# Submission to the 2025 Fatal Accident Inquiry Review call for evidence

12 September 2025 (amended 17 September 2025)

## INTRODUCTORY REMARKS

1. This submission outlines the views of the UK National Preventive Mechanism regarding the Fatal Accident Inquiry (FAI) system in Scotland.

2. The UK National Preventive Mechanism (NPM) was established in 2009 when the UK ratified the United Nations Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

3. OPCAT establishes the duty to prevent torture or cruel, inhuman or degrading treatment from occurring in places where people are, or may be, deprived of their liberty. The prevention of ill treatment is forward-looking and primarily about encouraging continuous improvement to create environments where ill treatment is less likely. Any state that ratifies the OPCAT must establish an NPM with the mandate of undertaking preventive monitoring of places where people are, or may be, deprived of their liberty.

4. The UK NPM is made up of 21 statutory bodies that independently monitor places of detention across the UK, including six Scottish bodies, which constitute the UK NPM Scotland Subgroup:

    - Scottish Human Rights Commission (SHRC)
    - His Majesty's Inspectorate of Prisons for Scotland (HMIPS)
    - His Majesty's Inspectorate of Constabulary in Scotland (HMICS)
    - Independent Custody Visiting Scotland (ICVS)
    - Care Inspectorate (CI)
    - Mental Welfare Commission for Scotland (MWCS)

5. The Subgroup also has two Associate Members, Healthcare Improvement Scotland (HIS) and the Children and Young People's Commissioner for Scotland (CYPCS).

## CONCERNS

6. The UK NPM echoes the concerns raised by several national and international organisations with regard to the Scottish Fatal Accident Inquiry process, including the length of time it takes for FAIs to be completed and the lack of meaningful recommendations made in FAI determinations.

7. With regard to the length of time between individuals' deaths and FAI determinations, we highlight the comments and recommendation made by the European Committee for the Prevention of Torture (CPT) following their 2018 visit to Scotland (emphasis in original)[1]:

[1] Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 17 to 25 October 2018, p. 64.

*118. According to the Scottish authorities, there were 55 deaths in custody from January 2017 to October 2018… Every death in custody (police and prison) was… automatically referred to the police for investigation and then on to the Crown Office and Procurator Fiscal Service for the opening of a Fatal Accident Inquiry (FAI).*

*Interlocutors with whom the delegation met criticised the excessive lengths of time that the FAIs took to be opened and concluded. The Scottish authorities informed the CPT that only eight FAIs had been concluded from January 2017 until October 2018 and, at the time of the delegation's visit, more than 44 remained to be held.*

*The CPT considers that while it is positive that the DIPLAR and FAI systems are in place, it* ***recommends that the authorities review the operation of the overall FAI system to find solutions to speed up the process.***

8. In 2023, the Scottish Human Rights Commission and the National Preventive Mechanism published a joint report, Review…Recommend…Repeat…: An assessment of where human rights have stalled in places of detention[2], which highlighted that:

   *No State-level review of the FAI system has taken place since the CPT made its recommendation in 2018. The Scottish Government has not accepted the need for further review although figures show that the process of an FAI continues to be lengthy and several other concerns about the effectiveness of the process have since been raised.*

9. Our own analysis shows that as of 11 September 2025, the most recent individual who died in prison custody for whom an FAI determination was published (Mr J.M.) died on 19 November 2022[3]. Our research shows that no FAI determinations have been published for individuals who have died in prison custody after that date[4].

10. Moreover, only 17 FAI determinations have been published for individuals who died in prison custody in 2022, of a total of 44 deaths (38.6%). While we find the average wait for the *existing* FAI determinations from 2022 was about 2 years (105.3 weeks), that number will be much higher once the remaining 27 FAI determinations are published, and their publication dates are known. Figure 1 below shows the time taken to receive an FAI determination, relative to the date of death. **We urge the Sheriff Principal to consider what changes may be made to the FAI legislation and process to enable determinations to be made much more promptly, so that families and communities can move forward, and duty bearers can more swiftly act on recommendations.**

[2] Review…Recommend…Repeat….An assessment of where human rights have stalled in places of detention p. 18.
[3] The UK NPM maintains a database of deaths in prison custody, using information from the SPS Death in custody website as well as the Scottish Courts and Tribunals database of FAI determinations.
[4] Although many of these individuals have hearing dates scheduled, as can be seen on the Scottish Courts and Tribunals database of FAI determinations.

