Criminal Justice Committee
Wednesday 25 June 2025
20th Meeting, 2025 (Session 6)

FAIs/Deaths in custody: letters from the Scottish Government

Introduction

1. On 2 June, the Cabinet Secretary sent three letters relating to fatal accident inquiries and deaths in custody (see **Annex**).

2. One is these letters is addressed to the Equalities, Human Rights and Civil Justice Committee, with the Criminal Justice Committee copied for information, about the announcement of a Chair to lead an independent review of the Fatal Accident Inquiry system when dealing with deaths in custody.

3. The other two letters are addressed directly to the Criminal Justice Committee and relate to wider deaths in custody reforms.

4. The Cabinet Secretary's office suggest that Members read the letter about the *Independent Review of the Response to Deaths in Prison Custody*, with an update about plans for the National Oversight Mechanism, first. This will then aid their understanding of the second letter about the response to the FAI determinations into Katie Allan, William Lindsay (Brown) and Jack McKenzie's deaths in custody and the establishment of a Ministerial Accountability Board.

5. The letters should explain the links between these pieces of work but for clarity:

- In November 2019, the then Cabinet Secretary for Justice asked Wendy Sinclair-Gieben, then Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) to undertake an *Independent Review of the Response to Deaths in Prison Custody*. Professor Nancy Loucks, Chief Executive of Families Outside and Judith Robertson, Chair of the Scottish Human Rights Commission joined the former HMCIPS as Co-Chairs of the Review in its early stages. The Review was tasked with making recommendations on how to improve the response when someone dies in one of Scotland's prisons. The Review's final report was published on 30 November 2021. It made one key recommendation, 19 other recommendations, and six advisory points, all of which were accepted in principle by the Scottish Government.

- Katie Allan and William Lindsay, also known as William Brown, died at HMP & YOI Polmont in 2018. Jack McKenzie died at HMP &YOI Polmont in 2021. The joint Fatal Accident Inquiry determination into the deaths of Katie and William was published on 17 January 2025, with 15 main recommendations, which Scottish Ministers accepted in full. The FAI determination on Jack's

death was published on 20 May 2025, with 7 recommendations. Scottish Ministers will respond formally to this FAI by the required deadline of 11 July.

- The Cabinet Secretary for Justice and Home Affairs gave statements to Parliament on 23 January and 27 March 2025 to provide updates on the response to Katie and William's FAI and the action the Scottish Government are taking to ensure the necessary reforms are made.

- In the January statement, the Cabinet Secretary committed commissioning a focused independent review of the FAI system that will look at the efficiency, effectiveness and trauma-informed nature of investigations into deaths in prison custody, noting that that the period of five years between the deaths of Katie and William and the first notice of the Fatal Accident Inquiry was far too long. This was also noted by Sheriff Collins who led the FAI.

- A Ministerial Accountability Board is being established to oversee the implementation of the recommendations from the FAI determination into the deaths of Katie and William. The Board is a temporary measure introduced in advance of establishing a fully independent National Oversight Mechanism (NOM) for all deaths in custody.

- The Cabinet Secretary remains committed to ensuring all outstanding commitments made in relation to the 2021 Independent Review are delivered.

6. When reading the different letters, Members will want to note the following paragraph which relates to the key recommendation made at the time of the *Independent Review of the Response to Deaths in Prison Custody* that there should be a separate independent investigation 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. This is no longer the view of the Scottish Government.

7. The Cabinet Secretary for Justice and Home Affairs is now of the following view:

> "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"

Recommendation

8. In light of the above, as well as the wider information received, it is suggested that Members consider the information received at today's meeting and discuss what, if any, follow-up action is required.

Clerks to the Criminal Justice Committee
June 2025

Annex A – Letters from the Scottish Government

Letter 1 from Cabinet Secretary

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 Custody1 ("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 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 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.

Angela Constance

CJ/S6/25/20/4

Letter 2 from Cabinet Secretary

30 May 2025

Dear Convener,

Fatal Accident Inquiries into the deaths in custody of Jack McKenzie, Katie Allan and William Lindsay (Brown), and an update on the establishment of a Ministerial Accountability Board

I write to update you following my previous updates to Parliament by statement on 23 January and 27 March 2025, regarding Deaths in Custody. On those dates, I set out the actions the Scottish Government and the Scottish Prison Service (SPS) are taking to address the systemic failures identified by Sheriff Collins in the joint Fatal Accident Inquiry (FAI) determination into the deaths in custody of Katie Allan and William Lindsay, also known as William Brown. The joint FAI contained 15 main recommendations which covered themes including the prison cell environment and ligature risks, suicide prevention policies, information sharing between courts and prisons, staff training and learning from previous incidents. Scottish Ministers accepted the recommendations in full in the formal response to the determination.

