Death in Prison Custody – Action Plan – Updated 21 June 2022

September 2023

Scottish Government
Riaghaltas na h-Alba

Death in Prison Custody – Action Plan – Updated 21 June 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) June 2022 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: A roundtable was held other administrations to understand current processes, best practice and lessons learned. A working group has been set up to progress the recommendation, current processes have been mapped and an options appraisal drafted which outlines existing public bodies with the expertise and legislative framework to conduct the pilot and advantages and disadvantages of creating a new investigative body.

Next key actions: Working group agreement on parameters of the new process will be sought. A decision will be made on the body best suited to conduct the pilot.

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: HIS have not included in work programme for 2022-23. Awaiting further updates.

Recommendation 1.2

Owner: NHS (to lead) and the SPS

Next key actions: A pathway outlining responsibilities of healthcare and operational staff following a death in custody will be developed.

Recommendation 1.3

Owner: SPS

Progress made: A pilot for submitting electronic concern forms was held with key stakeholders. An evaluation took place and positive feedback was received which was reported to the National Suicide Prevention Management Group (NSPMG). The pilot has been extended for further use and feedback. Work to establish an appropriate submission process has begun.

Next key actions: Further information is required.

Recommendation 1.4

Owner: SPS (to lead) and NHS

Progress made: Local processes are being adopted by establishments to ensure up-to-date information.

Next key actions: Further information is required.

2.3 Policies and processes after a death

Recommendation 2.1

Owner: NHS (to lead) and the SPS

Progress made: See recommendation 1.2 for an update.

Recommendation 2.2

Owner: SPS

Progress made: A review is being conducted with consideration given to the best model for ensuring ready access. 10 establishments have screens available and other establishments have ordered new screens to replace existing screens or ensure screens are in place.

Next key actions: A short-life working group to explore options of ligature cutters and implementation processes is being set up.

Recommendation 2.3

Owner: NHS (to lead) and the SPS

Progress made: Approval was provided for training prison nurses to provide confirmation of death. Health Boards were asked to implement the recommendation.

Next key actions: Health boards to confirm once training delivered.

Recommendation 2.4

Owner: SPS

Progress made: SPS' Strategy & Stakeholder Engagement Business plan for 2022-23 features this.

Next key actions**:** Further detail required.

Recommendation 2.5

Owner: SPS, NHS and Scottish Government

Progress made: The Current Expert Review of Mental Health addresses these issues, and future policy positions will consider the UNCRC.

Next key actions: Further detail required.

2.4 Key theme: Family contact and support following a death

Recommendation 3.1

Owner: SPS

Progress made: SPS confirmed this is completed by some Governors. Training has been requested to support them undertaking the role.

Next key actions: To complete a scoping exercise to identify training needs of senior staff in the prison setting.

Recommendation 3.2

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

Progress made: COPFS and SPS are developing a Memorandum of Understanding between organisations including disclosure of information to families.

Next key actions: Further detail required.

Recommendation 3.3

Owner: SPS and NHS

Progress made: awaiting update

Recommendation 3.4

Owner: SPS, NHS and Scottish Government

Progress made: awaiting 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: To progress, individuals with expertise need identified, such as psychology services, and an approach is needed. SPS are looking to discuss CIRS and future proposals. The Trauma Informed Delivery Group are exploring training and awareness raising sessions with the National Trauma Leads and HIS.

Next key actions: further information required.

Recommendation 4.2

Owner: NHS (to lead) and SPS

Progress made: 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: See recommendation 2.4 for an update.

Recommendation 5.2

Owner: SPS (to lead) and NHS

Progress made: SPS are considering Harm and Inclusion Manager posts to work with SPS college coordinators, support the management of prevention interventions and response to deaths in custody. A pilot post will be recruited to develop the role.

Next key actions: A pilot is due to commence in Quarter 2.

Recommendation 5.3

Owner: SPS (to lead) and NHS

Progress made: SPS Health team have a secondees for mental health and drug and alcohol recovery. The National Suicide Prevention Coordinator post will be formally filled from May 2022.

Next key actions: Further detail required.

Recommendation 5.4

Owner: SPS

Progress made: SPS health team members have aimed to attend all DIPLARs.

Next key actions: SPS health attendance at DIPLARS will continue.

3. Progress on Advisory Points

Advisory Point 1

Owner: SPS and NHS

Progress made: Awaiting update

Advisory Point 2

Owner: SPS
Progress made: A review of the placement of emergency alarms in cells has not yet begun.
Next key Actions: Further information required.

Advisory Points 3, 4, 5 and 6

Owner: SPS (to lead) and NHS

Progress made: awaiting update

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