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Investigating deaths in prison

A guide to a human rights-based approach

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Cover photo: Nurses in the men's section of Fleury-Mérogis Prison, France.
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Contents

Introduction

Investigating deaths in prisons is an essential part of a state's human rights responsibilities, including the obligation to guarantee the right to life and the prohibition of torture and other cruel, inhuman or degrading treatment or punishment.[1] Investigations of deaths in prisons provide crucial evidence to find out what went wrong, provide redress to families,[2] improve prison management and ultimately prevent future deaths. Human rights standards have stressed that effective investigations must be independent and impartial, prompt and ex oficio, thorough and transparent.[3] If investigations do not meet these requirements, in many cases the reasons and details surrounding an individual's death will remain uncertain, including any potential liabilities and factors that may have played a role.

This guide by Penal Reform International (PRI) and the University of Nottingham provides prison authorities, policy makers, law enforcement officials, and families of persons deprived of liberty guidance and analysis on the basic features of human rights-based investigations into deaths in prison. It sets out key international and regional jurisprudence and includes **recommendations** to assist in designing and implementing an effective investigation system, as well as promising practices to inspire authorities to develop and implement reforms.

While this guide focuses on the investigation of deaths in prisons, the guidance and examples described can also be relevant to deaths that occur in other custodial settings.

> "With very rare exception, almost every life lost in our sample could be deemed a preventable death.[4]"

Methodology

This guide is based on research on policies and practices for investigations of prison deaths in 19 countries worldwide,[5] conducted through desk-based and qualitative analysis with a focus on presenting a wide range of examples, rather than a full description of specific systems in any country or jurisdiction. To gain a more comprehensive understanding of the main challenges and learning across all of the world's regions, primary research by PRI included 15 interviews with prison authorities, national human rights institutions (NHRIs), persons who have lived experience of imprisonment, and legal practitioners from Chile, France, Kenya, Mexico, Portugal, Senegal and Turkey. These six countries were chosen based on diversity of contexts in terms of prison systems, populations and frameworks for investigations, as well as geographical representation and availability of relevant actors.

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1. General Assembly, *International Covenant on Civil and Political Rights*, Resolution 2200A (XXI), 16 December 1966 , Articles 6-7.
2. Family should be understood in a wider sense than only formal ties or kinship. Family can also be close friends, partners and other individuals having a connection and caring link with the deceased. See, Edward Kirton-Darling, E., 'Family in the Driving Seat' in *Death, Family and the Law: The Contemporary Inquest in Context*, 2022, pp. 122-147, Bristol University Press. See also Philippa Tomczak and Elizabeth A. Cook, 'Bereaved Family 'Involvement' in (Prisoner) Death Investigations: Whose 'Satisfaction'?', *Social & Legal Studies*, 32(2), 2023, 294-317.
3. Office of the United Nations High Commissioner for Human Rights, *The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016)*, 2017 (hereinafter the 'Minnesota Protocol'), pp. 7-8.
4. In relation to 186 lives lost between 2014 and 2021 in the custody of correctional facilities in Ontario, Canada. *An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody*, January 2023.
5. Argentina, Australia, Canada, Chile, Colombia, France, Japan, Jordan, Kenya, Korea, Mexico, Panama, Peru, Philippines, Portugal, Spain, Türkiye, United Kingdom, and United States.

Context: deaths in prison

Prison populations have higher mortality rates than people in the outside community.[6] Research by PRI and others has shown the leading causes of deaths in prison include interpersonal violence, suicide, infectious and non-communicable diseases, and torture and ill-treatment. Contributing factors include environmental issues such as poor conditions of detention, including those resulting from prison overcrowding, and inadequate access to healthcare.[7] The disproportionate number of deaths in prisons and the lack of institutional responses to prevent them raise serious concerns for human rights, public health, and prison management.[8]

Research has stressed that disaggregated information on who is dying in prison, and why, remains scarce. This is a critical gap in understanding the circumstances and causes of deaths in prison, and ultimately reducing their number.[9] Official information is often unreliable or lacking and, in some places, academia and civil society organisations have to be relied on to fill the knowledge gap. Other issues relate to unclear or inconsistent definitions of a 'death in custody', which determines the extent of a state's responsibility in terms of investigating the cause(s) and circumstances.

Furthermore, the processes to certify, determine and classify the cause of a death in prison vary widely among countries. For instance, so-called 'natural causes' officially account for many deaths in prison globally, yet the term is not clearly defined. It is commonly used as a catch-all term conflating different causes of death between old age, illness, and cardiovascular diseases,[10] and concealing a whole range of factors which may be unnatural. Without adequate investigations, deaths in prison will most likely be misclassified, impacting the deceased family's right to know the truth, and failing to identify contributing causes to prevent future loss of life.

Status of prison death investigations

The frequency, modalities and outcomes of investigations of deaths in prison vary significantly across the world. However, overall the level of accountability remains low and, where investigations do take place, the outcomes are rarely successful in translating lessons learned into reforms to address shortcomings identified, or prosecution in cases of individual responsibility. It is usually family members, human rights institutions, or civil society organisations that engage in advocacy efforts to demand accountability, with mixed results.[11]

Though limited in number, some jurisdictions such as Argentina, Australia, and England and Wales, have developed more complex systems to conduct independent investigations into all deaths in prison. While such systems have varying levels of effectiveness, features and practices from these countries should be looked to for replication elsewhere. In many other countries such as Mexico, Japan, France, Portugal, and Turkey, full investigations are usually triggered only in cases of suspicious or violent deaths, which rarely result in redress for victims and often exclude any preventive approach. In Chile, while investigations are under the responsibility of an independent institution, prison authorities have the mandate to be materially involved in investigative actions, risking their impartiality.[12] In other countries, such as Latvia, investigations of deaths in prison are carried out internally by the prison administration, and only in cases of violence or suspected crime.[13]

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6. UN Human Rights Council, *Human rights in the administration of justice: Report of the United Nations High Commissioner for Human Rights*, A/HRC/42/20, 21 August 2019, para. 30.
7. Róisín Mulgrew, 'Prisoner Lives Cut Short: The Need to Address Structural, Societal and Environmental Factors to Reduce Preventable Prisoner Deaths', *Human Rights Law Review*, Volume 23, Issue 2, June 2023.
8. Philippa Tomczak and Róisín Mulgrew, 'Making prisoner deaths visible: Towards a new epistemological approach', *Incarceration*, 4, 6 March 2023.
9. Ibid.
10. Penal Reform International, *Deaths in prison: Examining causes, responses, and prevention*, 2022, p. 7.
11. Philippa Tomczak, 'Reconceptualizing multisectoral prison regulation: Voluntary organizations and bereaved families as regulators', *Theoretical criminology*, 26(3), 2022, 494-514.
12. Article 79 of the Code of Criminal Procedure, which designates the institution as an auxiliary body of the Chilean Public Prosecutor's Office to investigate criminal acts committed inside prisons. See, Francisco J. Molina Jerez and Agustín Walker Martínez, *Estudio sobre los fallecimientos en las cárceles chilenas desde enero del año 2019 hasta agosto del año 2022* (to be published).
13. See response of the Latvian Prison Administration on the EuroPris Knowledge Management System www.europris.org/epis/kms/?detail=471 [accessed 15 August 2023].

A primary challenge in reducing deaths in prison is the lack of accountability. This is often due to deficiencies in medico-legal systems, such as insufficient investigative capacity and overburdened judicial systems. These challenges are exacerbated by the closed nature of prison systems and problems brought by prison overcrowding, violence, cultures of impunity and corruption. Dysfunctional institutions and stigmatisation of imprisoned people also contribute to a lack of adequate response and accountability when someone dies in prison.

Relevant international standards

There are several binding international conventions and soft law instruments relevant to investigations of deaths in prison. These instruments outline what authorities must do to meet their obligations to protect and guarantee the rights to life, health, and freedom from torture and ill-treatment of people they detain under state custody.

1. The Minnesota Protocol on the Investigation of Potentially Unlawful Death (the Minnesota Protocol)

The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016) is an updated version of the United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions of 1991. It provides practical guidance for implementing the UN Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions (1989). The Protocol establishes a common standard for investigating potentially unlawful deaths and provides technical guidance for institutions and individuals involved in death investigations, such as police, investigators, medical and legal professionals, and fact-finding mechanisms.

2. The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)

Set out the minimum standards for good prison management, including to ensure the rights of prisoners are respected. Relevant rules for managing and investigating deaths in prison are Rules 8(f), 69, 71 and 72.

3. The International Committee of the Red Cross (ICRC) Guidelines for Investigating Deaths in Custody

Provide standards and good practices based on international instruments, particularly the Minnesota Protocol, to help detaining authorities, investigating authorities, and practitioners to gather and analyse all relevant evidence, interview witnesses, and perform medical examinations to determine the cause of death.

