OFFICIAL REPORT
AITHISG OIFIGEIL

Criminal Justice Committee

Wednesday 20 September 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 20 September 2023

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CRIMINAL JUSTICE COMMITTEE
22nd Meeting 2023, Session 6

CONVENER

*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP)

DEPUTY CONVENER

*Russell Findlay (West Scotland) (Con)

COMMITTEE MEMBERS

Katy Clark (West Scotland) (Lab)
*Sharon Dowey (South Scotland) (Con)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
*Pauline McNeill (Glasgow) (Lab)
*John Swinney (Perthshire North) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Gill Imery (Deaths in Prison Custody Action Group)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 20 September 2023

[The Convener opened the meeting at 10:00]

Interests

The Convener (Audrey Nicoll): Good morning, and welcome to the 22nd meeting in 2023 of the Criminal Justice Committee. We have received apologies from Katy Clark.

Our first item of business is to welcome Sharon Dowey to her first meeting of the committee. I look forward to working with her. I invite her to declare any interests that are relevant to the committee's remit.

Sharon Dowey (South Scotland) (Con): Thank you. My husband is a retired police officer but, other than that, I have nothing to declare.

The Convener: I refer members to my entry in the register of members' interests in relation to agenda item 7, which is our approach to the Police (Ethics, Conduct and Scrutiny) (Scotland) Bill, albeit that we will discuss it in private. I am a former police officer.

Decision on Taking Business in Private

10:01

The Convener: Our next item of business is to decide whether to take items 6 and 7 in private. Do we agree to do so?

Members *indicated agreement.*

Deaths in Prison Custody

10:01

The Convener: Under the next item of business, we are to review the progress that is being made on improving the response to deaths in prison custody. I welcome Gill Imery, who is the external chair overseeing implementation of the independent review of the response to deaths in prison custody.

I refer members to paper 2, which contains background information on Gill Imery's work and a short summary setting out her views on the progress that is being made in response to the recommendations that are contained in the review report. I intend to run the evidence session for about 60 minutes, although we have a little bit of time in hand.

I invite Gill to make a short opening statement.

Gill Imery (Deaths in Prison Custody Action Group): Good morning. Thank you, convener and all members of the committee, for your continuing interest in the work. As you know, the independent review was published back in November 2021, and I was appointed the external chair in April 2022 to oversee the progress in implementing its recommendations.

I highlight the contribution that families made to the work. We have been privileged to hear the experience of families who have lost a son, daughter, father, brother or husband. People have given their time generously to explain their experience, with the aim of preventing other families from going through a similar experience in the future and of helping prison officers and staff who also experience trauma from responding to deaths in prison.

Although their contribution is generous, it is difficult to keep families motivated and to give them confidence that change is happening when the pace of change and improvement is so slow. I published a progress report in December last year, which was more than a year since the original review was published. At that time, only three of the recommendations had been implemented, with another being partially complete. That partially complete recommendation has now been implemented, as has one more, so a total of five recommendations have been implemented. We are fast approaching two years since the review was published.

That is not to say that there is not a lot of work going on to try to make improvements. The Scottish Prison Service has reviewed its internal process, and the revised process started at the end of August this year. The key recommendation working group started a pilot exercise for the revised process as recently as Monday of this week.

As you will remember, the key recommendation was to have a new investigative process—an independent investigation into every death. In Scotland, we already have that. We have an independent process in the form of the Lord Advocate, who is the independent head of investigation for all sudden and suspicious deaths, and every death in prison requires a fatal accident inquiry.

Fatal accident inquiries were outwith the terms of reference of the original review, and they are outside my remit, too. Nonetheless, when I have been discussing how to improve the response to deaths in prison, it has been unavoidable that people have expressed concerns—with which I agree—that FAIs take far too long and that communication with families is poor.

My opinion is that the key recommendation—which would introduce yet another process, with more expense—would not be required if the speed of the current FAI process and the quality of communication with families were improved.

The Convener: Thank you very much. Before I bring in other members, I will ask a general question about the expectation around timescales. There was one key recommendation and a number of other recommendations. Given that the recommendations apply across a system rather than across just one organisation, was there an expectation of how long might be considered reasonable for the recommendations to be implemented?

Gill Imery: I am not aware of a particular timescale for implementation being imposed. I think that it was acknowledged that some of the recommendations are complex and could reasonably take some time to implement. However, the work started in 2019—since then, some of the families have been involved, and four years is a long time for people not to see recommendations implemented and improvements made.

Some of the recommendations are not really problematic, in my opinion. I said that in the December progress report, and you will see from the updates that I have provided that, when a draft of that progress report went out in November last year, at least two of the recommendations that I said could be quite easily implemented were almost immediately then subject to a governors and managers action notice: a mandatory instruction from the chief executive of the Scottish Prison Service to make something happen. That was great, but it raises the question of why the SPS did not do that before.

The Convener: Absolutely. It is interesting that you say that, in your view, some of the recommendations should not have been particularly problematic to implement. Do you have a view on why progress was not made with those ones?

Gill Imery: It is very difficult to tell where the reluctance comes from. From the various meetings and discussions that I have had directly with people who work in the Scottish Prison Service, I think that they do care about the subject. However, I have picked up the impression that they do not necessarily agree with the review. I think that those in the service feel that they are being unfairly criticised—they are working as hard as they can and doing as much as possible to prevent deaths in prison, but such tragedies occur, and they do their best to respond when those situations arise.

I get the sense that there is some resistance to the findings of the review and that the service does not wholly embrace the idea that there is a need for change.

The Convener: I know that members will be looking more deeply into that aspect.

