sent [the Procurator Fiscal] back a lot, you know, a lot, [with] a lot of questions. Saying there was just too many discrepancies as far as he was concerned - he wasnae amused actually. He was… a good judge, to be fair.*

Another family that was unrepresented at the FAI said the Sherriff made sure they understood what was happening throughout and actually demanded that the reports were read out to the family when he learned they had not seen any of them.

Unfortunately, positive experiences were not universal, with families describing their experiences as humiliating and traumatising:

> *I actually sent a complaint in about [the Sherriff] because of the way he addressed [my solicitor and a statement] that I wrote. My being in court is my voice, and being mocked like that I was furious…. It was like, have you ever done it, a Fatal Accident Inquiry? If you've ever been involved in a Fatal Accident Inquiry - I almost fell off my seat… and he's speaking to her like that*

and speaking to me like that, and she's my voice. I just thought he was such a disrespectful man… [family member] should have been allowed to die with dignity and he couldn't even have any dignity after he died. I just felt like the Fatal Accident Inquiry was just going through the motions, 'Let's get this one done; let's get this one done' and I know, obviously, they've got a lot on their docket to deal with and stuff, but certain Sheriffs are very compassionate…. And I knew he was just another number to them, I get that, I understand they're just fodder, but it shouldn't be like that… shouldn't hang there on the Sheriff's opinion because he is a criminal, because he has a criminal record. He should be completely impartial…. But I felt [this Sherriff] was very much against us, because it was another Sheriff at first, [and] she was lovely, she was really nice….

… it just seems to be they have to do it because it's mandatory, the FAIs. It's a complete waste of the public purse; complete waste of the public purse…. I think the main way I'd like to describe it is as an exacerbation of trauma, the FAI process. That's what it is.

Management and perceived fairness of the FAI process

Very few families spoke positively about the experience of an FAI. While the issue of long delays before the FAI took place were raised again, the main issues related to feeling heard and feeling they were being taken seriously.

I just felt they don't actually listen, they don't actually hear you, you know, they look as if they're listening but I just felt no one had really listened to my opinions and my views on it and that sort of left me in a state of bewilderment and I'm not easily confused. I'm quite an intelligent woman but I'm like, well what was the point of this.

We asked for an independent review from somebody, from a health profession, to look at the situation. We were promised that there'd be an independent review but it turned out that the person who was doing the review was from the [Health] Board itself, so it wasn't very independent. [The reviewer] explained that if [family member had been] in a hospital, it would be a different situation and he could have survived, however… when we got his report back, he said that [family member] was never going to survive, which was quite conflicting, and we feel that because he was from the [Health] Board there was maybe some sort of pressure or – we just don't know. So… our lawyer pushed… to see if we could get another review of this. But it didn't happen.

But some of the stuff that they were saying was kinda a shock as if they didn't care about my brother. He was just another prisoner with mental health issues. They were saying he's a drug addict. I don't care if he's a drug addict or no, it disnae matter, he still has mental health issues…. It was as if he was just another drug addict in prison and they just didnae care about him really.

Families also raised concerns about the proceeding feeling one-sided and adversarial, with answers from officials appearing inconsistent or, conversely, prepared in advance. One family said they learned half-way through the FAI that prison staff had been offered immunity from the Crown if they told the truth, "*but they didn't tell the truth, we knew they weren't because of the way they acted and changed their stories and judge kept calling them out on it, and [they] would tell another version*." Another family noted:

… we felt ganged up upon by the NHS, the prison services, and the Procurator Fiscal. Just so everything that we were saying or our lawyer was trying to bring on board they had answer ready beforehand.

The few positive comments underlined the need for families to feel heard and able to contribute, even if this were only through their lawyers or through the Sherriffs themselves:

We were able to contribute a lot to be fair and we done quite a lot. We were able to get recommendations heard by the Sheriff who was able either to put the recommendations in place at the prison or not.

… when we had a preliminary hearing, obviously the Procurator Fiscal and the Sherriff they were really good friends, and you could see it was very unprofessional and they were laughing and giggling and there was like an exchange of alcohol within the court. And our lawyer caught on to this and he made a complaint… so the Sheriff was changed over and so was the Procurator Fiscal. So things changed after that, it got better. The Sheriff was listening. He was there for the reason he was there.

Other concerns from families were more varied. One mum worried that the findings of FAIs were not compared with each other, suspicious that her son's death was one of a number of similar deaths relating to people having drugs 'tested' on them by others held in prison. Another did not believe that the media should be allowed in to FAIs, while a third queried why an FAI was needed when a death was expected, saying that no one explained any of this.

Unsurprisingly, and following discussion of a number of these concerns, a specific request from the Family Advisory Group was for the FAI system to be reviewed as a matter of urgency.