Other relevant international and regional standards include:

- Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions;[14]
- UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (Principles 7, 34);[15]
- UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Principles 1, 2);[16]
- UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol);[17]
- Guide on Article 2 of the European Convention on Human Rights;[18]
- Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas (Principles I, II, IV, IX (3), XXIII (2)-(3));[19]
- Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa (the Luanda Guidelines) (Paras 20-22, 35-43).[20]

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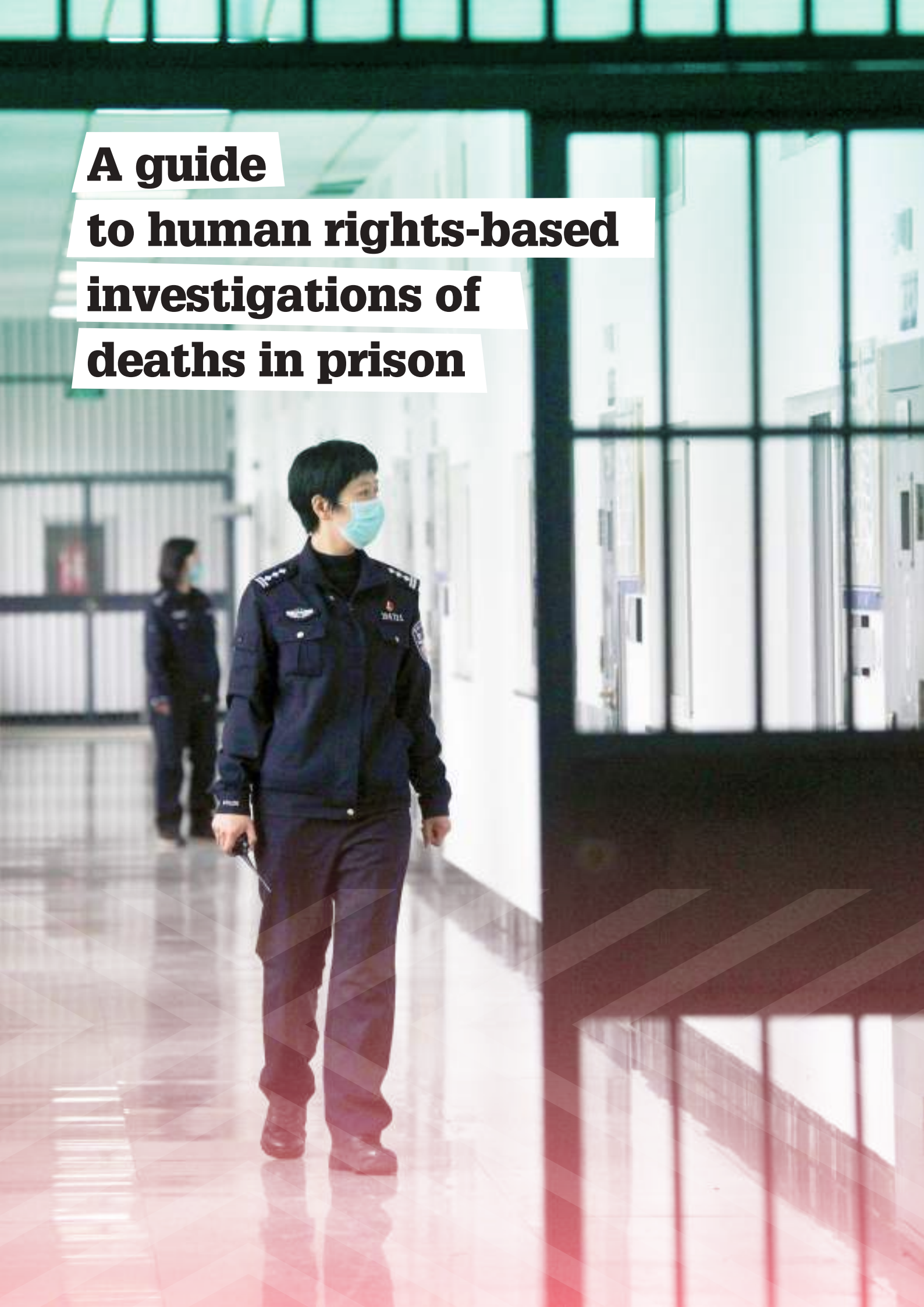
14. Economic and Social Council, *Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*, Resolution 1989/65, 24 May 1989.
15. General Assembly, *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, Resolution 43/173, 9 December 1988.
16. General Assembly, *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Resolution 37/194, 18 December 1982.
17. Office of the United Nations High Commissioner for Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, HR/P/PT/8/Rev.1, 2004.
18. Council of Europe, *Guide on Article 2 of the European Convention on Human Rights*, 31 August 2022, p.6; see also European Court of Human Rights , *Boso v. Italy*, December 2002.
19. Inter-American Commission on Human Rights, *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, Resolution 1/08.
20. African Commission on Human and Peoples' Rights, *Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa*, 28 July 2016.

A guide to human rights-based investigations of deaths in prison



PART 1

Legal and policy framework

A robust legal and policy framework for investigating deaths in prison in line with human rights standards is crucial to ensure a coordinated and effective response, and that every actor who should be involved knows their role.

The legal and policy framework must have the necessary institutional capacity and resources attached to it for effective implementation. This includes operational budget, adequate technical tools and work infrastructure, among other practical aspects. In Kenya, for instance, non-governmental organisations have reported that the 2017 Coroners Service Act, which sets out a comprehensive legal framework to investigate all deaths in prison, has not been fully implemented since its enactment, partly due to lack of appropriate funding.[21] **Governments should commit to allocate sufficient resources to ensure investigation systems can function effectively and independently, and be held to account, for instance by Parliamentarians, for any failures to do so.**

Human rights obligations require investigations of prison deaths to be independent, impartial, prompt and ex-officio, thorough, effective, credible and transparent.[22] Therefore, a comprehensive legal and policy framework must *at a minimum* include the following:

Obligation to investigate

The legal and policy framework must require that an investigation is undertaken into all deaths in prison regardless of the apparent cause. This legal obligation ensures that authorities automatically trigger an investigation and could be held to account if they fail to do so.

The obligation to investigate all deaths is explicit in some national laws, while in others, it is stated in institutional agreements. In **Jordan**, for instance, it is set down in the Law No. 9 of 2004 on Correction and Rehabilitation Centres, under the responsibility of the Ministry of Health and the Public Security Directorate. In **Chile**, the Inter-institutional Cooperation Agreement on Reporting and Investigation of Deaths in State Custody, Control or Care created in 2019 contains the legal obligation. In the province of Buenos Aires in **Argentina**, the duty to investigate is established in the Law 14.687, which creates Specialised Prosecutor's Offices for all cases of institutional violence, including deaths in prison.

Definition of a death in custody

In many places, there is no clear definition of what is considered a death in custody. This has implications for the obligation to investigate all deaths in custody. For example, it is common that, if a person deprived of liberty dies outside the confines of the prison compound, such as after being transferred to a hospital, the case is left without further investigation.[23] This has been identified as creating a problematic incentive to transfer individuals to hospital shortly before death in order to avoid an investigation and accountability.

A clear definition of what constitutes a death in custody should be in place, which should include all persons who die while in legal custody, even if the death occurs outside the prison facility, such as during a transfer, in hospital, or on temporary release. It should also include persons who die shortly after release from custody, including those released on compassionate grounds to die in the community, or to continue serving their sentence in the community.[24] As explained by the UN Special Rapporteur on extrajudicial, summary or arbitrary executions, "because the early post-release period is high risk, it should be presumed that all deaths occurring within 30 days of release are prison-related unless that presumption can be rebutted".[25]

21. *Joint Civil Society Organisations Shadow Report in Response to the Third Periodic Report by Kenya to the Committee Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2013-2022)*, available at www.omct.org/site-resources/legacy/Joint-Kenya-Civil-Society-Shadow-Report-on-CAT.pdf [accessed on 15 August 2023].
22. Minnesota Protocol; European Convention on Human Rights, Article 2.
23. For example in Italy, Mexico, and Spain.
24. Penal Reform International, *Deaths in prison: Examining causes, responses, and prevention*, 2022, p. 5.
25. Human Rights Council, *Deaths in prisons - Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz*, A/HRC/53/29, 18 April 2023, para. 45.

