Independent Review of the Response to Deaths in Prison Custody

Second progress report

February 2024

Scottish Government
Riaghaltas na h-Alba

1. Remarks from External Chair

This is the second Progress Report to be issued in relation to the implementation of the recommendations and advisory points contained in the Independent Review of the Response to Deaths in Prison Custody ("the Review"), which was published on 30 November 2021.

Sadly there were 40 deaths in prison in 2023, seven of which happened during November 2023. In 2022, there were 44 deaths over the course of the year.

The Review made one key recommendation, 19 other recommendations, and six advisory points, all of which were accepted in principle by the Scottish Government.

I was appointed as external chair in April 2022, tasked with overseeing the implementation of the recommendations and advisory points made by the Review.

My priority was to engage with families who have direct experience of losing a loved one through death in prison custody and, with the help of Families Outside (a charity working on behalf of families affected by imprisonment), I established a Family Reference Group.

The membership of the Family Reference Group has changed over time. Representatives from four more families, bereaved by the loss of a relative after the Review was published, have joined the Group. Some have left due to frustration at the slow pace of progress and finding it too difficult to continue.

Families involved in this work have shared painful experiences in the hope of improving the situation for other families. They want to help improve the understanding of factors leading to deaths in prison custody in order to reduce and prevent more deaths.

The Family Reference Group has met on eight occasions, and representatives from the group have attended the majority of the meetings of the Death in Prison Custody Action Group (DiPCAG), the Key Recommendation Working Group, and the Understanding and Preventing Deaths in Custody Working Group.

On 14 December 2022, I produced the Independent Review of the Response to Deaths in Prison Custody: progress report - follow up ("the Progress Report") and expressed disappointment about the extent of progress, with only three recommendations completed and another partially complete at that time.

On 18 December 2022, the Cabinet Secretary for Justice and Veterans and the Cabinet Secretary for Health and Social Care sent a joint letter to the SPS Chief Executive and all NHS Chief Executives and Integration Authorities Chief Officers urging them to prioritise the work to implement the recommendations. In recognition of the need for leaders across the justice and health system to work together to improve prison healthcare, it was decided to form a short-life Strategic Leadership Group (SLG).

Despite asking, I have not been invited to speak to the SLG but have had a meeting with the co-chairs.

On 21 December 2022, I had the opportunity to speak about the Progress Report at the national Scottish Prison Service (SPS) Governors in Charge Forum. I expressed my gratitude for the time Governors had given me when I visited four establishments earlier that month and emphasised the importance of having an operational perspective on the various changes being proposed. I repeated my request for one of the Governors to join the DiPCAG to participate in discussions about implementation of the Review's recommendations.

Following this meeting, a Governor was nominated to attend DiPCAG meetings, however this has only happened once. I have not been invited back to the Governor in Charge Forum and deaths in prison custody is not a standing item on the agenda.

During 2023, work continued to try to address more of the recommendations and advisory points. Formal updates were sought regularly from the relevant agencies.

On 20 September 2023, I gave evidence to the Criminal Justice Committee (Official Report - 20 September 2023) at which time I said that the pace of improvement continued to be slow, with only two more recommendations being completed since the Progress Report was published in December 2022, bring the total to number to five.

On 25 October 2023, I had the opportunity to discuss progress with the Cabinet Secretary for Justice and Home Affairs. On 21 November 2023, I met with both the Cabinet Secretary for Justice and Home Affairs, and the Cabinet Secretary for NHS Recovery, Health and Social Care.

During October and November 2023, I also had various meetings with people responsible for implementing changes operationally, including a representative of the Prison Officers Association (Scotland); the SPS Advisory Board member who acts as the independent chair for Death in Prison Learning, Audit and Review (DIPLAR) meetings; two Governors in Charge; a representative from HM Inspectorate of Prisons for Scotland (HMIPS) and a senior nurse working in prison healthcare.

Based on the most recent updates provided, coupled with the outcome of these meetings, I am now able to say that eight out of 19 recommendations have been completed, with another partially complete. Two of the six advisory points have been addressed. The key recommendation is work in progress.