I am keen for our session to focus on progress on the recommendations, but it might be helpful to step back a bit first. As you said, given the size of the prison population in Scotland, it is, sadly, inevitable that there will be some deaths in the prison estate. It might be helpful if you were to outline a bit of context regarding the experience of mortality in prisons. What are the common underlying reasons, for example?

Gill Imery: That is a really important element, and the availability and analysis of such data has, sadly, been lacking in Scotland. We were pleased to be able to produce, in August this year, the first of what I hope will be a number of reports. It sought to analyse deaths in prison between 2012 and 2022. That is a reasonable starting point for analysis in order to gain a deeper understanding of the factors that contribute to deaths in prison.

Between those years, there was a high level of prison deaths—350—just under half of which could be attributed to suicide or were drug-related deaths. More than half were attributed to natural causes such as illness and disease.

I caution against an acceptance of the number of people succumbing to disease and illness in prison. There needs to be greater scrutiny of the quality and availability of the healthcare that is available to people in the prison estate, and of the availability of resources, not least the capacity of the prison escort system to take people out of an establishment to access appointments and treatment. The initial report was not able to look at that.

The Convener: Thank you very much. I will open up the session to members and hand over to Russell Findlay. Other members can indicate when they would like to come in.

Russell Findlay (West Scotland) (Con): First, I go back to the chronology of events. The Scottish Government commissioned the review in November 2021—

Gill Imery: It was in 2019.

Russell Findlay: In 2019—sorry. The review then reported in November 2021.

Gill Imery: That is correct.

Russell Findlay: It is now almost two years since then. The report contained 19 recommendations and six advisory points. To be clear, of those 25 in total, almost two years later, only five have been implemented.

Gill Imery: That is correct, although the total is actually 26, if we count the key recommendation. There is a key recommendation, along with 19 recommendations and six advisory points, and only five are complete.

Russell Findlay: Five out of 26. How do you feel about that? Do you feel frustration or surprise? What are your thoughts?

Gill Imery: Frustration would be a fair description; I do not think that I am surprised. Many of the recommendations are shared between the Scottish Prison Service and the national health service. The SPS has mentioned that there is a system and a hierarchy in which the chief executive can issue a governors and managers action notice, which is an instruction with which all governors must comply. I have already talked about being puzzled as to why that has not been employed more widely more quickly.

As for the NHS, there is a hard-working network in Scotland—the prison care network—which seeks to improve healthcare provision and achieve an element of consistency across the prison estate. However, that network does not have any power to make health boards implement the recommendations that are proposed. That is very frustrating, and it is difficult to see how the situation will improve.

10:15

Russell Findlay: If I understood your opening statement correctly, the key recommendation of the report is that there should be an entirely new system of investigating deaths in custody.

Gill Imery: That is correct.

Russell Findlay: However, if I understand correctly, you are of the view that that would not

be necessary if the fatal accident inquiry system was fixed.

Gill Imery: That is correct.

Russell Findlay: Concerns have been raised about that for almost a decade.

Where is the reluctance coming from? Is it the Scottish Government, the Crown Office or both? Is it coming from the blob? What is the problem with fixing the FAI process when it is clear that it is fundamentally flawed?

Gill Imery: The only people who do not think that there is a problem with fatal accident inquiries is the Crown Office.

Russell Findlay: Will it take ministers to start insisting that the Crown accepts that there is a problem and does something about it?

Gill Imery: Absolutely. The reticence and the difficulty there is that the Lord Advocate's position is entirely independent. For that reason, the process was deliberately excluded from the terms of reference of the review and is, as I said, outside my remit. I am reflecting to you my observations and the feedback that I have had from families who are directly affected by the system.

Russell Findlay: However, there is nothing stopping any Government from saying to the Crown Office, notwithstanding the Lord Advocate's independence and the Crown's independence, that it could impose, create or fix a system without impinging on that independence.

Gill Imery: Constitutionally, the Lord Advocate is entirely independent, so it would be very difficult for ministers, without a change in legislation, to impose mandatory timescales or something like that. However, that would help, given that there has been criticism for many years. Problems continue, so something needs to change.

Russell Findlay: Finally, there have been 350 deaths in custody since 2012, and 23 this year alone. You were due to meet the Cabinet Secretary for NHS Recovery, Health and Social Care and the Cabinet Secretary for Justice and Home Affairs in August, but the meeting was cancelled. You were then due to meet them in September, and that meeting was cancelled. A new meeting has been scheduled for 21 November. Do you know why those meetings were cancelled? That does not suggest to me that there is any great urgency to sit down and work out what needs to happen.

Gill Imery: I have just been told that there was other pressing parliamentary business on both those occasions, but it is disappointing. Only half an hour would be needed to draw the cabinet secretaries' attention to the matter. I was pleased that it was not just the cabinet secretary for justice but the cabinet secretary for health, because the two areas are inextricably linked on this topic.

There have now been 26 deaths this year, the most recent of which, sadly, was at the weekend. Twenty of those deaths have happened since May, so there has been an acceleration during this year.

Rona Mackay (Strathkelvin and Bearsden) (SNP): Good morning. I am trying to establish the process of the group. You say that there has been reluctance to accept some of the findings of the report. How often, if at all, did all parties meet round the table to discuss issues, and why did you get the impression that there was resistance?

Gill Imery: After I was appointed in April last year, I set up the death in prison custody action group, which is the overarching group with all the stakeholders and various partners present. Underneath that, the Government chairs the key recommendation working group, which again includes all the various partners around the table. I introduced the family reference group that I referred to in my opening remarks and a further working group, called the understanding and preventing deaths in prison working group, to look at the data.