| Initials | Date of Death | Cause of death | FAI determination date | Time taken to complete FAI (weeks) |
|---|---|---|---|---|
| DT | 10/01/2022 | Suicide | Not found as of 11 Sept 2025 | |
| VB | 11/01/2022 | Medical | 20/05/2024 | 122.9 |
| DS | 11/01/2022 | Suicide | Not found as of 11 Sept 2025 | |
| GD | 13/01/2022 | Suicide | Not found as of 11 Sept 2025 | |
| SC | 22/01/2022 | Medical | 29/02/2024 | 109.7 |
| FD | 23/01/2022 | Injury | Not found as of 11 Sept 2025 | |
| WP | 12/02/2022 | Suicide | Not found as of 11 Sept 2025 | |
| JM | 14/02/2022 | Medical | Not found as of 11 Sept 2025 | |
| ES | 18/03/2022 | Medical | Not found as of 11 Sept 2025 | |
| RC | 04/04/2022 | Medical | 22/09/2023 | 76.6 |
| RH | 10/04/2022 | Drug Related | | |
| MM | 11/04/2022 | Medical | 07/03/2023 | 47.1 |
| JA | 11/04/2022 | Suicide | Not found as of 11 Sept 2025 | |
| CM | 20/04/2022 | Suicide | Not found as of 11 Sept 2025 | |
| WK | 29/04/2022 | Suicide | 22/12/2023 | 86.0 |
| GH | 30/04/2022 | Medical | 01/11/2023 | 78.6 |
| AW | 31/05/2022 | Medical | 04/06/2025 | 157.1 |
| DF | 04/06/2022 | Medical | 18/02/2025 | 141.4 |
| GF | 05/06/2022 | Medical | 23/09/2024 | 120.1 |
| LM | 11/06/2022 | Drug Related | Not found as of 11 Sept 2025 | |
| SC | 19/06/2022 | Medical | 12/02/2025 | 138.4 |
| DR | 23/06/2022 | Medical | Not found as of 11 Sept 2025 | |
| MM | 05/07/2022 | Drug Related | Not found as of 11 Sept 2025 | |
| MH | 09/07/2022 | Suicide | Not found as of 11 Sept 2025 | |
| JB | 29/07/2022 | Medical | 26/02/2024 | 82.4 |
| JM | 02/08/2022 | Drug Related | Not found as of 11 Sept 2025 | |
| MB | 04/08/2022 | Drug Related | Not found as of 11 Sept 2025 | |
| JM | 08/08/2022 | Suicide | Not found as of 11 Sept 2025 | |
| KW | 13/08/2022 | Medical | Not found as of 11 Sept 2025 | |
| EH | 14/08/2022 | Suicide | Not found as of 11 Sept 2025 | |
| AJ | 21/08/2022 | Medical | 24/10/2024 | 113.6 |
| CF | 05/09/2022 | Suicide | Not found as of 11 Sept 2025 | |
| ML | 09/09/2022 | Medical | Not found as of 11 Sept 2025 | |
| CM | 09/09/2022 | Suicide | Not found as of 11 Sept 2025 | |
| WT | 05/10/2022 | Medical | 27/06/2024 | 90.1 |
| PT | 08/10/2022 | Medical | 03/10/2024 | 103.7 |
| SG | 16/10/2022 | Drug Related | Not found as of 11 Sept 2025 | |
| AS | 26/10/2022 | Medical | 17/12/2024 | 111.9 |
| AC | 01/11/2022 | Medical | 28/02/2025 | 121.4 |
| KM | 15/11/2022 | Medical | Not found as of 11 Sept 2025 | |
| JM | 19/11/2022 | Medical | 15/08/2024 | 90.7 |
| SW | 25/11/2022 | Suicide | Not found as of 11 Sept 2025 | |
| RC | 12/12/2022 | Medical | Not found as of 11 Sept 2025 | |
| RC | 24/12/2022 | Medical | Not found as of 11 Sept 2025 | |

**Figure 1: Excerpt from the UK NPM Deaths in Custody Database, showing the last individual to receive an FAI determination (Mr J.M., highlighted in yellow), in terms of chronological date of death.**

11. Our other major concern is the lack of recommendations made in FAI determinations. We understand that at times, the Sheriff overseeing the FAI is not invited to make recommendations with regard to certain aspects of a person's death. However, if the FAI process is to help reduce deaths in custody, and protect people's Article 2 rights, it is crucial that the FAI system is structured in such a way to enable ongoing and continuous improvements that will help reduce deaths in prison custody.

12. As it stands, deaths in prison custody are rising steadily, more than doubling in the past ten years from 24 deaths in 2015 to 62 deaths in 2024, despite only modest population increases[5]. Despite this, and echoing findings from Armstrong in 2021, who found that 90% of FAIs do not result in any finding of reasonable precautions or defects, or recommendations, our research shows that for individuals who died in prison custody in 2022, not a single FAI determination to-date has listed any reasonable precautions, defects in systems, other relevant facts, and that no recommendations have been made to date (see Figure 2).