I have been given assurances that a further three recommendations and another advisory point will have been completed by the end of April 2024. In addition, the work carried out by the National Prison Care Network to develop a Toolkit will address another three recommendations, but these cannot be considered compete until all NHS Boards ensure the Toolkit is implemented.

This report contains a summary of the work carried out so far under each of the recommendations and advisory points. I will make comment on the position with some of the recommendations and advisory points as follows:

Key recommendation

The key recommendation is that *"a separate independent investigation should be undertaken into each death in prison and should be carried out by a body wholly independent of Scottish Ministers, the Scottish Prison Service or the private prison operator and the NHS".*

A working group met monthly between May 2022 and August 2023, chaired by the Scottish Government, and including representatives from the Family Reference Group, the SPS, NHS, Crown Office and Procurator Fiscal Service (COPFS), Police Scotland, and HMIPS. Initially the group mapped out the existing processes and sought to identify gaps that a new process would address. There has also been an effort to learn about approaches in other jurisdictions, namely England, Wales, Northern Ireland, and Ireland.

Various workshop exercises have taken place, including with the Family Reference Group, and a pilot of the new investigative process started in September 2023. The first pilot exercise has been completed and is currently being evaluated. A second pilot exercise is planned and the intention is to test the new process for different categories of deaths. When the pilot phase is completed, there will need to be careful evaluation to assess if it actually enhances the current approach.

My own view continues to be that the key recommendation is aimed at treating the symptoms (time delay and poor communication with families), rather than the problem itself, which is the Fatal Accident Inquiry (FAI) process. The terms of reference for the Review and for my role as external chair exclude looking at the COPFS and the arrangements for FAI, however I have found it impossible to ignore criticisms of the FAI process. Families feel the length of time between the death of their loved one and finding any answers at the FAI is far too long and that the communication from COPFS is inadequate and lacks empathy.

The proposed new independent investigative process would be in addition to the current processes. The Lord Advocate retains primacy as the head of the system for the investigation of sudden or suspicious deaths, which includes preparation for the FAI and an assessment of whether there is any criminality. The SPS has its internal process, the DIPLAR and the NHS has its process, the Significant Adverse Event Review (SAER). Prison officers, staff and healthcare professionals contribute to all three of these processes. The introduction of a fourth process seems to me to introduce added complication into a system that is already difficult for families to navigate and potentially more traumatic for everyone involved. In the current financial climate, it seems unrealistic to think that a new agency or body will be established to carry out the proposed new process.

I am not optimistic about the key recommendation being delivered any time soon or indeed at all: the introduction of a new body to carry out the new investigative process seems to me to be highly unlikely.

Recommendation 1.1

"Leaders of national oversight bodies should work together with families to support the development of a new single framework on preventing deaths in custody".

It has been disappointing that there is has been a lack of ownership and leadership from the scrutiny bodies to take this recommendation forward. In the absence of any enthusiasm, I have chaired the Understanding and Preventing Deaths in Prison working group myself.

It was quickly obvious that data on prison deaths and analysis of trends were essential to achieving this recommendation. Another recommendation (3.4) asks for a comprehensive review into the main causes of all deaths in prison custody.

One positive development was the publication of an initial analytical report on 30 August 2023, Deaths in Prison Custody in Scotland 2012-2022, which used data published by the SPS on deaths in prisons between 2012 and 2022. Of the 350 deaths recorded between 2012 and 2022, the majority (57% or 199) were attributed to disease, illness, and natural causes. Only three homicides were recorded over the whole time period analysed. 29% (103) occurred due to intentional self-harm and 14% (48) were attributed to poisonings (where drugs were mentioned on the death certificate).

As noted in the report, the production of this analysis is the starting point for a series of data and evidence publications that will be produced by the Deaths in Prison Custody Action Group (DiPCAG) in the coming year. Following the successful development of a data sharing agreement, work is now underway with the assistance of National Records Scotland (NRS), which will examine cause of death in custody in greater detail. This will also importantly provide comparisons to trends in the general population accounting for the age distribution. It is anticipated that this work will be completed in early spring 2024. Furthermore, it is also expected that further analysis using the official national prison statistics will also be undertaken in the coming year, which will consider the full custodial journey of individuals who have died in custody including examining in full their whole time spent in prison custody and possible movement across the different establishments.