The Prison Service is represented on all those groups, with the obvious exception of the family reference group, albeit that it has presented to the family reference group on a number of occasions about improvements that are under way. A family support booklet has been published and there will be a means for family members to contact a prison to express concern about a relative who is in prison. That is not yet established, although it is one of those things that do not seem to me to be hugely complicated or expensive.

The partners have all had ample opportunity to sit round a table together and every time there is an action group meeting, we seek updates from all parties, including the Prison Service and the NHS. We have a lot of detail on a spreadsheet that is available for public scrutiny.

Rona Mackay: On average, how many times a year do you have those meetings to get together and look at the data?

Gill Imery: I think that the action group has now met four times.

Rona Mackay: Four times this year?

Gill Imery: Four times since April 2022. There are also working groups underneath that, and the key recommendations working group. I would say that there have been at least a dozen meetings in those various iterations.

Rona Mackay: It seems that there are a lot of working groups. Is there a lack of communication?

Is the structure too layered, so that people are off in their own silos doing stuff but nothing is actually being done? How do you feel about that as the chair? Has your position been undermined by the delays?

Gill Imery: To answer your first point, I do not think that there is the excuse of any lack of opportunity to communicate effectively: there is constant communication to seek progress updates, populate spreadsheets and ask what is actually being done in relation to each of the recommendations.

I feel that it is difficult to continue having credibility in my position when the work is not having the impact that we would want it to have. When I came into the role, it seemed relatively straightforward because a huge amount of work had already been done—by others, not by me—to arrive at the 19 key recommendations and six advisory points, all of which had been accepted in principle by the Government. It should be a fairly straightforward task for me, as an external person, to oversee the implementation, but that has not proved to be the case, because everything is just very slow.

Rona Mackay: Could you have set a timeline or deadline for any of the implementation? Would it be within your remit to do that?

Gill Imery: Yes, absolutely, and we did that exact thing. I could show you the timeline, although it looks more complicated than it really is. We arrived at quite a high-level action plan, which I am happy to share with members, and we tried to impose deadlines of zero to nine months, nine to 18 months, 18 to 24 months and so on. I reflected on that in preparation for this meeting. In the nine-to-18-month period of the timeline, there are only two things that I could put a tentative tick beside, and there are none in the 18-to-24-month period.

Rona Mackay: Did you get any robust explanation from the groups as to why implementation did not happen, or did it just not happen and there was no comeback on that?

Gill Imery: There are lots of pressures on the system. There are lots of competing priorities—particularly in the NHS—and I have made positive comments about the national prison care network; people work very hard in that. That network sits under a Scottish health and custody network, and the chairs of both networks are very hard-working and enthusiastic people and have very small teams to support them. However, I have to say that, having tried very hard to get access to NHS chief executives and having ultimately got time at one of their private chief executive meetings, I have rarely experienced such a lack of interest in a piece of work in all of my 36 years of public service.

Pauline McNeill (Glasgow) (Lab): Good morning. What you said there is very concerning. With 350 deaths and numerous cases that members of the Parliament have taken on—such as the death of Alan Marshall, who was on remand in our care, and Katie Allan, a young woman who took her own life in Polmont—it is shocking to hear that.

All of the recommendations in the "Independent Review of the Response to Deaths in Prison Custody" seemed to be good ones, but what you told us—that very few of them have been pursued—is staggering.

There are two cases that I want to ask you about. I have had some involvement with Katie Allan's case. I met her family and understand that, through freedom of information requests and meetings, they received a commitment from the then Cabinet Secretary for Justice on the removal of ligatures from the prison estate, but they are led to believe that cost is preventing that from happening. Do you have any comment to make to the committee about that?

Gill Imery: That recommendation has now been implemented. There was a recommendation that suggested the introduction of privacy screens and the availability of ligature cutters, and in December last year that was partially complete: the screens had been made available, but ligature cutters had not. However, I have been told that ligature cutters have now also been procured and made available, so that recommendation is now fully implemented.

There is an issue with who goes in and checks to see that the improvement that has been reported is actually in place and that the systems are working. My role does not extend to that. Actually, my role will cease at the end of this year, anyway, so some consideration needs to be given to what the scrutiny mechanism should be, what the on-going monitoring process is and how people will be reassured that the improvements—some of which are very practical and straightforward things—have actually been achieved.

Pauline McNeill: That is some good news.

The second question that I will ask relates to the recommendation for unfettered access to information following a death in police custody, which is critically important; it is a question that I put to the cabinet secretary at the time. Given what you said about the exclusion of the Crown—in the case of Alan Marshall, as you are aware, the Crown took a decision not to prosecute any of the 13 officers who held him down before he died in an attempt to get answers at the FAI, but it took seven years to get there—is it possible for that unfettered access to happen? Families want to go in and get information; they do not want to be told

that they cannot go in or collect belongings or see what happened.

I thought that the recommendation was interesting, because, if there was a police investigation into a death, how could that commitment be made? However, the cabinet secretary made it. Is it possible to devise such a system? In this case, the family's view was that there was a cover-up. They would have preferred to have found out exactly what had happened so that they would at least have had their own answers before the FAI. Would it be possible for that to happen without the Crown's involvement?

10:30

Gill Imery: The short answer is no. The pilot that started, as I said, as recently as this week is probing exactly those complex issues about how information can be shared without compromising a future process. A fatal accident inquiry's purpose is to establish a cause of death, not to attribute blame to any party. If that process were to occur more swiftly, with more effective and more sympathetic communication with families, that would achieve the aim of the key recommendation, and it would allow access to information.

Pauline McNeill: If such a thing could be done—the timescale could be two years following the death, which I do not think is unreasonable—and families felt that they would get answers within 24 months, they might feel less concerned about getting immediate access to information. Do you agree?