Prevention

The remit of this Review was to examine processes following a death in prison custody. However, prevention of death was a recurring theme for families and one that often fed in directly to the subsequent response after a death.

A frequent concern was the perception that health care in prison was not equivalent to the care provided outside. Families felt that health concerns that they or their family member in prison expressed were not taken seriously and worried that the training and equipment provided to prison health care staff were not adequate. Some families believed that this related to people held in prison being viewed as prisoners and addicts rather than as patients. Some families alleged that medical information had not been transferred into the prison from doctors outside and that people held in prison faced long waits for access to medical care. They also wanted requests for compassionate release to be considered more seriously.

Other families expressed concern that more prison staff could be available and alert to "*see when something's not quite right*" and that staff should contact the family to let them know when they have concerns about someone's wellbeing. Families mentioned having contacted prisons themselves to raise concerns but felt they were not taken seriously and that no concern forms were raised.

Finally, some families raised very practical concerns such as the location of the emergency button in cells needing to be by the bed rather than next to the cell door, alongside increased access to fresh vegetables, protein, and good levels of exercise to improve general self-care. While recognising the need for prison authorities to prevent people abusing systems such as emergency call bells, such practical solutions were of great importance to families:

> *… it's something I've thought about a lot because… the Procurator Fiscal said he would have suffered before he actually dropped - he would have been suffering immense pain in his head obviously because of where this thing was and it burst in his brain. I don't even like to think about it. To me the… it's the fact, being a mother, it's the fact that he died on his own, locked up. That's the picture I have in my head all the time.*

Additional information

Invariably, some information families shared did not fit readily into the themes summarised above. Some of this related to the need to emphasise the humanity of the person who had died – that this was their family and that they needed prison authorities in particular to acknowledge this:

> *I think it would have made a difference… because I felt completely ignored. I felt as though [my son's] death was nothing to them. It was one less person for them to worry about. And that was exactly how I felt and that is how, well - I thought I'll never set foot inside that prison, even if in retrospect if they ask me later on down the line, do I want to come up and speak to someone, I thought, no, you're too late now; I don't want to speak to you; I don't need you any more – I needed you at the time and… you ignored me.*

Reassurance for families and engagement with them was important from an early stage, and something families felt was sorely missing. One family that attended a family induction session gave the following account:

> *It was the very early days when [family member] was in prison, you know. The prison officer who took [us] round said… "We can't guarantee your [family member] won't be battered" and [we] just looked at him and said … "By whom, by other prisoners or by prison officers?" And the guy just shrugged his shoulders. What a thing to say to try and give someone, a mother whose [child is] in prison some - you know, a feeling of comfort and that it was going to be OK. What a thing to say.*

Some expressed the need for simpler language to be used when communicating with families: they understood the need to meet legal requirements

but also felt that families needed to understand what was happening and have the opportunity to ask questions and receive clear information throughout.

Overall, families wanted to know more about what had happened: how did their family member take the drugs? Is anyone looking at patterns of deaths? Who was looking after their family member? Why did it go wrong? How does someone attract attention from prison staff if they are unable to move or to cry out? How does self-harm go unnoticed? How do they know how to take their own lives? Why does an FAI need to happen? If a news report named the wrong prison, could this incorrect location also explain why the right medication was never received? In sum, the families expressed clearly that "*We just want answers."*

Inquiries to the Families Outside Support & Information Helpline

In addition to the interviews with families of people who died in prison custody from 1 April 2018 – 31 March 2020, the Review requested a search of the Families Outside database regarding enquiries from families concerned about a loved one in prison. From 1 January 2019 – 1 January 2020, families raised 4,377 issues with the Families Outside Support & Information Helpline. Of these issues, 433 (about 10%) related to concern for a family member, 27% of which related to concerns about mental health.

Similar to the experience of the families interviewed following a death, the overarching impression from families contacting the Helpline with concerns about a family member is one of helplessness. Families appear to be battling for information without a means of accessing it. This lack of information is not just from prison staff but from social work, the parole board, and health care staff as well. Interestingly, many of the families had not yet contacted the prison or alternatively had had no success in reaching someone who would answer their questions - or indeed in reaching someone at all. Even with very serious incidents, such as an attempted suicide, families were not informed until the person held in prison chose to tell them.

One enquiry, for example, came from a mother whose son had telephoned to say he was suicidal but had failed to attend his visit with her, and she was not given a reason for this. On contacting the prison to share her concerns, she said the prison staff told her it was not possible for her son to have telephoned and that his claims were untrue. The Helpline staff explained the 'Talk To Me' SPS Suicide Prevention Strategy (which she had not heard of) and advised her to apply for Power of Attorney to ensure her involvement in her son's care. Tellingly, a mum who had Power of Attorney said she had received a letter from her son saying he was suicidal but otherwise had not heard from him in a fortnight. She was afraid to raise her concerns with the prison because she did not want to get her son into trouble. This wariness of families to contact the prison directly with their concerns was a common feature of contacts to the Helpline.