Since the publication of Katie and William's determination, a further FAI has been published relating to Jack Mckenzie. Sheriff Collins also oversaw these proceedings and published his findings, with 7 recommendations, on 20 May 2025. Three of the recommendations were identical to those in Katie and William's determination and the Sheriff himself noted significant overlap between the cases and the issues previously identified. A formal response to the FAI determination will be sent by SPS to the Scottish Courts and Tribunal Service, by the 8-week deadline of 11 July.

Ministerial Accountability Board

I am committed to strengthening oversight for all recommendations accepted by Scottish Ministers, and to driving forward their implementation to deliver the necessary reforms to ensure prisons are safe and rehabilitative. The Programme for Government this year reaffirms my commitment to this and to establishing a Ministerial Accountability Board. The Board's central focus will be to drive delivery against the commitments made in respect of Katie and William's determination. It will bring together relevant experts and play a vital role in holding delivery partners to account, monitoring progress against specific actions, and helping to address any challenges that arise. The first meeting is scheduled for 19 June, where the Board will agree its terms of reference and set out a work plan for the months ahead. I would be happy to keep the Committee updated as these plans progress, and the work of the Board takes shape.

The Board is a temporary measure introduced in advance of establishing a fully independent National Oversight Mechanism (NOM) for all deaths in custody. In my letter to the Criminal Justice Committee regarding the Independent Review of the Response to Deaths in Prison Custody, I have outlined further details on the NOM. I remain firmly committed to ensuring that all outstanding commitments made under

the Independent Review remain visible and are fully delivered. To support this, I will request that the Deaths in Prison Custody Action Group (DIPCAG) provide a comprehensive update to the Ministerial Advisory Board (MAB), ensuring the Board has a clear understanding of its remaining work and the broader context of the essential reform still required.

His Majesty's Inspectorate of Prisons for Scotland (HMIPS)

His Majesty's Inspectorate of Prisons for Scotland (HMIPS) will bring independent rigour and demonstrate whether the necessary actions have been taken and are having the intended impact on the ground. HMIPS will also work with Healthcare Improvement Scotland to assess the effectiveness of the action taken to implement the healthcare related recommendations. In my statements to Parliament I emphasised the critical importance of independent scrutiny and noted that the Chief Inspector shares my view on the need for rigour and transparency in this work, as well as the need to involve families, prisoners, SPS staff and expert advice. HMIPS will provide me with an initial report on progress by the end of the summer.

Scottish Prison Service progress

The Scottish Prison Service has made clear its commitment to meaningful reform in the FAI response and has reaffirmed this by establishing a Chief Executive-led taskforce to drive change.

SPS have launched an independent review of their suicide prevention policy "Talk to Me", led by Professor Graham Towl. A public Call for Views is open, and site visits are underway, with an overhauled policy expected by the end of the year.
SPS has taken forward work to remove ligature risks from the physical environment of HMP & YOI Polmont, and further progress is continuing at pace. SPS will consider the need for this work across the wider prison estate.

In response to FAI findings on ligature risks, SPS has, with external expert advice, developed a dedicated risk assessment tool, with a pilot planned for the Polmont population this summer. The pilot is supported by NHS expertise and options are being considered for a digital recording system to support a robust evaluation which will be reported to me later in the year.

SPS has also been actively exploring the use of 'Signs of Life' or presence detection technology to enhance safety within the custodial environment. Engagement with the wider market has identified three potential providers. It is anticipated that each supplier will provide a small number of devices for pilot testing, with trials set to begin for young people at both HMP Polmont and HMP Stirling this summer. The design and installation arrangements required for the pilot are already in place to support the rollout. The learning from this pilot will inform the operational consideration of any potential future business need.

Furthermore, work is also underway to strengthen safety and wellbeing in prison. A working group has been established to develop a new, robust and impactful Think Twice anti-bullying policy, which will reflect a broader understanding of bullying within

the prison environment. Additionally, policies around items in use are being reviewed, with the Governor of Polmont leading this work specifically.

SPS retains operational responsibility to get on and deliver the required actions but it will report its progress to the Ministerial Accountability Board regularly and will also provide updates in line with the undertakings set out in its formal response to Katie and William's FAI determination.

NHS Forth Valley progress

The Chief Executive of NHS Forth Valley considers that all recommendations from the FAI determination aimed at the healthcare team in HMP & YOI Polmont have been met as a result of work undertaken between 2018 and the determination being published in January 2025. The 2023 HMIPS inspection of HMP & YOI Polmont provides further evidence from external inspectors that appropriate actions have been identified, completed and are having the desired impact on outcomes to those within HMP & YOI Polmont. Whilst the determination focused on HMP & YOI Polmont, all actions identified have also been implemented across HMP Glenochil and HMP & YOI Stirling.

Scottish Government progress

Scottish Government officials are leading the development of a standardised approach to ensure that all information from relevant agencies is shared with SPS at the time of a person's admission to prison. This approach is at initial stages of development and will report regularly on progress to the Ministerial Accountability Board.

On 7 April 2025 the Legal Aid Determination, enabling close family members who are involved in deaths in custody FAIs to have access to non-means-tested legal aid, came into effect. The Scottish Legal Aid Board has advised that it has already been used to grant legal aid to family members.