Gill Imery: I completely agree. Family members have told me that they get the feeling that they are somehow the enemy or a risk, or that there is anxiety and fear about telling families what might have happened in case someone is blamed later on. I have been quite humbled to listen to how concerned family members are not just about their own family and other families in future but about prison officers and other staff. They know how traumatic such situations are, and they also feel sympathy for prison officers and other staff who have to deal with them.

Pauline McNeill: Thank you very much.

John Swinney (Perthshire North) (SNP): Good morning. I would like to follow on from where Pauline McNeill left off and ask about the interaction between the proposed investigation that would take place and a fatal accident inquiry. Has any thought been given to whether it is possible to have the type of comprehensive independent investigation that has been proposed—I completely understand the rationale for it—while a fatal accident inquiry is pending? We often rub up against the necessity of leaving things until the statutory process that, as you quite correctly say, has to take place in relation to a death in custody has taken place. Has there been any interaction between the group and the Crown on the sequencing of all this?

Gill Imery: Yes. The Crown has been represented at all the groups that I have spoken about—including, specifically, the working group on the implementation of the key recommendation—and it has been closely involved in the revised process that is being piloted. The pilot, which is being led by His Majesty's Inspectorate of Prisons for Scotland, will be a desktop exercise that will look into cases that are complete, in the sense that a fatal accident inquiry has already taken place. That set of circumstances will be used to test the new process.

The Scottish Prison Service has its internal review process, which is the death in prison learning, audit and review, or DIPLAR; the NHS has its internal process, which is the significant adverse event review; and the police investigation reports under the instruction of the Lord Advocate. The key recommendation is to introduce a fourth investigative process or review, and it implies that a new body should carry that out, but it would be quite unrealistic to achieve that in the current climate.

John Swinney: I listened to what you said in your responses to Pauline McNeill in particular about the perspective of families. Quite understandably, families want early information. A period of 24 months seems to me to be an awful long time to wait for information.

Gill Imery: It is a lot shorter than the period for which they have to wait at the moment.

John Swinney: But it still seems like an awful long time. What are the timescales for the scrutiny processes that are undertaken by the Scottish Prison Service and the national health service? Are those processes swifter than an FAI?

Gill Imery: Yes. They are introduced much more quickly but, until the review and the push for its recommendations to be implemented, the families sometimes did not even know that a DIPLAR was taking place and they were not involved in the process in any way. The revised process that was brought in last month puts an emphasis on family involvement and families having a point of contact—a liaison person—so that they have an opportunity to ask questions about the death of their loved one.

John Swinney: As you properly said, the arrangements for a fatal accident inquiry are entirely matters for the Crown, as FAIs are carried out independently of the Scottish ministers. Notwithstanding the issues in relation to those

arrangements, I am interested in whether a pragmatic adaptation of the processes that are undertaken by the SPS and the NHS could be carried out timeously so that families would get early, prompt, thorough and courteous engagement on the circumstances of the death of a loved one.

Gill Imery: I agree that the Scottish Prison Service's process and the NHS's process hold the potential to meet the needs of families for more prompt answers and more sympathetic and respectful communication.

John Swinney: I want to move on to the composition of the deaths in prison custody action group. Do you think that everyone is rowing in the same direction?

Gill Imery: I think that we have had good representation from the various agencies on that action group.

John Swinney: That is not quite what I am asking. Is everyone on board?

Gill Imery: There is a reticence on the part of the Prison Service about genuinely embracing the review, welcoming it and recognising that something really does need to change. At times, I have felt slightly humoured; at other times, I have felt slightly patronised, with the suggestion being that I do not understand how difficult it is. It is absolutely a challenging environment in which to work, and the system is under pressure.

However, I keep returning to what I feel is one of the most compelling parts of my duty, which is to the families of people who have died. It is very hard to sit in a room with relatives who are bereaved and ask them to give their time and repeat their experiences over and over again without getting the result that they are looking for, which is improvement for other families and, indeed, answers in relation to their own situations.

Therefore, I have felt that, at times, some people have not been pulling in the same direction. I also think that the Crown Office and Procurator Fiscal Service does not think that there is a problem with the fatal accident process. When I put out the draft of the progress report in November last year, the Crown Office immediately came back and asked me to remove the reference to fatal accident inquiries on the ground that it was not in my remit, so I had no business commenting on it. I refused to remove it because, as I am doing with you today, I am reflecting the feedback that I have had and the observations that I have made as an independent person, which have some validity.

John Swinney: Thank you for that. I was struck by your remark that you were cautious about relying on the data about, to summarise what you said, 50 per cent of deaths in custody arising from what one might describe as illness or natural causes. I understand your point about being cautious about that data, because it opens up a discussion about the extent to which being incarcerated exacerbates the decline in individuals' health and, therefore, what society must do to address that point. Am I correctly understanding the substance behind the point that you make in that observation?

Gill Imery: Absolutely. The lack of scrutiny of the availability and quality of healthcare across the prison estate is a national disgrace. Little scrutiny is applied to what healthcare is applied to people, some of whom already have complex needs. In the care of the state, people should access better healthcare than they ever would in the community because they are literally a captive audience for health interventions, but that does not appear to happen.

John Swinney: Has that perspective been the subject of discussion at the custody action group, given that you have the Prison Service, the national health service and Healthcare Improvement Scotland, among others, around that table?

Gill Imery: It has been discussed. The national prison care network is motivated to try to achieve consistency across the prison estate. However, I feel that NHS boards do not necessarily wholly embrace the priority that should be given to members of the community from every health board who could find themselves in prison. It is not just a matter for the health boards that have prisons physically located in their geographic areas; it is for every health board. However, as I have mentioned, no matter how hard working and well-meaning it is, the network does not have a mandate to make health boards take on the responsibility for healthcare provision in prisons.

