

Report finds that four people die in custody every week in Scotland

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A new report led by the University of Glasgow has revealed 244 people

have died while detained in custody or under the control of the state in a one-year period in Scotland—an average of four every week.

The research, which is the first of its kind to be carried out in Scotland, found most of these deaths occurred while people were detained under the Mental Health Act (144), 39 died after having contact with the police, and 38 died in prison between September 2022 and October 2023.

A further 14 "looked after children" died during the same period, four people died in detention centers for migrants or in housing for [asylum seekers](#), and three people with learning disabilities and autism died in hospital, while a further two died in police custody.

Authors of the [report](#), "Nothing to see here? Deaths in Scottish Custody 2023," which is published by the Scottish Center for Crime and Justice Research, said many of these deaths are going "unnoticed."

Sarah Armstrong, Professor of Criminology at the University of Glasgow, and co-author of the report said, "For the first time we are able to see the number of deaths across a range of settings for which the state has responsibility. Every week just in Scotland four people die, deaths that largely go unnoticed, and by far happen to and affect families with the least power.

"Each death is a tragedy but what makes it a public concern is the responsibility of the state for people's care. Given this, one would expect robust and public methods of investigation. Sadly, this does not seem to be the case for most deaths."

The research team also investigated 22 Fatal Accident Inquiries (FAIs) which are mandatory for people who have died in custody. Twenty involved a death in prison, one in police custody and another in

migration detention.

They found more than three-quarters of FAIs took longer than two years to complete and a third took more than three years. More than 90% of Inquiries concluded with neither a precaution nor a system defect which is consistent with previous years' findings.

Researcher and co-author Betsy Barkas said, "By looking at these specific FAIs we have learned harrowing details of the final days and hours of prisoners including young man who resorted to calling 999 from his cell because he was having a mental health crisis. Emergency services then tried to contact [prison staff](#) to carry out a welfare check, but no one picked up for 1 hour and twenty minutes. Even after speaking to [emergency services](#) prison staff didn't carry out the welfare check, but confiscated his phone. He was found hanged the following night.

"The Sheriff who presided over the Fatal Accident Inquiry, concluded the care provided to this prisoner was 'competent and compassionate' and that his death was unavoidable. No findings or recommendations means there were no lessons to be learned, or to put it simply, 'there's nothing to see here.'"

Professor Armstrong added, "These are not one-off cases but rather part of a worrying pattern. We identified reoccurring themes in these deaths such as inappropriate care for people with drug issues, ignoring medical histories when assessing suicide risk and delays in medical treatment. Of four suicides in prison investigated in FAIs, not a single one made identified any precautions, defects or made recommendations to prevent future deaths."

Barkas, said a new human rights approach to investigating deaths in custody with meaningful involvement of families and loved ones should be considered.

She said, "The current system shows evidence of limited involvement and disregard of families with Sheriffs declining to explore discrepancies between official accounts and family evidence. Families are often not represented in court or offered the chance to give evidence which leaves them feeling confused and alienated by the process."

"Many investigations are concluded based entirely on written evidence agreed in advance by the Crown and the parties responsible for the care of the person who died."

She added, "It is our belief that information about deaths in [custody](#) and how they are investigated should be more visible as a matter of public interest and state transparency in order to ensure these deaths no longer go unnoticed."

More information: Nothing to see here? Deaths in Scottish Custody 2023. [www.sccjr.ac.uk/publication/no ... is-in-scotland-2023/](http://www.sccjr.ac.uk/publication/no...is-in-scotland-2023/)

Provided by University of Glasgow

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