In **Argentina**, the Procedure for Investigation and Documentation of Deaths in Prison (2008) stipulates which deaths must be investigated, namely "the death of any person deprived of liberty under the material custody of the Federal Penitentiary Service, whatever the cause of death, and regardless of whether the death finally occurs inside a penitentiary establishment, in a transfer to or from it, or in a hospital to which he or she has been referred from a federal penitentiary unit."[26]

Mandate, scope, and purpose of the investigation

A designated body (or multiple bodies with clear and complementary roles) must be explicitly mandated to undertake investigations of deaths in prison and must be fully independent from the prison authorities. Clear guidelines should be in place to outline the role of the designated body or bodies and require authorities to cooperate fully throughout any investigative process. The European Court of Human Rights have referred to independence in this context as both hierarchical and institutional, but also in terms of practicality.[27]

Investigative authorities should be granted powers similar to National Preventive Mechanisms (NPMs) under the Optional Protocol to the Convention against Torture, such as unfettered access to facilities, including without notice, and all areas within a facility, relevant documentation and people.[28]

There should be a statutory duty for all relevant actors to cooperate during the investigation following procedures that can be independently enforced, with clear accountability mechanisms for authorities that fail to do so. To ensure accurate and reliable information is provided, a 'duty of candour' could require public authorities and employees to tell the truth and act with candour.[29] Whistleblowing processes and Codes of Ethics are also important in providing positive institutional cultures where honest accounts of incidents are given to investigative bodies.

Ensuring effective cooperation across authorities has many benefits and uses throughout the investigation process and outcomes.

The main purpose of prison death investigations is to discover the true circumstances of the death, which includes:

- Identifying the deceased person;
- Determining the cause and manner of death (distinguishing between homicide, suicide, accidental, and health-related death), including any environmental and systemic factors that may have contributed to it, such as poor prison conditions, lack of access to healthcare or discriminatory treatment; and
- Identifying any individual or institutional responsibility, if applicable, to ensure accountability and that the deceased's next of kin can access remedy.[30]

The scope of an investigation into a death in prison should therefore be non-exhaustive and set widely enough to capture all relevant details, including the authorities' response.

In **Chile**, the 'Interagency Cooperation Agreement on the Reporting and Investigation of Deaths in State Custody, Control or Care' was signed in 2019 by the Ministry of Justice and Human Rights, the Ministry of Health, the Investigative Police, *Carabineros de Chile*, the Public Prosecutor's Office, *Gendarmería de Chile*, the National Service for Minors, the National Service for the Elderly, the Forensic Medical Service and the National Institute of Human Rights. It sets down a series of commitments and agreed actions to ensure effective investigations of deaths in custody, including providing prompt and clear information to the investigative authorities. Despite being a positive step towards cooperation, the NPM in Chile has reported challenges in compliance, such as delays or lack of notification of deaths.[31]

In the **United Kingdom**, non-governmental organisations have proposed a legislative amendment to establish a statutory duty of candour for members of the police workforce. The proposed clause emphasises the importance of acting in the public interest and with transparency, candour, and frankness. It highlights the duty to actively assist court proceedings, official inquiries, and investigations, particularly when their own activities or actions may be relevant. Compliance with this duty entails prompt action, disclosure of relevant documents and facts, and providing ordered information. The amendment recognises that these duties are subject to existing laws on privacy, data protection, and national security. Enforcing these duties can be done through applications to courts or inquiry chairs.[32]

26. Procuración Penitenciaria de la Nación, *Procedimiento para la investigación y documentación de fallecimientos en prisión*, Resolución No. 169/PPN/08, August 2008.
27. European Court of Human Rights, *Paul and Audrey Edwards v UK*, Application 46477/9914, March 2002, para. 70; European Court of Human Rights, *Kukhalashvili v Georgia*, Applications nos. 8938/07 and 41891/072020, para. 130.
28. See General Assembly, *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, A/RES/57/199, 18 December 2002, Part IV-National preventive mechanisms.
29. The Right Reverend James Jones KBE, *'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated*, 2017.
30. Minnesota Protocol, p. 4.
31. Mecanismo Nacional de Prevención de la Tortura, *Segundo Informe Anual 2021 / 2022, Prevención de la tortura y situación de las personas privadas de libertad en Chile*, November 2022, p. 151.
32. JUSTICE and INQUEST, *Police, Crime, Sentencing and Courts Bill, Amendment 71 - Accountability of public authorities: duties on police workforce*, February 2022.

Analysis and dissemination

Investigations of prison deaths and any potentially unlawful acts by state authorities should always allow public scrutiny. **The findings of investigations should be shared with all relevant authorities and actors, including the deceased's next of kin, and should be published, protecting sensitive information, to enable relevant stakeholders to identify trends and develop recommendations for remedy and reforms to prevent future loss of life; to be effective, these recommendations must have enforceable mechanisms.**[33]

In **Argentina**, Law 14.687 establishes a Registry of Judicial Proceedings for Acts of Institutional Violence within the Public Prosecutor's Office. This registry documents all judicial proceedings related to institutional violence, including deaths in prison. It provides information on the investigations, processing time, accused individuals, trial proceedings, outcomes, and relevant details, such as the place where the person deprived of liberty died. The registry is publicly accessible while maintaining the confidentiality of the accused individuals' identities. Additionally, the Provincial Commission for Memory in Buenos Aires (described as a local mechanism for the prevention of torture) operates a programme called Registration of Deaths in the Context of Imprisonment, analysing and publishing data on the profile, causes and circumstances of deaths occurring within the provincial criminal justice system, including prisons and police stations, on a user-friendly platform.[34]

33. Sharon Shalev and Philippa Tomczak, *Improving prisoner death investigations and promoting change in prisons: A findings and recommendations report*, January 2023.
34. 'Muertes', *Comisión por la memoria*, www.comisionporlamemoria.org/datosabiertos/carceles/muertes [accessed on 6 June 2023].

PART 2

Pre-investigation procedures and immediate actions

Protocol for immediate actions

Each prison system and individual facility should have a clear protocol (e.g. Standard Operating Procedure) outlining the immediate actions that must be taken in the event of a death in prison, including the responsibilities of staff, management, and prison healthcare staff. Any procedure should include the obligation to promptly report the death to the relevant authorities, outlining practically when and how this should happen so all staff are empowered to do so.

Depending on the system in each prison, the action protocol should be developed by the Ministry of Justice and/or the Ministry of Health, for instance. It should guide all relevant actors to notify the external investigative authority of the death, secure the death scene and the body of the deceased person, and to cooperate with the authorities mandated to carry out the investigation, as detailed in the Minnesota Protocol.[35]

When a death occurs in prison, prison staff are often required to respond and deal with the immediate aftermath without the necessary training, tools, or experience. Ensuring the protection of the body and the area where a death occurs, safeguarding all evidence, and enabling effective response from prison staff requires specific guidance. Adequate training, along with technical and material support, should be provided to all individuals involved, particularly frontline prison staff, in order to effectively implement the action protocol.

Prisons are often places of high security and can also be located in remote areas. These factors may pose challenges for investigative authorities to arrive promptly, or to access all the areas within a prison facility. **To ensure that the immediate actions are carried out as promptly as possible, the protocol should be designed with and adopted by all the relevant institutions and should explicitly state which authorities are responsible for, and involved in, each action.** There should also be an individual designated within each authority to act as the focal point for communication and coordination purposes.

In **Panama**, the prison administration's internal protocol sets out the various steps to be taken when a death occurs which include: to inform the Director of the prison administration and notify the police. There is also the obligation to secure the body and death scene, and to make a brief report on the profile of the deceased person and the circumstances in which the body was found, noting whether there were other people around, and any other relevant information to be shared with the investigation authorities.[36]

Medical assessment

The first action to be taken upon a death occurring in prison is to notify a doctor or, in the absence of one, a medical professional. The basic elements of the doctor's role are to check the person's vital signs, confirm the death, check for evidence of any sign of violence and estimate the time of death. As explained in the ICRC Guidelines, at this stage, only a qualified medical officer should have access to the body.[37] Medical staff in the prison should be able to make independent assessments according to the UN Principles of Medical Ethics,[38]

35. See, Minnesota Protocol, pp. 13-16.

36. Ministerio de Gobierno, Dirección General del Sistema Penitenciario, *Protocolo de Actuación en Caso de Muerte de Personas Privadas de Libertad*, www.sistemapenitenciario.gob.pa/wp-content/uploads/2019/07/Protocolo-en-caso-de-muerte-ppl.pdf [accessed on 15 August 2023].

37. International Committee of the Red Cross, *Guidelines for Investigating Deaths in Custody*, 2013, p. 16.

38. UN General Assembly, *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Principles 1, 2.

and should be trained in how to secure the deceased person's body and the death scene until the investigative authority arrives.

Conducting a prompt medical assessment in the case of a person's death can be hampered by many challenges, often linked to structural limitations in the provision of healthcare in prisons. For instance, many prisons will not always have doctors available, which can complicate or delay the immediate medical assessment. Health and prison staff might also be subject to pressures by prison authorities or by other detainees not to include details that might result in liability.