Sharon Dowey: You have already answered a few of the questions that I wanted to ask.

You said that five of the recommendations had been implemented. In written communication with the committee, you said that one of the recommendations

"could be said to be addressed".

Are five of them now fully implemented or is one of them still being addressed?

Gill Imery: Five of them are now complete. It may be that I have used a different word.

Sharon Dowey: That is fine. Could you tell me which recommendations have been completed?

Gill Imery: Absolutely.

Sharon Dowey: Even if you could just tell me what numbers they are—I have the numbers here—that would be fine.

Gill Imery: I can absolutely do that, because I anticipated that question. However, where I have put that information in my notes is a different matter.

Sharon Dowey: I can come back to that.

10:45

Gill Imery: No—it is absolutely fine. Recommendation 1.4, which is on next of kin, has been implemented. That was one of the three that were in the progress report last year. I discussed recommendation 2.2 with Ms McNeill; it is about the provision of ligature cutters and screens. That has been implemented, as has recommendation 3.1, which is about the governor in charge being in contact with families. Recommendation 3.3 is on the family support booklet, which, as I said, has been implemented. Recommendation 5.4, which is that the Prison Service should conduct the DIPLAR internal review process for all deaths, has also been implemented. Those five recommendations have been implemented.

Sharon Dowey: I was going to ask you about an action plan for the rest of the recommendations. You have already mentioned that, but do the Scottish Prison Service and the NHS have an action plan that gives a timescale for when they think that each of those recommendations will be implemented? Is there someone who is accountable for making sure that that is actioned?

Gill Imery: We have pushed hard to get updates. As I have explained, we have sought updates at every stage. When another action group meeting is pending, we seek an update in order to be able to populate a spreadsheet and make it publicly available to show the various activities that are under way. There are timescales, but they slip. You can see from the briefings that I provided in June this year and at the start of this month that it was anticipated that certain things would be available, but that did not happen until much later.

Responsible people have now been identified in every health board for healthcare in prison. We have yet to see that manifest in change, but I hope that that will help. The network that I mentioned is at an advanced stage of producing a toolkit to achieve consistency of response to deaths in prison across the prison estate. Health boards are obviously pivotal to making that a reality across the country.

We keep pushing for timescales, but they tend to slip.

Sharon Dowey: Is somebody accountable for those areas in the SPS and the NHS? Is there somebody to whom you could write to ask how they are progressing with, say, recommendation 3.2?

Gill Imery: There are named people, but there are limitations to their mandate. That is what I explained in relation to the national prison network. There are named people who are working hard in that network, but they cannot make the chief executives implement the recommendations.

After the progress report was published on 14 December last year, the then cabinet secretaries for health and justice wrote to the chief executive of the prison service and all the NHS chief executives on 18 December and told them to prioritise that work. Unfortunately, that has not quite had the effect that was hoped for.

Sharon Dowey: I also wanted to ask about the cancelled meetings, which Russell Findlay mentioned. Another thing that I noted in your submission was that you are due to finish in your role in November. How many meetings have you had with the cabinet secretaries since you took up your post?

Gill Imery: One.

Sharon Dowey: Was that with both cabinet secretaries or just one?

Gill Imery: With both, in November last year.

Sharon Dowey: Have you had any written communication with them since then?

Gill Imery: No—not apart from the progress report in December.

Sharon Dowey: What will happen with your post in November? Will you be kept on, or will the post end? Have you had any communication on that?

Gill Imery: No. I have certainly agreed to stay until the end of the year, so I will have time to produce another report. I would call it a final report, but it will be final only in the sense that it will be the last report from me, not in the sense—I am pretty sure—that all the recommendations will be complete.

The rationale for bringing in someone external was to provide some impetus for the implementation of the recommendations. I think that it is difficult to justify keeping someone on in that capacity beyond two years after a report has been published.

Sharon Dowey: What do you think is going to happen after you leave? As you said, progress in the past two years has been slow, and you are trying to keep pushing it on.

Gill Imery: My biggest concern is for those family representatives who have given their time and gone through the triggering process of not just telling their own stories but listening to other families' experiences. They might feel that I have let them down, because I will not be able to look them in the eye and say, "I came in to do this, and I've done it."

The responsibility then falls to the statutory bodies, most obviously HM Inspectorate of Prisons for Scotland. Again, however, there is limited resource there to drive the scrutiny. I have spoken to other groups such as the National Preventive Mechanism, which is a network of scrutiny bodies for people deprived of their liberty, to raise the question of whether they feel that they have some capacity to monitor and keep some pressure on to get the recommendations implemented.

Healthcare Improvement Scotland should, I think, look much more regularly at the quality and availability of healthcare in prisons. HIS participates in the joint inspections that are led by HM Inspectorate of Prisons, but those involve only two or three establishments a year.

Sharon Dowey: To go back to what you said, nobody has spoken to you about extending your term, and you do not know whether anybody else is coming in. What do you think needs to happen to increase the pace of implementation?

Gill Imery: There absolutely needs to be continued scrutiny, and somebody needs to be driving the activity. However, having been in the role since April last year, I am not sure that bringing in another external chair will make any difference.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Good morning. I will follow on from where Sharon Dowey left off. I think that we can all hear today the passion in your voice for this piece of work, which is probably prompted by your time coming to an end, with the process not being as complete as you would like—that is probably an understatement.

In many ways—I am putting words in your mouth here; this might be a bit extreme—it almost feels as though your contacting the committee and coming back to committee today is a wee bit of a cry for help in relation to this piece of work. What do you think that the committee can do to help to progress the recommendations that you have made? You have made your case very powerfully today.