As I said in my statement of 23 January, I am also commissioning a focused independent review of the FAI system that will look at the efficiency, effectiveness and trauma-informed nature of investigations into deaths in prison custody. Retired Sheriff Principal Ian Abercrombie has agreed to Chair the review, which I have asked to report this year. I have written separately to the Equalities, Human Rights and Civil Justice Committee about this and have copied the letter to you.

I am also continuing to pursue the lifting of Crown Immunity with the UK Government. The Scottish Government wrote to the previous UK Government on this issue and did not receive a response. I have continued to pursue this issue with the current UK Government and will personally raise it with UK Government ministers at the first opportunity.

The deaths of Katie, William, and Jack should not have happened whilst they were in the care of state. I have expressed my deepest condolences to their families and I am truly sorry for their deaths. Systemic change is needed to address the systemic

failures identified and that is the driver for the action the Scottish Government, and our partners, are taking.

I hope the Committee has found this information useful and I will continue to keep Parliament informed as work in this area progresses.

Angela Constance

CJ/S6/25/20/4

Letter 3 from Cabinet Secretary

30 May 2025

Dear Convener,

APPOINTMENT OF CHAIR OF THE REVIEW OF FATAL ACCIDENT INQUIRIES RELATING TO DEATHS IN CUSTODY - 2025

As you know, I announced a review to consider the Fatal Accident Inquiry system relating to deaths in custody in Parliament on 23 January 2025. I restated that commitment in parliament on 27 March 2025.

The purpose of this independent Review is to consider the Fatal Accident Inquiry system and make detailed and actionable recommendations which focus on improving the efficiency, effectiveness and trauma-informed nature of investigations into deaths in prison custody. The Review will also identify the specific barriers that families face in engaging with the process and the timescales involved, identifying any improvements that can be made on both fronts.

I am writing today to provide Parliament with an update on the above review. I can now confirm that Retired **Sheriff Principal Ian Abercrombie** has been appointed as Chair. He will be supported by an advisory group, recommended by the Chair and appointed shortly by Scottish Ministers.

Sheriff Principal Abercrombie graduated with an LLB Hons from Edinburgh University in 1978 and joined the Faculty of Advocates in 1981. He has served as a Curator of the Advocates Library and was a member of the disciplinary committee of the Institute of Chartered Accountants of Scotland, and of a Scottish Law Commission advisory group. He became a QC in 1993 and was appointed a sheriff in 2009. He became Sheriff Principal of South Strathclyde, Dumfries and Galloway in 2014 and retired in 2020.

I also attach the terms of reference for the review at the **Annex**, for your information.

Angela Constance

TERMS OF REFERENCE

FATAL ACCIDENT INQUIRY REVIEW

Purpose and remit

The Cabinet Secretary announced an independent review to consider the Fatal Accident Inquiry system in Parliament on 23 January 2025 in response to the fatal accident inquiry into the deaths of Katie Allan and William Lindsay or Brown. Ms Constance restated that commitment in Parliament on 27 March 2025.

The purpose of this independent Review is to consider the Fatal Accident Inquiry system and make detailed and actionable recommendations which focus on improving the efficiency, effectiveness and trauma-informed nature of investigations into deaths in prison custody.

The Review will also identify the specific barriers that families face in engaging with the process and the timescales involved, identifying any improvements that can be made on both fronts.

Membership, timescales and reporting arrangements

The Review will be led by an independent Chair appointed by Scottish Ministers. The Chair will provide strategic direction and leadership to the Review.

It is anticipated that work will be supported by an advisory group recommended by the Chair and appointed by Scottish Ministers. The advisory group will provide input on the work of the Review, including its priorities and strategic direction. The Chair will decide how the aims of the Review should be prioritised and achieved. A report, which will be published, containing recommendations should be presented to the Scottish Government before the end of 2025.

Once a report and recommendations have been submitted prior to 31 Dec 2025, the Chair may consider that there are further areas that the Review may address. If so, Scottish Ministers may consider it appropriate to extend the appointment for up to five months, after which point, consideration of any further work would be a matter for the next Parliament.

The Review will engage with stakeholders as appropriate. Work undertaken may make use of Scottish Government analysis which will be provided at the outset of the group’s deliberations.

Sponsorship

The Review will be sponsored by the Civil Law and Legal System Division of the Scottish Government. They will advise the Chair and Secretariat on any issues (particularly financial or logistical) which cannot be resolved by the Secretariat. Updates from the Review will be submitted to the Sponsorship lead within the Civil Law and Legal System Division in the first instance, though periodic meetings between the Chair and the Cabinet Secretary for Justice and Home Affairs will also

be arranged. The Review may engage with the Scottish Government's Justice Analytical Service.

Secretariat support

Secretariat support for the Review will be provided by the Scottish Government. Relevant officials will report directly to the Chair for the duration of the Review and meet regularly to provide support in taking forward the work plan.