The information they had was almost entirely from the person held in prison, sometimes with questionable reliability (for example from people suffering from severe mental ill health, or from a family member in one part of a prison giving an account of something that happened in another part they did not have access to, allegedly conveyed via prison staff). The information families shared gave a consistent picture of the person held in prison not receiving medical treatment, psychiatric assessments, or crucial medication such as insulin or drugs to manage mental ill health. Importantly, one family member who had experienced a death had contacted the Helpline for information about how to express concern about the process of care in prison for people suffering from mental ill health. Despite having experienced a suicide in prison, this family member had never heard of the Talk To Me Strategy and was asking how long the FAI would take to be completed. Contacting the Helpline should not have been the first time the family accessed this information but, frustratingly, this appeared to be the case.

Recommendations from families

Two central tenets of trauma-informed practice are choice and control. The findings of the Review showed clearly that families had neither.

The common themes arising from the Review's discussions with families focused on the need for Communication, Consistency, and Compassion. Families clearly felt excluded from processes both before and after the death, with limited information and support to help them with this. Their experiences were not consistent, and processes and practice appeared to differ between prisons. Finally, families needed above all else to feel they were being treated with compassion:

For them, it's just a paper exercise.

You get the impression that they're so damn

scared of being sued that they're forgetting the humanity.

Only one family felt they had been treated with compassion throughout and were alone in saying that they "could not fault the process".

In keeping with the human rights-based focus of the Review, specific recommendations from families have been grouped under the PANEL principles of Participation, Accountability, Non-discrimination and equality, Empowerment, and Legality.

Participation

Families need to feel they have a voice, that they are taken seriously, and that their concerns are heard, both before and after a death. Lack of information and lack of participation in the DIPLAR and FAI actively prevent families' participation. Limited information and eligibility for Legal Aid contributed to this lack of voice. At the very least, families (as Next of Kin) wanted better communication with the prison about any concerns, noting that the Next of Kin will know about the person and their background, potentially improving the likelihood of prevention of a death. Families universally needed someone to talk with them and to answer their questions.

Information should be offered without the family having to push for it, such as via a Family Liaison person similar to a Victim Support Officer. The Family Advisory Group noted a desire for information for families / carers / next of kin regarding health care, what care families can expect for their family member in custody, and what their rights are. Orchard House in Edinburgh was flagged as a model of good practice for this, flagging up the need for parity between care under the NHS and care in prisons. Families reiterated their experience that, when they did contact the prison, no one responded to their queries and that direct contact from the prison should be mandatory, even where they family had been estranged. In sum, communication with the prison, even when attempting to raise legitimate concerns, was a consistent source of frustration.

Accountability

Families wanted to know that people held in prison were safe and cared for. For them, this included adequate training for prison staff and especially for health care staff in the prison, with equipment that was fully functional, accessible, and appropriate. It also meant prison staff following up when someone held in prison failed to attend work or a medical appointment. Families called for a review of the prevention of deaths in prison custody as well as an overhaul of the suicide prevention strategy. Starkly, when the Family Advisory Group was asked what one thing they would wish to say to the Scottish Prison Service and prison-based health care providers, they asked, "*would you be open to change so that people can live longer?*"

Specifically regarding Fatal Accident Inquiries, families called for less time between the death and the FAI. They also wanted to see the recommendations from FAIs implemented, with a process for keeping track of this, noting patterns of deaths and holding agencies accountable for failure to address agreed recommendations. Families described FAIs as a defensive process and expressed a desire for these to be more investigative and inquisitorial in style. The Family Advisory Group believed a full review of the FAI process should be a priority.

Finally, families needed to see improved communication between agencies when a person in prison custody had died. More than one family speaking about being contacted regarding the whereabouts of their family member following the person's death - an entirely preventable scenario that caused significant and wholly unnecessary distress. This must change.

