Death in Prison Custody – Action Plan – Update March 2023

September 2023

Scottish Government
Riaghaltas na h-Alba

Death in Prison Custody – Action Plan – Update March 2023

1. Overview

The Independent Review of the Response to Deaths in Prison Custody was published in November 2021. The review made one key recommendation, nineteen other recommendations and six advisory points. We accepted all the recommendations made by the review in principle.

Since the 2021 report, the Scottish Government and partners have progressed a variety of actions on the recommendations. This page provides an update of the progress following the Deaths in Prison Custody Action Group (DiPCAG) March 2023 meeting from the Scottish Government and partners including Scottish Prison Service (SPS), Crown Office and Procurator Fiscal Service (COPFS) and the NHS.

2. Progress on recommendations

2.1 Theme: Key Recommendation

Recommendation 1

Owner: Scottish Government

Progress made: The key recommendation working group met to finalise draft process, focusing on areas of complexity such as minimising trauma to staff and communication with families.

Next key actions: Guidance draft for the pilot to be finalised. Organisations to consider what needs done, and timescale to enable to pilot to commence. Cabinet Secretary approval for HMIPS to undertake the pilot is required.

2.2 Theme: Family contact with prison and involvement in care

Recommendation 1.1

Owner: Various – Healthcare Improvement Scotland (HIS), NHS boards, the Care Inspectorate, National Suicide Prevention Leadership Group, Her Majesty's Inspectorate for Prisons in Scotland (HMIPS) and Scottish Government

Progress made: The Understanding and Preventing Deaths in Prison Custody working group has met on one more occasion, focusing on improving data and evidence around deaths in prisons. A data and evidence working group is proposed to explore enhancement of data, and conduct peer reviews of individual organisations' analysis. NHS and colleagues are looking into drug-related deaths and suicides in prison. A forum for all prison GPs has been established. Discussion occurred on the draft guidance for clinical management of people suspected of intoxication which aims to ensure better outcomes for patients.

Next key actions: Data and evidence group to be established and workplan developed. NHS are to complete consultation with community and prison health teams to ascertain a full picture of healthcare needs in prison. Undertake analysis on drug-related deaths and suicides in prisons as part of the Network's 2023 workplan.

Recommendation 1.2

Owner: NHS (to lead) and SPS

Progress made: The response to a death in custody flowchart is drafted. Roles and responsibilities are being agreed with partners.

Next key actions: Flowchart to be redrafted in line with feedback, including Standard Operating Procedures to be followed following a death, outlining individual role and responsibilities and links to training modules, webinars, and resources from Confirmation of Death to wider work on delivering Trauma Informed Care.

Recommendation 1.3

Owner: SPS

Progress made: Consultation was carried out with establishments regarding processes for receiving concerns. The Electronic Concern Form (ECF) pilot with Families Outside is working well. The preferred option is to have the ECF available on the SPS website and assistance offered by Families Outside for completing. Phone call concern tests were conducted, and work is being carried out to improve this. There is consideration of having a dedicated concerns phone number.

Next key actions: Complete the Raising a Concern booklet, then consult and present to the Tasking Group (TG). Submitting and managing concerns proposals will be presented to the TG including extended use of the ECF. NHS to link with SPS to discuss how proposed process highlights prison healthcare team concerns that pertain to healthcare/treatment.

Recommendation 1.4

Owner: SPS (to lead) and NHS

The recommendation has been implemented.

2.3 Policies and processes after a death

Recommendation 2.1

Owner: NHS (to lead) and SPS

Progress made: Please see recommendation 1.2 for an update.

Recommendation 2.2

Owner: SPS

Progress made: The new model of ligature cutter has been received, which will replace the existing model in all crash packs, at staff desks and be carried by all patrol staff during nightshift and lock up periods across the prison estate. A meeting was held to introduce the new ligature cutter and roll out. A ligature cutter has been supplied to each establishment to allow for staff briefings and training in advance of introduction. Security lanyards are also received, awaiting delivery of pouches.

Next actions: Each establishment to confirm processes are in place to introduce the new tool. Arranging distribution of required stock to each establishment.