To improve independence of healthcare staff working within prisons, system-wide reforms to place the responsibility of prison health within the ministry responsible for public health have been recommended by the World Health Organization and others. This model also improves access to well-trained, independent, professional healthcare staff who can take coordinated actions with local hospitals, including when there is a death in prison.[39]

Securing the scene of death and the body of the deceased

In addition to the intervention of a medical doctor, a representative of the prison should be present to secure the perimeter of the death scene and the body to avoid interference with or contamination of any evidence.[40] The area where the death occurred, including the body, should be treated as a crime scene, regardless of the apparent cause and manner of death, until the investigation of the scene is concluded.

In practice, securing the death scene, both immediately and until the investigation is completed, can be highly complicated due to overcrowding and delays in investigative authorities arriving at the scene. In some instances, such as in Kenya, there have been reports of prison staff removing items of the deceased person's clothing, among other key pieces of potential evidence.

The personal belongings of the deceased and all documents related to them should be gathered, secured, and handed over to the investigating authorities.[41] **A protocol should be in place on how to safeguard the chain of custody of the belongings and other documents, including a signed record of everyone that handled the evidence, with time and date stamps, and staff should be trained to implement it.**

In **Portugal**, the General Regulations of Prison Establishments provide that, in cases of unknown or violent deaths, the prison director is responsible for taking the necessary measures to preserve the death scene and the body until the arrival of the police, prohibiting access to the scene and, if necessary, creating a security perimeter or ordering all persons to stay inside the prison cells.[42]

Reporting to investigative authorities

Prison authorities must ensure adequate reporting on any death in prison is undertaken. Such reports are critical for investigations. Therefore, the protocol setting out immediate actions should include the duty for prison authorities to make a report containing, at least, personal information about the deceased person (name, age, gender, ethnicity, etc.), their medical record, a brief description of events around and leading up to the person's death, and the persons who were involved or intervened (e.g., who was there at the time of death or who found the body, who reported it, and who secured the scene).[43]

The report should be shared immediately with the investigative authorities and systematised into a prison registry of deaths or incident management database. In some countries, such as India, Argentina and South Africa, there is a legal requirement to also notify and share the report with the Ombudsperson, which can be helpful to improve oversight throughout the investigation process.

In **Jordan**, the law stipulates that in the event of a detainee's death, the director of the facility is required to promptly notify the relevant authorities and the deceased person's relatives. If the detainee is a foreign national, the appropriate foreign entity should also be informed. The facility's doctor is also responsible for submitting a report on the deceased person's condition, including details such as any illness they were suffering from (if applicable), the date of its onset, the last medical examination conducted, and the date and time of death.[44]

39. 'WHO reveals one-third of prisoners in Europe suffer mental health disorders', *UN News*, 14 February 2023, news.un.org/en/story/2023/02/1133507#:~:text=The%20WHO%20regional%20office%20in,related%20policy%20and%20legislative%20frameworks.
40. Minnesota Protocol, para. 54.
41. International Committee of the Red Cross, *Guidelines for Investigating Deaths in Custody*, 2013, p. 16.
42. Código da execução das penas e medidas privativas da liberdade, Law no. 115/2009 of 12 October, Article 36.
43. For more details see International Committee of the Red Cross, *Guidelines for Investigating Deaths in Custody*, 2013.
44. Law No. 9 of 2004 on Correction and Rehabilitation Centres, Article 29.

Notifying the family

International standards require the next of kin (typically family members) to be informed immediately of the death of a loved one in prison.[45] They should also be provided with the incident report and any further details required. This should include information on which investigative authorities are involved, where the body is located, process and likely timeline for when the body will be returned, and information relevant to funeral arrangements.

In practice, there are often significant delays in notifying families, who are often poorly informed regarding the death of their loved ones and subsequent procedures and findings. For example, in France, a woman was reportedly only informed about the death of her spouse in prison 23 days after he died in 2020, and in January 2022, a mother learned about her son's death when she attended his court hearing and the magistrate announced that it would not go ahead because the defendant was found dead in his cell that morning.[46]

In many countries, people are often located in prisons far from their families and, in some cases, this can present challenges for authorities to contact them and promptly inform them of a death. In some cases, contact details for family or next of kin were not provided to prison authorities. **Prison authorities should keep up-to-date contact details of family members, including of foreign nationals.[47] Collaboration agreements with embassies, consulates and other foreign services can also help facilitating the contact with and support to family members in other countries.**

45. Minnesota Protocol, para. 67.

46. 'Prisons: Pourquoi est-ce si difficile d'enquêter sur la mort des détenus?', *20Minutes*, 7 August 2018, www.20minutes.fr/societe/2260675-20180807-prisons-pourquoi-si-difficile-enqueter-mort-detenus#:~:text=Il%20y%20a%20encore%20des,d%C3%A9tresse%20de%20la%20personne%20d%C3%A9tenue%20%C2%BB.

47. Council of Europe, *Recommendation of the Committee of Ministers to member States concerning foreign prisoners*, CM/Rec(2012)12, 10 October 2012.

PART 3

Medico-legal systems

National medico-legal systems typically comprise the judiciary, law enforcement, and forensic institutions. They are responsible for investigating and determining the cause and manner of deaths, both inside and outside of detention, and are essential for promoting justice, safeguarding public health, and providing crucial information to grieving families. The findings of their investigations can also help to evaluate existing policies and inform preventive measures.

However, in many parts of the world, particularly in low-resource settings, medico-legal systems face significant challenges. The UN Special Rapporteur on extrajudicial, summary or arbitrary executions has highlighted a lack of independent and trained investigators and inter-agency cooperation, insufficient resources, and deficiencies in data infrastructure and quality.[48] Without strong medico-legal systems, investigating deaths in prison becomes extremely challenging, particularly in contexts of high levels of corruption and impunity. **Steps must be taken to address these challenges and strengthen the integrity, independence, and capacity of medico-legal systems to ensure effective investigations, promote accountability, and uphold human rights principles.**

Independence of forensic services

In many countries, such as in France, Kenya, Mexico, Portugal, and Turkey, forensic services serve under law enforcement or security agencies. As noted by the UN Special Rapporteur on extrajudicial, summary or arbitrary executions, "subordinating forensic medical services to the police, prosecutors or judges, or placing services in departments where they have little priority, is unlikely to promote independence." **The independence of forensic services must be protected. This could include creating an oversight body such as a commission or board, made up of respected professionals in the field.**[49]

In **Costa Rica**, under the Law No.5524, forensic medical services are under the administration of the judicial branch of government, which is both constitutionally and budgetarily independent.[50]

Technical capacity of forensic services

In many countries, there is a huge gap in trained forensic professionals with the capacity to implement international standards. In Greece, for instance, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) reported in 2022 that, in some instances, "a single forensic medical doctor and a technician were responsible for carrying out some 800 autopsies a year, including supposedly attending the scene of the death and the court hearings", which made it evident "that autopsies could not be conducted professionally as good practice requires".[51]

Particularly when prisons are located in remote or rural areas without adequate forensic infrastructure, it is more likely that potentially unlawful deaths are not detected or investigated. For instance, in a case relating to deaths in Pedrinhas prison in the state of Maranhão, Brazil, the Inter-American Court of Human Rights expressed its concern regarding the prison administration's statement that many of the "natural deaths" were classified as such only because there was no forensic capacity to conduct autopsies and determine the causes of death.[52]

A 2022 UN report on medico-legal death investigations presents a series of good practices to strengthen the capacity of national forensic services, for instance, through technical advice by the International Committee of the Red Cross (ICRC) and peer-to-peer collaboration and knowledge exchange, such as in the Asia Pacific Medico-Legal Agencies network.[53]

48. Human Rights Council, *Medico-legal death investigations: Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz,* 16 June 2022.

49. Ibid, para. 61.

50. Ibid, para. 56.

51. Council of Europe, *Report to the Greek Government on the ad hoc visit to Greece carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 22 November 2021 to 1 December 2021*, CPT/Inf (2022) 16, 2 September 2022, p. 38.

52. Corte Interamericana de Derechos Humanos, *Medidas provisionales respecto de Brasil Asunto del complejo penitenciario de pedrinhas*, Resolución de 14 de marzo 2018, para. 72.

53. Human Rights Council, *Medico-legal death investigations: Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz,* A/HRC/50/34, 16 June 2022, paras. 70, 72-76; see also 'The Asia Pacific Medico- Legal Agencies (APMLA)', theapmla.net [accessed on 06 June 2023].

