Death in Prison Custody – Action Plan – Updated 27 September 2022

September 2023

Scottish Government
Riaghaltas na h-Alba

Death in Prison Custody – Action Plan – Updated 27 September 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) September 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: Workshops were held to refine and assess the potential new investigative process. The Family Reference Group (FRG) workshop raised number of questions to ensure the process works for families.

Next key actions: To pilot the process, organisations involved need to consider requirements and how to overcome challenges. The Cabinet Secretary's approval is required to instruct an organisation to undertake 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, 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 been established and met. The initial focus has been mapping ongoing work that could feed into a framework on preventing deaths in prisons and ascertaining available data on cause of deaths in prisons.

Next key actions: Develop a workplan with responsibilities, targets, and measurable outcomes.

Recommendation 1.2

Owner: NHS (to lead) and SPS

Progress made: Existing processes in NHS Boards following a death in custody have been mapped and existing SPS process have been requested.

Next key actions: Develop Standard Operating Procedures based on the mapped processes. Look to understand current SAERs practices with the aim to standardise procedures.

Recommendation 1.3

Owner: SPS

Progress made: Consultation was undertaken with establishments on submitting the electronic concern form (ECF). Establishments are confident a system can be implemented whereby the forms can be monitored and actioned.

Next key actions: The Family Reference Group (FRG) to provide feedback on the ECF, systems for raising concerns, and improving awareness raising concerns. Feedback received will be considered. Introduction of shared mailboxes to raise ECF to be considered. Implementation and roll out of the ECF to be agreed.

Recommendation 1.4

Owner: SPS (to lead) and NHS

Progress made: Consultation has been undertaken with establishments to ensure Next of Kin (Nok) details are up-to-date and how follow up checks are carried out.

Next key actions: Consultation feedback to be consolidated and creating guidance should be considered. To discuss recording of NoK details to ensure understanding.

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: Privacy screens are in place within establishments. Consultation with other agencies to explore use of ligature cutters and equipment access has occurred.

Next key actions: A business case outlining options and costs to be submitted for approval. Further consultation and risk assessment to be carried out regarding identified staff holding ligature cutters to facilitate access.

Recommendation 2.3

Owner: NHS (to lead) and SPS

Progress made: ‘Confirmation of death by registered healthcare professional’ framework was approved for use in prisons. Implementation timeframes and potential barriers are being considered. Initial meetings between SPS and Scottish

Ambulance Service (SAS) occurred to agree processes for calling ambulances via Control Rooms. SAS are leading on protocols for call handler to ensure appropriate and timely responses.

Next key actions: Discussion occurred with NES on webinar development options to allow for remote training.

Recommendation 2.4

Owner: SPS

Progress made: The current DIPLAR form has a specific question on support. Completed DIPLARs have been audited and show a lack of consistency in reporting on this. A DIPLAR Review Group has been established.

Next key actions: The DIPLAR subgroup to develop a draft action plan. Guidance to be reviewed to ensure consistent reporting of required information. Guidance will be shared with Suicide Prevention Co-ordinators to reinforce importance of evidencing the support offered to those in the care of SPS. FRG have been asked to provide their feedback on the current DIPLAR form.

Recommendation 2.5

Owner: SPS, NHS and Scottish Government

Progress made: awaiting update

2.4 Key theme: Family contact and support following a death

Recommendation 3.1

Owner: SPS

Progress made: Practice varies between establishments. Consultation was held with establishments to understand training requirements of Governors / Deputy Governors or other point of contact. Additional support needs and training requirements were identified.

Next key actions: Framework to be agreed and the first point of contact when the GiC is not available to be considered. Collaborate with various parties on training needs and potential support package.

Recommendation 3.2

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

Progress made: The COPFS and SPS are developing a Memorandum of Understanding (MOU) between the organisations. Issues surrounding disclosure of information to families to be factored into discussion.

Next key actions: Further information required.

Recommendation 3.3

Owner: SPS and NHS

Progress made: The family support booklet (FSB) has been revised and includes details on the engagement families can expect with the DIPLAR process, details of point of contact and Healthcare Lead. The FSB should include contact numbers for the health centre administration team. NPrCN will lead on training for NHS staff around communication with families.

Next key actions: FRG were asked to provide feedback on the FSB. NHS to contribute Healthcare Lead details. FSB to be made available on SPS website. Business Case to be submitted for printed booklets. To consider further resources which could be contained within the FSB, including bereavement and suicide support. Readability and accessibility of FSB to be ensured.

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: Discussions on wellbeing training and support packages available for staff who have experienced trauma and mechanisms of support occurred with NES. SPS are developing a paper for senior management which proposes the CIRS process be replaced by an interim Employee Assistance Programme solution. If supported, research will be undertaken to review best practice and an options appraisal will be put to senior management. Psychological services are in the early stages of developing a trauma informed package in line with the NES framework.

Next key actions: Develop framework that supports NHS/SPS debriefs. Paper to be finalised detailing the current position and proposed interim actions. Introduce interim arrangements. Research of best practice and related literature to be conducted.

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 2.4 and 3.1 for an update.

Recommendation 5.3

Owner: SPS

Progress made: To provide objective oversight, a non-executive member of the SPS Advisory Board Chairs all DIPLARs except those confirmed as natural cause, although, if requested will chair. 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 or medium term while a review is underway.

Next key actions: Current Chair remains extant and will sit on the DIPLAR Review Subgroup.

Recommendation 5.4

Owner: SPS

Progress made: SPS Health HQ staff have attend DIPLAR meetings and establishments have been informed that HQ Health should be invited to all meetings. DIPLAR documentation must be completed in all cases following a death in custody, including those in hospital. However, where the death is an expected natural cause the paperwork can be completed jointly by SPS and NHS without the requirement to hold a DIPLAR meeting.

Next key actions: SPS Health HQ will continue to attend DIPLAR meetings and learning from that will feed into the overall review. The current DIPLAR process is followed. The action in the DIPLAR review is to consider the guidance around expected natural causes.

3. Progress on Advisory Points

Advisory Point 1

Owner: SPS and NHS

Progress made: Awaiting update.

Advisory Point 2

Owner: SPS

Progress made: SPS a review into the placement of emergency alarms in cells has not yet been commenced.

Next key actions: Further detail required.

Advisory Points 3, 4, 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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