Gill Imery: Thank you. I think that if you had the time to invite some of the people who are responsible for delivering on the recommendations to come and speak to you, that would be helpful, as you could have a direct exchange about what it is that is making implementation so difficult to achieve.

Many of the recommendations have not been implemented yet, but that is not insurmountable—in total, there are 20 recommendations and six advisory points that, as a country, we should be capable of achieving for people who are literally without power, imprisoned in our country's prison estate.

Fulton MacGregor: You have certainly given us a lot of food for thought when we come to discuss what we have heard today.

There are two wee points that I want to ask about—well, they are wee in terms of the evidence session, but they are not small by any means. During the pandemic, there was an increase in the number of deaths in prison. John Swinney asked about that. Did you ever get any information, or was information ever released as part of the work that you did, about what caused those deaths? Did they relate to the pandemic—either the virus or the restrictions? Did you ever get a feel for that?

Gill Imery: No, I did not. The number of deaths peaked at 53 in, I think, 2021, so there was a noticeable increase. However, I have not seen any further analytical work to establish what that was about. As I said, the report that was published in August should be just the starting point. More analysis of those deaths should be carried out by comparing the trends in prison with trends among the general population, with a view to trying to understand the factors so that interventions can be made to prevent deaths in the future.

Fulton MacGregor: On a similar point, you mentioned that there had been an increase in the number of deaths over the summer, since May. Is there any analysis of why that has happened?

Gill Imery: No, there is not, but you will have heard about pressures in the system and increases in the prison population, so it will be interesting to see what the factors are. It is concerning that the level of deaths is increasing over time.

Fulton MacGregor: Thank you very much for your evidence.

Russell Findlay: I have two very quick questions. First, the Scottish Government will be watching this evidence session and will have read your submissions. If it were possible for your tenure to be extended for, say, 12 months, would you consider staying on, or are you completely scunnered and have you had enough? Is staying on an option?

Gill Imery: I would be willing to continue to try to help, if I could, but I would temper that enthusiasm by noting the reality of how much I

have managed to achieve so far. I would not say no.

Russell Findlay: I will return to the fundamentals. The fatal accident inquiry system is central to investigating deaths in custody, but you and others involved in the review were told that you could not even look at that system. You, quite rightly, said that that was ridiculous and you did look at it. Uniquely, the Crown Office seems to think that fatal accident inquiries are fine, despite the abundance of evidence of all the misery and pain that they cause, in addition to that caused by the deaths that have occurred.

Given the reluctance or the inability to fix the FAI system, we are left with one key recommendation—one that you would rather not be enacted but that is surely the direction of travel and that, at some point, might be enacted. Has any work been done on, or have there been any discussions about, the cost of setting up a new organisation that would deal specifically with deaths in custody?

Gill Imery: Not to my knowledge. When looking at how the organisation might coexist with the three existing processes, I was very aware of how much more pressure would be put on the public purse and of the inherent difficulties of asking families, prison officers and other staff to comply with potentially four processes, not just three.

Russell Findlay: Thank you very much.

11:00

John Swinney: I will follow up on the point that Russell Findlay just advanced in relation to the adequacy of the immediate SPS review—I will call it the immediate review—and the immediate health service review of a death in custody. I understand that by statute there is a requirement for a fatal accident inquiry to be undertaken when somebody dies in legal custody. From the perspective of addressing the needs of the families, which you have powerfully put to us this morning, could those processes—I am not sure whether you are familiar with the content of those processes—provide sufficient information in advance of a fatal accident inquiry to, in essence, avoid the need for a fourth process to be added to the system?

Gill Imery: They could; the revised process that I mentioned started at the end of August this year. An instruction was issued for all governors in all establishments in Scotland to introduce the new revised DIPLAR process, which prioritises liaison with families. I understand that that will be evaluated and reviewed in February next year. There will have been the opportunity to try it in real time and, obviously, it would be a great improvement if that delivered what it is hoped it will deliver.

On the NHS side, the network is at an advanced stage of providing national guidance—it is being called a toolkit—on how a serious adverse event review should be carried out in response to a death in prison. The issue there is to ensure that all NHS boards implement the toolkit. I hope that the fact that there is now an executive lead in every health board for prison care will ensure that the toolkit is implemented.

Those two parts should improve and enhance the existing internal processes of review for the prison service and the NHS. I certainly would not say that that would negate the need for improvement in the FAI process; that improvement is also absolutely required.

John Swinney: Does the improvement of those two processes provide you with sufficient confidence that, in theory, they would substantively address some of the early issues that families may have in the absence of a fatal accident inquiry being able to be undertaken in a timeous fashion?

Gill Imery: Yes; in theory, those improvements give me confidence. All that families want is a few answers to perfectly reasonable questions about what happened to their loved one in prison—that is all that they want.

John Swinney: I understand; thank you very much.

The Convener: We are just about up to time. I will stay with the key recommendation on an additional independent review process. I note in the review report the context around the needs of families, which we have discussed robustly this morning. I noticed in the review that there was reference to the fact that that change—creating another independent process—

"would bring Scotland into line with practice in other jurisdictions including England, Wales, and Northern Ireland."

I know that it is not just a case of taking a model from somewhere else and slotting it into our policies and processes, but I wonder whether any work was done to look at that practice and whether there was a feeling that there was good learning from that that could realistically form part of a new process in Scotland—bearing in mind what we have discussed about the other option of, potentially, looking at the existing processes and making some changes to them?

Gill Imery: The Government has engaged with relevant people in other jurisdictions to understand their approaches and to try and take any good practice and learning from elsewhere to bring to bear on the review of processes here. So, yes, absolutely, there is an interest in and efforts have been made to look at approaches elsewhere.

Obviously, the big difference in Scotland is the role of the Lord Advocate.