In **Colombia**, following an outbreak of violence in La Modelo prison in Bogotá, the International Rehabilitation Council for Torture Victims (IRCT) provided independent expert support to analyse 24 post-mortem examinations of people that had died in the clash, concluding that they had been victims of homicide.[54]

How forensic evidence is used

A common challenge in medico-legal investigations is the lack of shared understanding between the two fields. This means that prosecutors and judges may lack the necessary knowledge to interpret forensic evidence.[55] While they play a crucial role in ordering, managing, and interpreting investigations, the limited understanding of forensic aspects among the judiciary and legal profession can hinder the effective use of forensic evidence and well-trained forensic experts. Conversely, forensic professionals often lack the legal expertise to effectively present their findings to prosecutors and judges, and are not adequately trained to understand how their findings fit into the broader investigative process. This fragmented approach often focuses on individual steps rather than embracing a systemic approach that encompasses the entire investigation.[56]

In **Mexico**, the Department of Forensic Science of the National Autonomous University developed a set of guidelines for the assessment of expert evidence. The guidelines aim to provide prosecutors and judges with concrete support on technical aspects of evidence to make informed decisions and provide certainty to the parties involved that the evidence is being properly evaluated.[57]

In **Kenya**, the Independent Medico Legal Unit (IMLU) has collaborated with the state to enhance capacity for forensic investigations. However, a key challenge remains the establishment of medico-legal links. To address this issue, IMLU conducts annual training sessions for both police officers and doctors, focusing on the significance of medico-legal linkages and their role in ensuring accountability. The training emphasises the collection of information with the understanding that it may be required as evidence in court proceedings. By strengthening these linkages, IMLU aims to improve the effectiveness and reliability of forensic investigations in Kenya.

In addition to resource limitations, the involvement of forensic professionals in death investigations is also often hindered by legal and procedural obstacles. In many jurisdictions, such as Japan, the decision on whether an autopsy is necessary is made by the police or prosecutors.[58] This poses a significant risk as these authorities typically lack the medical expertise required to properly examine the body and determine the need for further investigation or autopsy.[59]

Forensic services are also usually only permitted to report their findings to the requesting party, which is often the police. This prevents any interaction between forensic professionals and the family of the deceased or prison authorities, who may be able to provide context or other relevant information, have a right to be informed of the outcome, or use the findings to take remedial or preventive action.

The European Committee for the Prevention of Torture (CPT) has recommended that all forensic reports of deaths in prison are systematically shared with prison authorities and healthcare staff. This would allow for any operational lessons that can be learned from past incidents to improve future responses and preventive measures.[60]

54. International Rehabilitation Council for Torture Victims, International Committee of the Red Cross and Independent Forensic Expert Group, *Review of autopsies from La Modelo prison riot and responses to your inquiries*, 10 November 2020.

55. Human Rights Council, Medico-legal death investigations: Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz, A/HRC/50/34, 16 June 2022.

56. PRI Interview with forensic professionals on 16 and 17 March 2023.

57. 'Guías para la valoración de la prueba pericial', *UNAM Escuela Nacional de Ciencias Forenses*, www.enacif.unam.mx/?page_id=7821 [accessed on 06 June 2023].

58. Yoshida, Ken-ichi, 'Investigation of deaths in prison in Japan', *The Lancet*, Vol. 362, September 13 2003.

59. Human Rights Council, Medico-legal death investigations: Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz, A/HRC/50/34, 16 June 2022, para. 77.

60. Council of Europe, *Report to the Government of North Macedonia on the visit to North Macedonia carried out by the European Committee for The Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 2 to 12 December 2019*, CPT/Inf (2021) 8, 11 May 2021.

PART 4

Implementing the legal framework for death investigations

It is up to each state to determine the most suitable procedure to conduct an investigation into a death in prison, provided it meets the requirement of independence from the prison administration. **The scope and methodology of an investigation into a death in prison should meet the objectives of determining the cause and circumstances of death, identifying underlying factors contributing to it, and, if applicable, establishing any individual or institutional responsibility.**[61]

Types and scope of investigations

Independent investigations of deaths in prison are usually conducted or led by the police, coroners, ombudsperson institutions, or a hybrid mechanism. In some cases, agencies with different mandates and roles within the same jurisdiction will conduct simultaneous, complementary, or consecutive investigations. Having two or more investigative authorities involved can strengthen rigour and reliability of outcomes, but might also produce different outcomes or result in lengthier, fragmented or incomplete inquiries.

Where there are multiple parallel investigations undertaken by different agencies into prison deaths, it is particularly important to be explicit about what is being done in each process and why, for the benefit of all stakeholders.[62] Communication and cooperation between the different authorities involved will also be fundamental for an efficient outcome.

The Inter-American Court of Human Rights has stressed that due diligence in an investigation includes analysing the context of the facts to identify the existence of any pattern or practice within which it took place.[63] The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol) also states that investigations should consider "contextual factors such as sexual orientation, gender identity, disability, race, ethnicity, nationality, age and socioeconomic status of the victim(s)".[64]

A study by the English non-governmental organisation INQUEST, found that deaths of racialised people in prisons in England and Wales from 2015 to 2021 often occurred in contexts of violence and neglect. Despite evidence of institutional racism and the experiences of racialised people in the prison system, none of the investigations conducted by authorities addressed race or ethnicity, or the potential role of racism and discrimination in the deaths.[65] In Australia, an analysis of coroners reports over 10 years found indigenous people were three times more likely not to have received all required medical care prior to death, and prison systems and hospitals were less likely to have followed their own procedures.[66] **The relevance of systemic racism or discrimination should be presumed, unless rebutted, in the context of how individuals from marginalised groups die in prison.**

Police investigations

Police investigations are the most common type of independent investigations in cases of death in prison. However, full police investigations are often only triggered only in suspicious or violent cases, and the scope is usually limited to identifying any

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61. Economic and Social Council, Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions, Resolution 1989/65, 24 May 1989, Principle 9; Minnesota Protocol, para. 25.

62. Sharon Shalev and Philippa Tomczak, *Improving prisoner death investigations and promoting change in prisons: A findings and recommendations report*, January 2023.

63. Inter-American Court of Human Rights, *Contreras et al. v. El Salvador*, Judgment of 31 August 2011, 2011, para. 150; Inter-American Court of Human Rights, *Gonzalez et al v. Mexico*, Judgment of 16 November, 2009, para. 284.

64. United Nations, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol), as revised 2022*, para. 190.

65. INQUEST, *Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination, 2022*.

66. 'The facts about Australia's rising toll of Indigenous deaths in custody', *The Guardian*, 8 April 2021, www.theguardian.com/australia-news/2021/apr/09/the-facts-about-australias-rising-toll-of-indigenous-deaths-in-custody.

criminal conduct. This leaves many deaths that are initially attributed to natural causes unchecked. This is problematic as the term "natural causes", which is not always clearly defined, does not necessarily mean that the death was not preventable, or a result of neglect, inadequate medical care, or other factors related to the prison conditions.[67]

For instance, in Argentina, 106 out of the 425 deaths that occurred in federal prisons between 2009-2018 did not activate any police intervention; 104 of these were classified as "natural" deaths, hence, without further need to investigate.[68]

Police investigations should be designed to incorporate human rights-based approaches and broaden their scope to include contributing or underlying factors, such as prison conditions or systemic discrimination, in the analysis of causes and circumstances of death.[69] For instance, in the case of women and LGBTQ+ persons, there should be an obligation to conduct the necessary analyses to determine whether any form of sexual or gender-based violence occurred or played a role in the person's death.[70] Notwithstanding this, coronial inquests or ombudsperson investigations in many cases will be better equipped to address contextual or environmental causes or contributing factors to deaths in prison.

In **Chile**, the National Prosecutor's Office issued general guidelines for handling cases of deaths in prison, including the possibility of receiving technical assistance from the Specialised Unit on Human Rights, Gender Violence and Sexual Crimes to carry out investigations with a broader scope that consider risk factors and negligence, in accordance with the standards set out in the Minnesota Protocol.[71] In 2022, a woman in prison died due to septic shock. The case was initially classified as a natural death due to illness. However, with the technical advice of the Specialised Unit, authorities discovered that the septic shock was due to an infection caused by an intrauterine device (IUD) and that the prison authorities did not take steps to transfer the woman to an outside medical facility during the days when she was experiencing symptoms including severe pain, fever, diarrhoea and urinary tract infections. She only received care at a prison hospital that caters mainly to men, with no gynaecologist or midwife available.[72]

Coronial inquests

Coronial inquests are the most common type of investigation in some countries, including Australia, Canada, England and Wales, Hong Kong, Ireland, and New Zealand. In 2017, Kenya also adopted a law to move to coronial inquests, although it is not fully functional yet.

Coroners are independent judicial or government officials mandated by law to investigate the identity of a deceased and the cause and manner of their death. Depending on the jurisdiction, coroners will be proposed or appointed by the local or national government, and are usually qualified lawyers or medical doctors (or sometimes both). The scope of coronial inquests is generally limited to fact-finding, and not determination of any liability or criminal responsibility.[73] In conducting the inquest, coroners may rely on information obtained from pathologists, police officers, prison personnel, medical practitioners, family members, and ombudsman institutions. Coroners may act as liaison offices for families, having a key role in ensuring they are involved in the investigation.[74] In some instances, they can make recommendations to prevent future deaths. If, during or after the investigation, there are elements of a possible crime, they may inform law enforcement authorities to conduct a criminal investigation.