Recommendation 2.3

Owner: NHS (to lead) and SPS

Progress made: The final webinar recording took place. Prison healthcare staff's frequently asked questions are addressed in the webinar. Confirmation of death pocket cards received for distribution to nursing staff following the webinar. Standard Operating Procedures to accompany the training webinar.

Next key actions: Webinar recording to be edited and uploaded. All prison nurses to complete within 6 months and revisit every 2 years.

Recommendation 2.4

Owner: SPS

Progress made: The DIPLAR Review Group are undertaking a review of several aspects of the DIPLAR process to progress all recommendations and advisory points relating to the DIPLAR. Consultation was undertaken with those involved in the process on the current process and paperwork. Revised drafts of the paperwork addressing each of the recommendations and advisory points has been produced.

Next key actions: Revised Guidance is being drafted and will be presented at Tasking Group. Tests of paperwork are planned in tandem with existing agreed process. Outstanding questions on the NHS' role and responsibility within the DIPLAR to be answered before finalisation.

Recommendation 2.5

Owner: SPS, NHS and Scottish Government
Progress made: No further update provided.

2.4 Key theme: Family contact and support following a death

Recommendation 3.1

Owner: SPS

The recommendation has been implemented.

Recommendation 3.2

Owner: SPS (to lead), NHS and the Crown Office and Procurator Fiscal Service

Progress made: Work between COPFS and SPS continues, with a view to entering an information sharing protocol. NHS is looking into training and looking at previously developed packages to support communication with families following an adverse event, there is not capacity to tailor the training to prisons.

Next key actions: Information Sharing Agreement to be concluded and signed off. NHS to consider learning from existing training packages and signpost to available training.

Recommendation 3.3

Owner: SPS and NHS

Progress made: The Family Support Booklet (FSB) has been redrafted following consultation. A template letter to families has been included for GiCs and a process developed to include the sharing of the booklet and letter, following the phone call made to families following a death. A non-personalised version and a Prison Support and Contacts list are to be placed on the SPS website. Final version was sent for accessibility, EHRIA checks and to SPS communications for sign-off and publication.

Next key actions: Final additions to be made to the FSB such as details of the SAER's process and family engagement. Comments have been requested before publication and distribution across networks.

Recommendation 3.4

Owner: SPS, NHS and Scottish Government

Progress made: Please see recommendation 1.1 for an update.

2.5 Key theme: Support for staff and other people held in prison after a death

Recommendation 4.1

Owner: NHS (to lead) and SPS

Progress made: The NHS are developing a framework to support the implementation of trauma-informed care modules for all healthcare professionals working in prisons. The framework will detail training that should be undertaken in each role. Available resources on wellbeing training and support packages for staff have been mapped. Approval was received to replace the Critical Incident Response and Support (CIRS) process with an interim Employee Assistance Programme (EAP) solution. Work has begun to develop the EAP.

Next key actions: Approaches to supporting healthcare professionals in prisons needs further consideration. Introduce the interim EAP process and develop staff Trauma booklet. SPS College's research to be finalised with recommendations on a best practice approach. A paper will be developed to consider budget, pros and cons of joining up with Lifelines Scotland.

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Recommendation 4.2

Owner: NHS (to lead) and SPS

Progress made: Please see recommendation 4.1 for an update.

2.6 Key theme: SPS and NHS documentation concerning deaths

Recommendation 5.1

Owner: SPS (to lead) and NHS

Progress made: Please see recommendations 2.4 and 3.3 for updates.

Recommendation 5.2

Owner: SPS (to lead) and NHS

Progress made: Please see recommendations 2.4 and 3.3 for updates.

Recommendation 5.3

Owner: SPS

Progress made: Please see recommendation 2.4 for an update.

Recommendation 5.4

Owner: SPS

The recommendation has been implemented.

3. Progress on Advisory Points

Advisory Point 1

Owner: SPS and NHS

Progress made: Awaiting update.

Advisory Point 2

Owner: SPS

Progress made: SPS noted that there are no immediate plans to progress this recommendation as it would require a large estates project and significant budget implication which the SPS is not currently resourced to deliver.

Advisory Points 3, 4 and 5

Owner: SPS (to lead) and NHS

Progress made: Please see recommendation 2.4 for an update.

Advisory Point 6

Owner: SPS

Progress made: An 'Options for Support and Tribute' document has been produced for establishment use.

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