Death in Prison Custody – Action Plan – Updated 12 December 2022

September 2023

Scottish Government
Riaghaltas na h-Alba

Death in Prison Custody – Action Plan – Updated 12 December 2022

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) December2022 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: Workshops were held to refine and assess the potential new investigative process. The Family Reference Group (FRG) workshop raised number of questions to ensure that the process works for families.

Next key actions: Organisations involved need to consider requirements and how to overcome any challenges to pilot the investigative process. The Cabinet Secretary's approval is required to instruct an organisation to undertake and commence the pilot. Pilot parameters need to be agreed.

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, His 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 three times. They have mapped policies and programmes of work ongoing that directly or indirectly contribute to the prevention of deaths in prisons. Chair is working with SPS and NHS National Prison Care Network (NPrCN) to commence analysis of publicly available data relating to deaths.

Next key actions: Engagement will continue with SPS, Justice Analytical Services (JAS) and NPrCN to identify relevant data to be obtained and analysed to help identify trends or reasons for deaths in prisons. Consider the possibility of inspection standards relating to deaths in prisons.

Recommendation 1.2

Owner: NHS (to lead) and the SPS

Progress made: A standard national process (Toolkit) for both NHS and SPS staff to use on best practice responses following a death in prison custody has been developed. Existing processes in NHS Boards following a death in custody have been mapped. SPS response processes have been considered by the NPrCN.

Next key actions: The NHS mapping exercise to be added to Visio and shared with SPS for agreement. The Toolkit thereafter requires approval via NPrCN governance groups.

Recommendation 1.3

Owner: SPS

Progress made: Feedback from the FRG on the electronic concern form was provided to SPS.

Next key actions: SPS to consider feedback from the FRG and make amendments to the form. SPS to consider improving awareness of the ways family members can raise concerns about someone in prison. A single point of contact or a mailbox to be established within each prison for the submission of the forms and standardised processes. Access and signposting to the form to be considered e.g. on the SPS website, stakeholder websites and other methods (family centres or visitor centres). An audit and review process to ensure compliance and timely response and engagement with persons raising concerns to be developed.

Recommendation 1.4

Owner: SPS (to lead) and NHS

Progress made: A Governors and Managers Action Notice (GMA) was issued to all prisons requesting assurance to SPS Headquarters that processes are in place that ensure up-to-date next of kin (NOK) details are recorded electronically, along with records of whether the individual has given consent for their NOK to be contacted in emergencies. This GMA served as a reminder of the relevant Prison Rules.

Next key actions: No further actions as 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: A model of ligature cutter considered more effective than the model currently available within prisons has been purchased, which will replace the existing

model in all crash packs at staff desks and will be carried by all patrol staff during nightshift and lock up periods across the prison estate.

Next key actions: SPS are waiting for delivery of the new ligature cutters.

Recommendation 2.3

Owner: NHS (to lead) and SPS

Progress made: The NHS staffing capacity has affected ability to attend training. Other modes of delivering training have been explored to improve access to training. NHS Education for Scotland (NES) have agreed to develop a webinar that will be tailored to prison specific confirmation of death training.

Next key actions: Filming of the webinar is due to take place in February and ready for roll out in March 2023. NPrCN will monitor NHS Boards for uptake of training and implementation of Framework.

Recommendation 2.4

Owner: SPS

Progress made: The SPS DIPLAR Review Group have been undertaking a review of several aspects relating to the DIPLAR process to progress all recommendations and advisory points relating to the DIPLAR. The FRG have provided feedback on the current process and paperwork.

Next key actions: A consultation process on the current DIPLAR process and paperwork with those involved in the process to be conducted, including SPS Suicide Prevention Co-ordinators, NHS staff and Prison Chaplaincy. An initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points to be produced.

Recommendation 2.5

Owner: SPS, NHS and Scottish Government

Progress made: The SPS are developing a corporate approach that will place responsibility on all senior leads to ensure compatibility with the UN Convention on the Rights of the Child (UNCRC) in the development of their legislative considerations, policies, strategic frameworks, action plans and other key initiatives. DIPLAR Review Group to consider whilst undertaking review of process and paperwork.