In **England and Wales**, in cases of death in state custody, coroners may conduct an Inquest under Article 2 of the European Convention on Human Rights – the right to life and the State's duty to protect it. Under Article 2 Inquests,[75] in addition to "who, when, where and how" a person died, the Inquest examines "in which circumstances", which should include any systemic failures and broader factors that contributed to the death.[76]

In **Australia**, recent amendments to coronial inquest protocols have expanded the scope to include identifying and addressing underlying factors that contribute to avoidable deaths and formulate recommendations, as recommended by the Royal Commission into Aboriginal Deaths in Custody since 1998.[77]

67. Philippa Tomczak and Róisín Mulgrew, 'Making prisoner deaths visible: Towards a new epistemological approach', *Incarceration*, 4, 2023.
68. See, Procuración Penitenciaria de la Nación, *Morir en prisión: fallecimientos bajo custodia y responsabilidad estatal*, 2020.
69. Inter-American Court of Human Rights, *Contreras et al. v. El Salvador*, Judgment of 31 August 2011, para. 150; Inter-American Court of Human Rights, *Gonzalez et al. ("Cotton Field") v. Mexico*. Judgment of 16 November 2009, para. 283.
70. Inter-American Court of Human Rights, *Velásquez Paiz et al. v. Guatemala*, Judgment of 19 November 2015, para. 147.
71. Fiscalía Nacional, *Instrucción general que imparte criterios de actuación en delitos de violencia institucional*, Oficio FN Nº618/2021, p. 14.
72. PRI interview on 31 January 2023.
73. See, for instance, The Crown Prosecution Services in England and Wales.
74. See, for instance, House of Commons Justice Committee, *The Coroner Service First Report of Session 2021–22*, 27 May 2021.
75. These were established after the case of *R. Middleton v West Somerset Coroner* in 2004.
76. Coroners and Justice Act 2009, Paragraph 7 of Schedule 5; Regulations 28 and 29, Coroners (Investigations) Regulations 2013.
77. See, for instance, The Coroners Court of Victoria, Practice Direction 6 of 2020 Indigenous Deaths in Custody. For challenges of how this works in practice, see Philippa Tomczak, 'Highlighting "Risky Remands" through prisoner death investigations: People with very severe mental illness transitioning from police and court custody into prison on remand', *Frontiers in psychiatry*, Volume 13, 2022.

Ombudsperson investigations

Less common but seen in countries such as Argentina or England and Wales, Ombudspersons can have a statutory duty to investigate deaths in custody or to oversee investigations conducted by other institutions. In England and Wales, for instance, investigations by the Prison and Probation Ombudsman (PPO) aim to identify any shortcomings in the treatment received by the deceased person and highlight any lessons that can be learned. The PPO produces a report that is shared with relevant authorities, the family of the deceased person, and the coroner.[78]

In **Argentina**, the Prison Ombudsman's National Office, an independent institution, carries out administrative investigations into each death that occurs in federal prisons. For deaths that are classified as violent, unknown, or suspicious, proceedings are focused on formulating separate conclusions on the cause and circumstances of death and assessing the effectiveness of the judicial investigation. For deaths from "natural causes" the objective and methodologies will evaluate if the person received appropriate healthcare in prison or if their right to health was neglected.

> "Even if it seems clear that a person died of pneumonia, you should always be suspicious and rigorous, taking as many body samples as possible, because you only have one opportunity to gather evidence and that is during the autopsy.[82]"

In **Mexico**, laws and guidelines in place require that every violent death of a woman is investigated as potential femicide, following the *Protocol for ministerial, police and expert investigation with a gender perspective for the crime of femicide*.[83] However, figures from the Executive Secretariat of the National System of Public Security, which compiles data from state prosecutors, suggests that between December 2018 and September 2022, only 1 in 4 violent deaths were investigated as a femicide (the majority as intentional homicide), so significant challenges remain in implementing the requirement.[84]

Post-mortem examinations

Post-mortem examinations, also called autopsies, are medical examinations of a deceased's body to determine the exact cause of death. In cases of deaths in prison, full autopsies should be conducted every time it is possible, following the procedure for homicides[79] and incorporating gendered approaches, such as collecting samples to identify any possible signs of sexual violence.[80] The Minnesota Protocol, the ICRC Guidelines and the UN Manual for Staff Skill Requirements and Equipment Recommendations for Forensic Science Laboratories provide practical information to strengthen forensic capacity and performance, including step-by-step checklists for conducting autopsies.[81]

International standards have stressed the importance of forensic professionals attending the death scene to evaluate the effects of injuries, physiology, bleeding, unconsciousness, death and post-mortem changes.[85] Due to the remote location of many prison facilities and the limited availability of forensic professionals, this is rarely the case. The most common practice is that the police arrive, record the death scene and collect the evidence, and then arrange for transportation of the body either to the morgue or to forensic facilities. For instance, in the case of 24 deaths in the aftermath of a prison riot in the Colombian prison La Modelo in November 2020, the forensic authorities did not attend the scene.[86] When forensic doctors are not present at the death scene, they may not have all necessary information and rely on reports from non-medical personnel.

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78. 'Why does the Ombudsman investigate deaths?', *Prison and Probation Ombudsman*, www.ppo.gov.uk/investigations/investigating-fatal-incidents/why-investigate-deaths, [accessed on 05 March 2023].

79. International Committee of the Red Cross, Guidelines for Investigating Deaths in Custody, October 2013, p. 18.

80. For recommendations to incorporate gendered approaches, see Oficina Regional para América Central del Alto Comisionado de las Naciones Unidas para los Derechos Humanos, *Modelo de protocolo latinoamericano de investigación de las muertes violentas de mujeres por razones de género (femicidio/feminicidio)*, 2014.

81. United Nations, *Staff skill requirements and equipment recommendations for forensic science laboratories*, 2011; International Committee of the Red Cross, Guidelines for Investigating Deaths in Custody, October 2013, Annex IV.9.

82. Forensic professional, Mexico City, in interview with PRI on 10 January 2023.

83. Procuraduría General de la República, *Protocolo de investigación ministerial, policial y pericial con perspectiva de género para el delito de feminicidio*, www.gob.mx/cms/uploads/attachment/file/253267/Protocolo_Feminicidio.pdf.

84. 'Feminicidio un delito que se mantiene "oculto" en las cifras oficiales', *Expansión Política*, 23 November 2022, https://politica.expansion.mx/mexico/2022/11/23/feminicidio-delito-oculto-en-las-cifras-oficiales.

85. Minnesota Protocol, para. 90.

86. International Rehabilitation Council for Torture Victims, International Committee of the Red Cross and Independent Forensic Expert Group, *Review of autopsies from La Modelo prison riot and responses to your inquiries*, 10 November 2020.

In **Portugal**, in the case of a death in prison, the corpse of the detained person may not be moved until a forensic doctor from the National Forensic Institute has examined the body and provided an opinion on whether or not to carry out an autopsy (the decision on whether it is conducted is ultimately made by the Public Prosecutor).[87]

Interviewing witnesses

A thorough investigation, according to international standards, should cover all relevant details, including the events leading to the death and the authorities' response. This involves interviewing witnesses to gather evidence on the circumstances that led to the person's death.[88] In coronial systems, the coroner can summon witnesses and request evidence to be provided. When death investigations are conducted by the police, such power will depend on the type of legal system and the inquisitorial or adversarial role of the public prosecution.

In some investigations, the testimony of detainees and relatives of the deceased is not given enough importance. According to an analysis of deaths in custody from 2009 to 2018 by the prison ombudsman's office in Argentina, judicial authorities interviewed other detainees in only 47% of cases analysed, and family members in only 17%. In contrast, prison officers were interviewed in 70% of cases.[89] Overreliance on the authorities' testimonies can undermine the impartiality and practical independence of the investigation.