[5] We note that while the population increases have been small, approximately 6-7% since 2015, the increase has pushed many prisons over their maximum capacity, a significant concern and probable contributing factor to rising deaths in prison custody.

| Initials | Date of Death | Cause of death | Reasonable precautions listed? | Defect in system found? | Other facts relevant to circumstances? | Recommendations? |
|---|---|---|---|---|---|---|
| DT | 10/01/2022 | Suicide | | | | |
| VB | 11/01/2022 | Medical | N | N | N | N |
| DS | 11/01/2022 | Suicide | | | | |
| GD | 13/01/2022 | Suicide | | | | |
| SC | 22/01/2022 | Medical | N | N | N | N |
| FD | 23/01/2022 | Injury | | | | |
| WP | 12/02/2022 | Suicide | | | | |
| JM | 14/02/2022 | Medical | | | | |
| ES | 18/03/2022 | Medical | | | | |
| RC | 04/04/2022 | Medical | N | N | N | N |
| RH | 10/04/2022 | Drug Related | | | | |
| MM | 11/04/2022 | Medical | N | N | N | N |
| JA | 11/04/2022 | Suicide | | | | |
| CM | 20/04/2022 | Suicide | | | | |
| WK | 29/04/2022 | Suicide | N | N | N | N |
| GH | 30/04/2022 | Medical | N | N | N | N |
| AW | 31/05/2022 | Medical | N | N | N | N |
| DF | 04/06/2022 | Medical | N | N | N | N |
| GF | 05/06/2022 | Medical | N | N | N | N |
| LM | 11/06/2022 | Drug Related | | | | |
| SC | 19/06/2022 | Medical | N | N | N | N |
| DR | 23/06/2022 | Medical | | | | |
| MM | 05/07/2022 | Drug Related | | | | |
| MH | 09/07/2022 | Suicide | | | | |
| JB | 29/07/2022 | Medical | N | N | N | N |
| JM | 02/08/2022 | Drug Related | | | | |
| MB | 04/08/2022 | Drug Related | | | | |
| JM | 08/08/2022 | Suicide | | | | |
| KW | 13/08/2022 | Medical | | | | |
| EH | 14/08/2022 | Suicide | | | | |
| AJ | 21/08/2022 | Medical | N | N | N | N |
| CF | 05/09/2022 | Suicide | | | | |
| ML | 09/09/2022 | Medical | | | | |
| CM | 09/09/2022 | Suicide | | | | |
| WT | 05/10/2022 | Medical | N | N | N | N |
| PT | 08/10/2022 | Medical | N | N | N | N |
| SG | 16/10/2022 | Drug Related | | | | |
| AS | 26/10/2022 | Medical | N | N | N | N |
| AC | 01/11/2022 | Medical | N | N | N | N |
| KM | 15/11/2022 | Medical | | | | |
| JM | 19/11/2022 | Medical | N | N | N | N |
| SW | 25/11/2022 | Suicide | | | | |
| RC | 12/12/2022 | Medical | | | | |
| RC | 24/12/2022 | Medical | | | | |

**Figure 2: Excerpt from the UK NPM Deaths in Custody Database, showing selected details of FAI determinations for deaths that took place in 2022, including whether or not any recommendations were made.**

13. We believe that the FAI process, and FAI determinations, can play a more meaningful role in helping to drive changes that will help to curb the concerning rising trend in deaths in prison custody. **We urge the Sheriff Principal to consider what changes may be made to the FAI system, whether legislative or procedural, to make it more effective at driving change within the organisations and systems that exist to keep people safe in prison custody.**

14. We would like to highlight additional concerns raised in the 2021 Independent Review of the Response to Deaths in Prison Custody, which we believe should be considered during the FAI review[6]:

    *[E]vidence provided to the Review by families and prison staff highlighted concerns about the adequacy of the FAI process, in particular the length of time between a death in custody and the FAI; the limited opportunity for family participation in the FAI; the narrow focus of the FAI; and the lack of broader learning from FAI findings and recommendations*. (p. 13)

    *Families and staff both reported that they found the FAI intimidating and adversarial and universally would prefer a less formal setting.* (p. 69)

15. Finally, we remain concerned with the lack of mandatory investigation into deaths in mental health settings, which we believe may be in conflict with the Article 2 procedural duty to investigate deaths of individuals in the care of the state. **We urge the Sheriff Principal to interrogate the details of this gap and encourage the Scottish Government to fulfil its procedural duty of investigation.**

16. We are pleased that the Scottish Government has acknowledged the need to review the FAI system and are happy to provide any additional information or comments as needed. We look forward to reading the results of the review.

[END]

[6] Independent Review of the Response to Deaths in Prison Custody, p. 13.