The Convener: Indeed. I have one final question about the feelings of families, as things stand, in respect of the slow pace of implementation of the recommendations. You clearly have close contact with families. What do they feel about where we are now?

Gill Imery: They are disappointed and frustrated by the lack of real change. Some of the families have been involved since the review was commissioned in 2019, so it has been nearly four years and not much has changed.

They have been remarkably resilient in continuing to attend the various meetings. Representatives from the families attend every one of the groups that I have mentioned. That is because when I started, there was so little trust on the part of the families in what they were being told that they wanted to have someone in the room at every meeting of every group—and they have that.

They are encouraged, to some extent, that the committee is interested and wants to hear more about the review, although they would rather have answers to the questions on each of their individual cases. More generally, they want to see improvements for other families in future and to prevent future deaths.

The Convener: I will bring the session to a close. I thank you very much for attending. There will be a short suspension to allow us to have a comfort break and to allow Gill Imery to leave.

Gill Imery: Thank you, convener; and thank you, everyone, for your interest.

11:08

Meeting suspended.

11:15

On resuming—

Domestic Abuse (Scotland) Act 2018: Post-legislative Scrutiny

The Convener: Our next item of business is to review the Scottish Government's response to our post-legislative inquiry on the Domestic Abuse (Scotland) Act 2018. I refer members to paper 3. I invite members to come in with any comments or points that they would like to make on the Scottish Government's response, or to give any suggestions for further follow up.

Russell Findlay: I have a few points to make. One of the most important is on the statutory aggravator relating to the involvement of a child in a domestic abuse incident. Our report, which made eight recommendations, is perhaps key. We said that that aggravator is not really being measured, and that it is not clear how well it is being used; we do not really know. It is hard to work out the detail, and it is not entirely clear how that aggravator is being used. The response to that point in the report is a little bit vague. It talks in generalities and does not really say what exactly the Government is doing to address the issue.

My second point relates to communication to the public. Our report also made the recommendation that the previous public awareness campaign was quite effective, and it suggested that something similar could be done again, because people might not realise what the legislation does. Again, the word that I have used in my notes to describe the response from the minister is "vague." The Government's response says:

"There is consideration of a campaign to address these issues."

It would be nice to know whether something material is happening in respect of both those points.

The Convener: The aggravator is clearly an operational issue and whether it is appropriate to include it would be at officers' discretion, but I note your point.

My recollection is that we were quite keen that something like a public awareness campaign be explored because there are previous indications that that would be quite effective.

Russell Findlay: To come back to the point about the aggravator, I note that the minister said that the Government will

"publish more detailed statistical information"

at some point "Later this year". It would be nice to know when that will be. There is quite a lot of evidence in the report from witnesses saying that the aggravator has not been used properly and that it is not clear when and how it is being used. It is hard to assess how well it is being used. The

frustration is that the Government could not get the data, so it would be nice to pin it down a bit more on that.

The Convener: I am happy to go back and stress that we are keen to ensure that that issue is incorporated in the report.

Rona Mackay: I have not had the chance to read the domestic abuse and stalking charges report that was published on 12 September, but I look forward to reading that, because I think that it will bring up a lot of information.

I am not clear whether there are statistics on the coercive element of the act in the main findings of the report. I am not sure whether the statistics that are used include those that are related to the new statutory offence of

"a course of behaviour which is abusive of the person's partner or ex-partner"

that might be considered to be coercive. The report does not state that; I would quite like to know whether that is the case.

I am interested in the stalking charges. The paper says:

"921 stalking charges … were reported to"

the Crown Office and Procurator Fiscal Service and,

"Of these, 485 … were identified as domestic abuse."

Those are really useful statistics to have but, once I have read the full report, I will be better informed.

Pauline McNeill: Following what Rona Mackay has said, I would be interested in spending more time looking at the stalking charges. That offence is broader than domestic abuse and there are issues, with victims having reported failures in the system in relation to the law on that—but that is for another day.

Are we to assume from the paper that the changes under item 3 have already happened or been agreed? The list includes

"creating a standard condition of bail … placing a restriction on granting bail"

and

"allowing certain ... evidence".

The paper says:

"The 2018 Act created a new offence of engaging in an abusive course of conduct ... For example, when a child sees, hears or is present during a domestic abuse incident."

That is the point that Russell Findlay raised. It then says, "Further changes included" and lists changes. Are we to assume that those changes have all happened?

The Convener: Are you referring to paragraph 3 in the paper?

Pauline McNeill: Yes.

Stephen Imrie (Clerk): I will need to check for you, Ms McNeill. The act was passed in 2018. I am not aware that there are provisions in it that are not yet in force. I believe that the changes are in force, but I will clarify that for you.

Pauline McNeill: That is what I thought. If the top ones in the list have not been implemented, they would require further discussion. The bottom three are:

"applying certain special measures aimed at protecting child witnesses … requiring the court to consider the future protection of the victim when sentencing an offender … and telling the court to always consider making a non-harassment order ... against a person convicted of a domestic abuse offence."

That last one is really important because, until now, complainers in many cases have had to seek an interdict under one of the civil processes, which is costly for most people. It would be helpful to clarify whether those are just recommendations.

The Convener: That is fine. We can check that.

Sharon Dowey: All the way through the Scottish Government response, I have written "When?" There are a lot of actions in the response but no dates for when they will be achieved. It says things like "later this year", "we will reconvene", and that work will

"inform future consideration of a campaign to address these issues."

There are no dates on when anything will happen, so I would be interested to see that. Does a report being published "later this year" mean 31 December or can we expect it before that?