Investigations into human rights abuses in any context can be politically sensitive and encounter resistance, either from institutional actors or from other detainees. In many regions, organised crime groups and gangs have control or significant power in prisons, which may make witnesses reluctant to provide testimony due to fears of reprisals, posing risks to both witnesses and investigators. Mechanisms to provide anonymous information and ensuring that detainees give testimony confidently and confidentially can help to address these challenges.[90] The UN Guidelines against Intimidation or Reprisals is a useful resource for guidance on protecting witnesses and individuals providing evidence to the investigation.[91]

The use of non-coercive methods of investigation, especially during interviews, is important for gathering accurate and reliable information and evidence. The Principles on Effective Interviewing for Investigations and Information Gathering (the "Méndez Principles") provide safeguards to ensure better protection of people in the context of interrogations, particularly with regard to persons in situations of vulnerability (i.e., due to their age, sex, gender identity, nationality or ethnic origin, disability and other risks factors).[92] **The Méndez Principles should be followed for interviewing of any victims, witnesses, and suspects in investigations of deaths in prison.**[93]

The **Kenya** National Commission on Human Rights (KNCHR) conducts investigative interviewing into deaths in prisons by determining the specific point at which the death occurred within the prison's daily schedule. If the death occurred during a specific activity, such as mealtime, detainees present during that time are randomly interviewed without prison authorities present to identify individuals and circumstances involved. In addition, the KNCHR investigates trends such as reports of torture or abuse by specific officers by conducting interviews and independent medical analyses.[94]

Role of the family

According to international standards, effective investigations into deaths in prison must provide family members ('next of kin') with accurate, timely and comprehensive information about the circumstances of the death.[95] **From the moment that the death occurs, the next of kin should be supported in a respectful and culturally appropriate manner, including for instance, the provision of interpretation, or considering religious practices in post-mortem examinations and return of the body to the family.**

Losing a family member or friend under state custody can be a traumatising event, and poorly conducted investigations can impact their right to know the truth about what happened and exacerbate their pain.[96] Furthermore, families may have information on the background or circumstances of death that is not readily available to the investigative authorities.

87. Council of Europe, *Report to the Portuguese Government on the visit to Portugal carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 14 to 25 January 2008*, 19 March 2009, para. 106.
88. Minnesota Protocol, p. 7.
89. Procuración Penitenciaria de La Nación, *Morir en prisión: fallecimientos bajo custodia y responsabilidad estatal*, 2020.
90. Minnesota Protocol, para. 75.
91. United Nations, *Guidelines against Intimidation or Reprisals ("San José Guidelines")*, HRI/MC/2015/6, 30 July 2015.
92. Principles on Effective Interviewing for Investigations and Information Gathering, May 2021.
93. 'The Méndez Principles: a step forward for preventing torture and ill-treatment worldwide', Valentina Cadelo for *Penal Reform International*, 13 October 2022, www.penalreform.org/blog/the-mendez-principles-a-step-forward.
94. See Kenyan National Commission on Human Rights, www.knchr.org/About-Us/Establishment.
95. General Assembly, *Interim report of the Special Rapporteur on extrajudicial, summary or arbitrary executions*, A/65/321, 23 August 2010.
96. Philippa Tomczak and Elizabeth A. Cook, 'Bereaved Family 'Involvement' in (Prisoner) Death Investigations: Whose 'Satisfaction'?', *Social & Legal Studies*, 32(2), 2023, 294-317.

Active engagement of families can contribute to ensure an adequate focus and scrutiny throughout the investigation. Unfortunately, experiences from a range of contexts suggest that the right of families is often neglected, and that they are excluded from key parts of the process. For instance, in Turkey, it was reported as a common practice that families are informed of a person's death after the autopsy has been performed.[97] In the case of a fire that resulted in the death of 107 persons detained in Honduras, it took several days for authorities to provide families any information on the identification of the bodies and several mistakes were made in the delivery of corpses, which exacerbated their suffering.[98]

The family of the deceased should be included meaningfully throughout the investigation, including access to free legal advice and representation, the ability to attend or be represented at the autopsy, present further evidence, be notified of decisions and have access to relevant information.

In many places, non-governmental organisations and human rights bodies play a key role in providing legal advice to families who have lost loved ones in prison, either to request a second post-mortem examination or take cases to court when there is inaction by investigative authorities. In **Kenya**, for example, the National Human Rights Commission has intervened as the legal representative of bereaved families and has partnered with the Independent Medico Legal Unit (IMLU) to conduct a second autopsy.[99]

In the **UK**, the organisation INQUEST has been providing support to families since 1980 through deaths investigations and pushing for legal and policy changes based on their learning and findings. With bereaved families, INQUEST has contributed to significant reviews into state-related deaths and key issues affecting people in detention. Their website has an area called the 'Family Hub' where bereaved families and friends can access resources and support, as well as opportunities to engage in the organisation's work. Their Family Reference Group is an alliance of bereaved families, ensuring that the family perspectives inform their work.[100]

97. PRI interview on 23 March 2023.
98. Inter-American Court of Human Rights, *Pacheco Teruel et al. v. Honduras*, Judgment of April 27, 2012, para. 52.
99. PRI interview on 30 March 2023.
100. For more information, see INQUEST: www.inquest.org.uk.

PART 5

Investigation outcomes

Timely conclusions

The prompt conduct and timely conclusion of investigations into deaths in prison is an important element of their effectiveness.[101] Long processes delay the learning process to prevent future harm and add to the anguish and mental distress suffered by the deceased person's family.[102] When determining any individual or institutional responsibility, delayed investigations also have a negative impact on accountability processes. By the time prosecutors evaluate whether to pursue prosecution, crucial evidence may be lost, and key individuals involved in the case may have moved on or become unavailable.

There are many cases documented where investigations have taken an unreasonable amount of time or remained unresolved. In Australia, for instance, it was not until 2019 that the investigation of five out of the eight deaths that occurred in 2015-2016 were completed.[103] Similarly in Canada, the organisation Tracking (In)Justice has highlighted that families "are waiting five, 10 years for an inquest to actually find out the truth".

Conclusions from investigations should be made public in a timely and prompt manner, with a timeline communicated to all relevant parties at commencement. Ideally, time limits should be established for investigations, with accountability ensured for failure to deliver on time. If delays are foreseen, the reasons for the delay and a new timeline should be communicated immediately.

Public scrutiny and dissemination

The findings of any investigation into a prison death must be produced in a publicly accessible written report within a reasonable period. The report must set out the methods used, findings, conclusions, and recommendations as to the facts and applicable law. It must describe in specific detail the events that were found to have occurred and the evidence that the findings are based upon, including a list of all witnesses that testified (unless this is not possible due to concerns about protection). Finally, an analysis should be undertaken of each death in prison to consider what general lessons may be learned.[104]

In many of the jurisdictions analysed, police investigations will not usually disclose information such as autopsy reports to the prison administration or the family, at least until the investigation is concluded and often, not even afterwards. Results or reports of the investigation are not usually made public, largely because it is considered to contain sensitive private information.

Transparency is a tool for ensuring accountability.[105] For example, in the case of a woman who allegedly took her own life in a Turkish prison in December 2021, her family claimed they were denied access to the investigation files until its completion. In January 2022, the prosecutor concluded that no charges would be brought against the prison administration, despite alleged evidence of the deceased person being physically and sexually abused by prison officers prior to her death and denied medical treatment.[106]

Positively, in some places like Scotland (see below), investigation reports or decisions following open criminal procedures are published, with policies in place to protect the privacy and security of those involved, such as, by redacting or summarising certain parts of the report prior to publication.

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101. European Court of Human Rights, *Kukhalashvili and others v. Georgia*, Applications nos. 8938/07 and 41891/07), 2 April 2020, para. 131.

102. Human Rights Committee, *Khadzhiyev and Muradova v Turkmenistan* (2018), Communication No. 2252/2013, para. 7.6.

103. 'He's Never Coming Back', *Human Rights Watch*, 15 September 2020, www.hrw.org/report/2020/09/15/hes-never-coming-back/people-disabilities-dying-western-australias-prisons.

104. Economic and Social Council, *Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*, Resolution 1989/65, 24 May 1989, Principle 17.

105. University of Nottingham, *Improving prisoner death investigations and promoting prison safety*, February 2023.

106. 'Garibe Gezer'in işkence ve tecavüz dosyasına 'takipsizlik' kararı', *Mezopotamya Ajansi 35*, 4 January 2022, mezopotamyaajansi35.com/tum-haberler/content/view/157584; 'Sister of inmate who was mistreated and found dead in prison to run for parliament', *Stockholm Centre for Freedom*, 31 March 2023, stockholmcf.org/sister-of-inmate-who-was-mistreated-and-found-dead-in-prison-to-run-for-parliament.

In **Scotland**, summaries of some Fatal Accident Inquiries, particularly in cases where there is a wider public interest, are published on the government website of the Judiciary. The summaries provide details of the case, the main findings of the inquiry and a link to the sheriff's full determination.[107]

The National Coroners Information System is an online publicly accessible database of information on deaths reported to a coroner in **Australia** and **New Zealand**. Data includes demographic information on the deceased person, contextual details on the nature of the fatality and searchable medico-legal case reports including the coronial finding, autopsy and toxicology report and police notification of death. This allows investigation results to be used by relevant institutions to create prevention strategies, as well as by third sector and academic bodies for research and analysis.[108]

Prevention and policy changes

International standards require that investigations of deaths in prison serve the dual purpose of understanding the causes and circumstances, and informing measures to prevent further deaths. By analysing individual as well as cumulative trends authorities can make evidence-based policy changes to improve prison conditions and prevent future harm.