Non-Discrimination and Equality

Equivalent access to health care for people held in prison, including preventative care (e.g. blood pressure checks), needs to be genuinely equivalent. For some families, that included using National Institute for Health and Care Excellence (NICE) guidelines as a basis for questions to ask people on their reception to prison. Throughout the Review, we saw a regular deference to prison processes above NHS processes. For example, only one family was aware of a Serious Adverse Event Review taking place following the death of their family member, and even then, the family had not been notified of it. We also saw regular examples of the prison acting as the 'carer' (rather than the family, as per mental health legislation). Prison staff took responsibility for identification of the body, for transfers to hospital, and for addressing any concerns prior to a death, with families (including Next of Kin) completely excluded from notification of these things. Families needed to understand what processes may differ and why, for example why a body needed to be moved from one hospital to another after a death. Particular sensitivity, awareness, and information need to be in place for families when prison procedures prevent them from

complying with their religious beliefs, such as when they are unable to bury a family member quickly. Families should also not be required to apply for Power of Attorney in order to have a voice in the care of their family member in prison.

Part of the desire for equivalence included ensuring that prison staff and health care staff viewed their family member as a person rather than as an addict, and as a patient rather than as a prisoner: *"He's not an animal!".* They wanted to identify the body and to know the actual time of death rather than the time their family member was found. They wanted the option to see where their family member had lived and did not want to have to chase the return of personal property and private cash. Information about the return of property should be added to the new Information Booklet for Families After a Death in Prison.

Families were conscious of the lack of information regarding support that they may have received in another context (e.g. hospital). Again, this support included the need for direct contact from the prison (not just via the chaplain, whom they didn't usually associate with the prison), as basic acknowledgement of their loss if nothing else:

> *I'm still waiting for the Governor to get in touch with me… It wouldn't have changed the circumstances; it would have just made it easier for me.*

Some also identified a desire for an earlier start to the process of compassionate release once person is known to be terminally ill.

Empowerment

Families need to know what to do, where to go, and whom to speak to. They needed someone assigned to them to talk through things, to answer questions, and someone they could contact before and after a death. Crucially, none of the families had received information about where they could access support until the Review team provided this shortly after making contact with them. The Scottish Prison Service and Families Outside have since published an information booklet for families following a death in prison, but information about support and where to go with concerns should be available to all families (or at least to the Next of Kin, including an overview of what this responsibility involves) as soon as someone enters prison.

Prior to a death, families needed to feel they had access to their family member in prison, such as via unrestricted access to in-cell telephones. Funnelling their communication and concerns via the prison staff was ineffective and anxiety-provoking. They also needed a clear and consistent means of asking questions and sharing their voices and concerns in DIPLAR and FAI processes. This included simplification of reports such as the FAI report *("Just tell me why he died!")* and the choice about how and when to share the news of a death with others (rather than allowing the media to report a death once the Next of Kin had been notified). Both families and chaplains need an awareness of the key role of the chaplain in conveying families' questions and concerns for the DIPLAR process.

A platform for families to share and process their experiences was also important for them. The Family Advisory Group spoke of the value of the Group in sharing their stories and hearing others' experiences, reducing feelings of guilt and isolation they had previously been processing alone. A Bereavement Care Forum was recommended in the evaluation of the Talk To Me Strategy (Nugent 2018)[1], though none of the families was aware of the apparent existence of such fora at some prisons, nor of the access to trauma services for bereaved families outlined in the Scottish Prison Service's Bereavement Care Strategy.

Finally, families needed closure. In addition to support and answers to their questions, this should include support for funeral costs from the prison. This is not about allocating responsibility for the death but about ensuring the family is cared for at an exceptionally difficult time and in a context often lacking in support. Those families who attended services organised by the prison, often with attendance from staff and prisoners alike, greatly appreciated this visible expression of condolence.

Legality

Processes following a death in prison custody need to recognise and respect families' experiences and relative lack of power. Families should automatically be granted legal representation for Fatal Accident Inquiries, for example, just as the prison and health care staff have legal representation. The FAI should conduct a genuine investigation of the death rather than engage in adversarial procedures that evoke defensiveness and blame, ideally taking place in a closed setting (no media) around a table rather than in a formal courtroom setting, with families represented as equal partners in the

[1] Nugent, B. (2018) *Evaluation of the Scottish Prison Service's Suicide Prevention Strategy 'Talk to Me': Phase 2*. Edinburgh: Scottish Prison Service (unpublished).

discussion. This includes a need for retention of evidence such as blood tests and CCTV footage until the FAI has concluded, with families having access to reports (redacted if necessary) without being charged prohibitive sums for Freedom of Information requests. Recommendations from the FAI should be logged and their implementation monitored, with opportunities for learning between cases also noted and pursued.

The Review team remains grateful for the openness and willingness of so many families to speak with us about such a personal and painful subject:

> *It's a hole that can't be filled. It can't be sealed, it can't be resolved – it's just a hole. People's lives have holes, but this one's mine.*

Their motivations were clear and consistent, and the Review commends their recommendations to you on that basis:

> *If even one family is saved by this, then it will be worth it.*

HM Inspectorate of Prisons for Scotland is a member of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.

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