I am new to the committee, so I want to ask something about sentencing. For an outsider looking in, it seems that a lot of the issues in the press are about sentencing. Is anything being done with the Scottish Sentencing Council on the sentences that are being given out? I know that there are questions about under-25s.

The Convener: You are right that no specific date is included in the response, but my interpretation of

"We will publish a final report later this year"

is that it would be by the end of the year. However, we can monitor that.

The Scottish Sentencing Council is independent, so the matter is more about tracking the policy on sentencing for domestic abuse and violence against women. I assume that that will be included in the further response that we get.

Russell Findlay: Paragraph 89 of our report mentions that we took evidence about how, with some domestic abuse cases that are being heard in the criminal courts, a civil case is running in tandem. Often, an abuser will use one or the other to continue the abuse, so our recommendation was that the Government consider and come back with a view on using a single-sheriff model when civil and criminal cases operate simultaneously. The response from the cabinet secretary is not satisfactory. It talks generally about "joined-up" thinking and uses the dreaded phrase, "a series of workshops." It does not say whether the Government agrees or disagrees with the proposal, even in principle, and it does not give any indication as to what will happen next—if anything. The response ends by talking about child contact centres, which is a completely different subject and therefore looks like padding.

The Convener: Thanks for that—I remember that we raised that valid point. Consideration of that model is, potentially, quite a big piece of work to undertake, but we can ask more questions, because it is a valid point.

Russell Findlay: Maybe the Government does not want to go down that road and maybe there are no plans to do so; in that case, it should just tell us.

The Convener: There are no more points on that subject, so we can ask the Scottish Government for a wee bit more detail on the points that have been raised this morning. Another option might be to reach out to witnesses whom we engaged with during that piece of work to seek updates or their reflections on progress. Are members happy with those actions?

Members *indicated agreement.*

Fireworks and Pyrotechnic Articles (Scotland) Act 2022

11:26

The Convener: The final item in public session is consideration of a letter from the Minister for Victims and Community Safety on the issue of misuse of pyrotechnic devices at football matches and other events. Members will recall that we wrote to ask the minister whether the police can prevent someone who is detained after being found with such a device from simply going into the ground after they are released after a search. We also asked whether football banning orders can be used.

The minister replied on both points, and her letter is set out in paper 4. I am pleased that we raised the matter, because we highlighted an issue that the Scottish Government has indicated it is now considering how to resolve.

I ask members to comment and say whether they agree with my suggestion that we now give the Scottish Government a bit of time to come back to us with a response and any plans in that regard.

Russell Findlay: Maybe this is clear, but I do not know whether we know and, more important, whether the public know, what the timeline is for implementation of the legislation, which was brought in quite quickly on the basis of needing to address the issue of proxy purchasing of fireworks for under-18s. The expected timelines for implementation of firework control zones, licensing and so on have already been put back.

I think that there was a suggestion in the letter from the minister that it is still the Government's intention to implement a key part of the legislation this year—I think that it was the provision on firework control zones—but it seems to be pretty unlikely that that is going to happen, given that we do not know what different authorities are doing and how that looks. Are we up to speed on a timeline? Forgive me if we are, and I do not know that.

The Convener: Your question is about the broader issue of implementation of the legislation; we know that there have been challenges in and delays to the timescales. I understand that the minister is aware that we maintain an interest in that and has undertaken to keep the committee informed—specifically about the issues that you have raised, of firework control zones and the licensing scheme. I know that members are very interested in those matters but, for today, I am interested in ensuring that members are content with the response that we have received on the

specific points that we raised in connection with football banning orders and the actions of an individual on release from being detained by police after being found to be in possession of a pyrotechnic device.

I am quite keen to maintain that focus, but I absolutely understand the points that Russell Findlay has made, which are, I think, reflected around the room.

Pauline McNeill: Reading the letter takes me back to an issue that the committee raised previously, which was that the legislation felt really rushed. The relationship between football banning orders and the legislation should have been clear. Far be it from me to say it, but surely the role of lawyers and Government officials when they are drafting legislation is to match it up with all other legislation. There is an obvious relationship in this case, and we are asking the question with hindsight, and the minister is having to answer that question.

Although the minister is correct to say that it is a matter for the courts, it is for the Parliament to determine what it wants when it legislates. I would have thought that, to a party and to a person, what we wanted was to give maximum powers to arrest people for use of pyrotechnic devices at football matches, which is extremely disruptive. We are now trying to fix the issue with hindsight. It probably should have been drawn to the committee's attention that the legislation might have a relationship with a pre-existing act. It would not have occurred to me.

The Convener: I cannot speak on behalf of the Government in relation to the preparation process for the bill, but I absolutely acknowledge your point. I am pleased that we have now highlighted the issue and that some work is under way on it.

Sharon Dowey: My question follows on from Pauline's. What would the penalty be for repeated convictions for possession of pyrotechnic articles? Section 4(2) of the Fireworks and Pyrotechnic Articles (Scotland) Act 2022 states that

"A person who commits an offence"—

who is found with fireworks in their possession but does not have a licence—

"is liable ... to imprisonment for a term not exceeding 6 months".

I wonder whether the penalty would be the same, but we have the presumption against sentences of less than 12 months, so is that relevant?

The Convener: I cannot answer that off the top of my head.

Sharon Dowey: I know—it is just a question to ask.

The Convener: We can look at that. I cannot answer off the top of my head, but I am happy to take that away as an action point.

If there are no further questions, are members content that we give the Government a wee bit of time to come back to us?

Members *indicated agreement.*

The Convener: That concludes our business in public. Next week, we will begin our stage 1 evidence taking on the Victims, Witnesses and Justice Reform (Scotland) Bill, and we will hear from the Cabinet Secretary for Justice and Home Affairs.

11:33

Meeting continued in private until 12:09.

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