In the **United States**, the National Science and Technology Council's Fast-Track Action Committee on Strengthening the Medicolegal-Death Investigation System was established in 2015 to make strategic policy recommendations at the Federal level on how to address issues related to accessing and working with data generated by Medico Legal Offices.[109]

Efforts to reduce deaths in prison often focus on enhancing security and limiting opportunity for self-harm.[110] However, comprehensive actions are necessary to address underlying causes including environmental factors such as discriminatory treatment. This includes promoting broader criminal justice reform such as utilising alternatives to imprisonment, reducing prison overcrowding, improving prison conditions, ensuring adequate health services in prisons and the community, and prioritising rehabilitation.[111]

For instance, in the case of the San Pedro Sula prison fire in Honduras, which resulted in the death of 107 individuals, investigations revealed overcrowding, lack of ventilation, no natural light, and inadequate access to essentials like running water contributed to the severity of the tragedy.[112] In Estonia, the National Prevention Mechanism (NPM) reported that all deaths by suicide during September 2019 and September 2020 occurred in solitary confinement, indicating that the effects of this measure is linked to increased self-harm and mortality.[113]

The impacts of imprisonment and poor prison conditions affect different population groups in different ways, and this is key to designing and implementing effective measures to protect the rights of people in detention. For example, research in England and Wales has evidenced a disproportionate prevalence of suicide among women, which is influenced by their particular experience of issues such as separation from family, bullying, inadequate staff, increased isolation, and unmet mental health needs.[114]

Accountability and access to remedy

In addition to determining the cause and circumstances of death, investigation findings provide a base for bringing disciplinary proceedings or other processes to enable remedies for to victims and their families, including criminal prosecution and reparation measures.[115]

If investigations reveal a violation of an individual's rights, state authorities must ensure those responsible are brought to justice. A failure to do so can, in and of itself, give rise to a separate rights violation. This is particularly the case for breaches of criminal law, such as torture, inhuman and degrading treatment and punishment, summary and arbitrary killing, or enforced disappearances, where criminal investigation and consequential prosecution are necessary remedies for violations of the right to life and freedom from torture.[116]

In practice, once the cause and circumstances of death are determined, procedures for criminal responsibility may take even longer. Poorly conducted investigations and lack of judicial independence leads to lower levels of accountability. For instance, in the state of Maranhão, Brazil, from 2010 to 2017, only five investigations into acts of torture or violence inside the Pedrinhas

107. 'Fatal Accident Inquiries', *Scottish Courts and Tribunals*, 7 August 2019, www.gov.scot/publications/follow-up-review-fatal-accident-inquiries.
108. 'National Coronial Information System', http://www.ncis.org.au, [accessed on 14 June 2023].
109. Executive Office of the President, National Science and Technology Council, *Strengthening the Medicolegal-Death-Investigation System: Improving Data Systems*, December 2016.
110. For instance, see 'Australia: Deaths of Prisoners with Disabilities', *Human Rights Watch*, 15 September 2020, www.hrw.org/news/2020/09/15/australia-deaths-prisoners-disabilities.
111. United Nations, *United Nations System Common Position on Incarceration*, April 2021.
112. Inter-American Court of Human Rights, *Pacheco Teruel et al. v. Honduras*, Judgment of April 27, 2012, para. 36.
113. Deputy Chancellor of Justice-Adviser, Opinion in administrative case No 3-18-1895, 10 October 2021.
114. INQUEST, *Still Dying on The Inside*, May 2018.
115. European Court on Human Rights, *Makaratzis v. Greece*, Application no. 50385/99, 20 December 2004, para. 73; European Court on Human Rights, *Khashiyev and Akayeva v. Russia*, Application nos. 57942/00 and 57945/00, paras. 120-121.
116. Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication No. 2252/2013*, CCPR/C/122/D/2252/2013, para. 7.5.

Complex were initiated, and none were concluded.[117] In Egypt, human rights organisations have denounced that the prosecutor's office has consistently neglected to conduct thorough investigations into allegations of abuse and torture, even when these incidents have resulted in death.[118]

In March 2023, the prosecuting body of **Scotland** instructed the police to investigate the Scottish Prison Service for corporate responsibility, including corporate homicide, following the death of a man in 2015, four days after he was allegedly violently restrained by up to 17 prison officers. While a decision on whether charges will be imposed are pending as of June 2023, the case represents the first time that proceedings have been initiated against a public or government body in the UK for corporate homicide.[119]

The right to a remedy includes the right of affected individuals to claim that violations of their rights have taken place and to request reparation for the harm suffered.[120] **In addition to pecuniary compensation, comprehensive reparation systems should include measures for restitution (when possible), satisfaction, rehabilitation and guarantees of non-recurrence for the next of kin in accordance with international human rights law standards.**[121]

Many of these reparation measures can and should be achieved through a meaningful investigation process. For instance, when an investigation identifies the shortcomings that contributed to or caused a person's death, and institutions implement the necessary legal or policy changes to guarantee that no one else is affected by the same issue. An inadequate investigation, on the other hand, can not only increase the damage caused to the family of the deceased person, but also undermine the possibilities of reparation measures.

However, access to reparations is generally dependent on the determination of responsibility for the death, which can often take a long time, or may never arrive. For instance, in the case of death of a 20-year-old man that died in a fire in his cell in France, his family had to wait twelve years for the State to be found responsible.[122] As recognised by the Inter-American Court of Human Rights, in some cases, the suffering and harm caused to the next of kin by the traumatic circumstances in which a person dies in state custody, does not need to be proved nor depend on individual criminal liability.[123]

Since 2018, **Ecuador** has experienced more than 14 prison massacres in which approximately 591 persons deprived of liberty have lost their lives. In April 2023, a group of family members of victims filed a complaint against the Ecuadorian State for the lack of responses and actions to address or prevent prison massacres. They demand comprehensive reparation measures aimed at assisting the victims in coping with the violence they have experienced, which resulted in the violation of their rights, and to foster the changes required to enhance trust in society and its institutions.[124]

117. Inter-American Court of Human Rights, *Medidas provisionales respecto de Brasil Asunto del complejo penitenciario de pedrinhas*, Resolución de 14 de marzo 2018.

118. For instance, in an online court hearing in November 2022, the judge abruptly disconnected the detainees from the call when they started expressing their grievances regarding the ongoing violations against them. In another hearing, the judge rejected the lawyers' plea to document the detainees' statements separately and initiate an investigation into their complaints. See 'Egypt: Rights Groups Warn of Collective Punishment at Badr Prison', World Organisation Against Torture, 20 March 2023, www.omct.org/en/resources/statements/egypt-rights-groups-warn-of-collective-punishment-at-badr-prison.

119. 'Allan Marshall: Unprecedented corporate homicide investigation against Scottish Prison Service announced', *INQUEST*, 7 March 2023, www.inquest.org.uk/allan-marshall-homicide-investiation.

120. Human Rights Council, *Promotion of truth, justice, reparation and guarantees of non-recurrence: Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence*, A/HRC/42/45, 11 July 2019, para. 38.

121. *Ibid.*

122. 'Prisons: Pourquoi est-ce si difficile d'enquêter sur la mort des détenus?', *20minutes*, 7 August 2018, www.20minutes.fr/societe/2260675-20180807-prisons-pourquoi-si-difficile-enqueter-mort-detenus.

123. Inter-American Court of Human Rights, *Pacheco Teruel et al. v. Honduras*, Judgment of 27 April 2012, para 74.

124. 'Familiares de personas privadas de libertad asesinadas en cárceles demandan al Estado ecuatoriano, estas son sus exigencias', *Wambra medio comunitario*, 26 April 2023, wambra.ec/familiares-personas-privadas-libertad-demandan-al-estado-ecuador.

About Penal Reform International

Penal Reform International (PRI) is a non-governmental organisation working globally to promote criminal justice systems that uphold human rights for all and do no harm. We work to make criminal justice systems non- discriminatory and protect the rights of disadvantaged people. We run practical human rights programmes and support reforms that make criminal justice fair and effective.

Registered in The Netherlands (registration no 40025979), PRI operates globally with offices in multiple locations.

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About *prison*DEATH

Preventable prison deaths are common in every country, causing significant harms to families, prisons and societies. *prison*DEATH brings together a multidisciplinary team from the University of Nottingham (Prof. Philippa Tomczak), University of Galway (Dr. Róisín Mulgrew), St Olavs University Hospital and the Norwegian University of Science and Technology (Dr. Catherine Appleton). Facilitated by the University of Nottingham Faculty of Social Sciences, this academic team are working in partnership with Penal Reform International and the international community, seeking to put the overlooked issue of prison deaths on the global penal reform agenda.

www.nottingham.ac.uk/research/groups/prisons-health-and-societies/research-projects

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