2.4 Key theme: Family contact and support following a death

Recommendation 3.1

Owner: SPS

Progress made: SPS issued a GMA that provides the name and contact details of the Duty Governor that should be shared with Police Scotland to be passed onto families so they can make immediate contact if they wish to do so. The Governor (or

Deputy Governor in their absence) should contact the family the next day and offer support from the Chaplaincy Team; actions must be recorded within the DIPLAR paperwork. The Family Support Booklet (FSB), provided to family members following a death, contains contact details of the senior management team point of contact and the chaplaincy contact. Chaplains will continue to offer pastoral support to families.

Next key actions: No further actions as the recommendation has been implemented.

Recommendation 3.2

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

Progress made: There is ongoing communication between the COPFS and SPS legal teams to develop a Memorandum of Understanding (MOU) between the organisations. The issues surrounding disclosure of information to families to be factored into these discussions.

Recommendation 3.3

Owner: SPS and NHS

Progress made: The revised draft FSB details engagement families can expect from the DIPLAR process and includes contact details of the relevant Governor, Chaplain and healthcare practice lead along with bereavement and suicide support. Feedback from the FRG has been received.

Next key actions: The FSB is to be revised and shared for a final consultation. FSB is to be made available on SPS website and a business case to be submitted for printed booklets. NHS to provide further details regarding Significant Adverse Event Reviews (SAER) process and family engagement for inclusion in FSB. NHS equality and diversity colleagues to ensure readability of the FSB.

Recommendation 3.4

Owner: Scottish Government, SPS and NHS

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 in a tailored and tiered approach to separate roles. Available resources, including those provided by NES, on wellbeing training and support packages for staff which can be adapted to the prison setting have been mapped. SPS College is in the preliminary stages of developing a trauma-informed package in line with the NES framework which will

include psychological education training for staff, a staff supervision model and psychological interventions. SPS are developing a draft paper for senior management consideration which proposes a temporary interim Employee Assistance Programme solution to replace the Critical Incident Response and Support (CIRS) process. If supported, research will be undertaken by SPS College and Psychology to review best practice and put forward an options appraisal to senior management.

Next key actions: The NHS to finalise their trauma-informed practice framework, which requires agreement through NPrCN governance structure. Approaches to supporting healthcare professionals in prisons needs further consideration. SPS to decide on the proposed interim alternative to CIRS, and thereafter, to be introduced. Two day mandatory workshop on trauma-informed leadership to be rolled out to all senior leaders. Framework of trauma-informed practices for all staff to be developed with the support of NES.

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 recommendation 2.4 for an update.

Recommendation 5.2

Owner: SPS (to lead) and NHS

Progress made: Please see recommendations 3.1 and 2.4 for an update.

Recommendation 5.3

Owner: SPS

Progress made: A non-executive member of the SPS Advisory Board Chairs all DIPLARs except for those confirmed as natural cause, although will chair if requested. This position changed in 2020 following the last review of the process to provide objective oversight. The Chair has experience of health management, prison and is an independent appointed safeguarder outwith SPS. There is no plan to change that position in the short to medium term while a review is underway.

Next key actions: The current Chair remains extant and will sit of the DIPLAR Review Subgroup.

Recommendation 5.4

Owner: SPS

Progress made: A process is in place whereby a member of SPS Health Headquarters attends all DIPLAR meetings. They provide an overview of national policy, take forward any national action points and developed a checklist for use in the interim to ensure all relevant information is discussed and recorded at the DIPLAR meeting. A GMA has been issued to all prisons to remind them of the need to invite SPS Health Headquarters to be part of each DIPLAR meeting.

Next key actions: No further action as 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 has noted that there are no immediate plans to progress this recommendation as this 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: SPS have no formal protocols. It was agreed at the National Suicide Prevention Management Group (NSPMG) that no standard template for letters of condolence should be drafted.

Next key actions: SPS to create a suite of options that exist via the Suicide Prevention Co-ordinators Group and provide a summary for amendment or approval.

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