In my view, analysis of prison deaths should be mainstream work for the Scottish Government in order to enhance the understanding of trends and causes of deaths in prison to inform work to prevent future deaths. This work should include consideration of the recurring and systemic issues identified via the DIPLAR process.

Recommendation 1.3
"The Scottish Prison Service should develop a more accessible system so that where family members have serious concerns about the health or wellbeing of someone in prison, these views are acknowledged, recorded, and addressed, with appropriate communication back to the family".

This is one of the recommendations I identified in December 2022 as not being difficult to achieve, yet it is still not completed. There has been work to install dedicated telephone lines in every establishment however there has been no change to the SPS website. Online is an obvious start point for anyone wanting to highlight concerns, however it is difficult to find anything on the SPS website about what a family member can do if they are concerned about someone in prison.

Recommendation 3.2
"The SPS and NHS should review internal guidance documents, processes, and training to ensure that anyone contacting the family is clear on what they can and should disclose. SPS should work with COPFS to obtain clarity as to what can be disclosed to the family without prejudicing any investigation, taking due account of the need of the family to have their questions about the death answered as soon as possible".

Whilst this recommendation is not overly resource dependent, I could see that it might take time and did not highlight it in my first Progress Report as one that should be easy to achieve. However, I would not have expected it to still be incomplete after two years. The work the SPS has done to revise the DIPLAR process includes improving communication with families, which makes it all the more important that SPS is confident about what information can be shared. Meaningful communication with families, particularly from COPFS, is something that has been raised repeatedly.

Joint NHS and SPS Recommendations 1.2, 2.1, 2.3, 4.1, 4.2
The NHS National Prison Care Network deserves credit for producing a "Death in Prison Custody NHS Support Toolkit", which is a comprehensive product covering all the training and support aspects highlighted in the Review. The Toolkit has also been circulated to SPS HQ and SPS College so is available for SPS to use. These are joint recommendations and as such I believe that SPS should be using this product to train and support its staff.

It is vital that all Health Boards use the Death in Prison Custody Support Toolkit to train and support their staff. The National Prison Care Network works hard to achieve improvements across the country and to seek responses from health boards in relation to completion rates for training and implementation of changes.

I have been told that in July 2023 NHS Chief Executives agreed to implement the outstanding NHS recommendations by the end of 2023, however not all Boards have responded to the National Prison Care Network's request for information and I know some have yet to begin the Confirmation of Death training included in the Toolkit. This illustrates the point that, despite their best efforts, the National Prison Care Network does not have the power to ensure compliance.

At my meeting with the co-chairs of the SLG, I was given assurances that a network of Executive-level leads from all territorial Health Boards had been established to promote prisoner healthcare. I would expect these senior people to ensure the hard work of the National Prison Care Network in producing the Toolkit is followed up by ensuring implementation across the country. The Network has done as much as it can: the NHS recommendations that remain open are for the NHS Boards to address.

DIPLAR recommendations 2.4, 5.1, 5.2, 5.3
Throughout 2023, the SPS has carried out significant work on its DIPLAR process. The DIPLAR Review Group was set up in September 2022, and the revised process was introduced at the end of August 2023.

In terms of recommendation 5.1 ("*SPS and NHS should ensure that every family is informed of the DIPLAR and, if applicable, the SAER process, and their involvement is maximised"*), I think the SPS revised DIPLAR process and associated guidance does address this point. I am less convinced about the consistency of the NHS position in relation to SAER about the types of deaths in prison custody that result in a SAER and genuine engagement and transparency with families.

I have been impressed by the SPS's Advisory Board member who chairs the DIPLAR for all deaths in prison, apart from those deaths from natural causes (in one establishment, the Advisory Board member chairs the reviews for these deaths too). This individual has the necessary breadth of experience across health, social care, and prison environments, as well as a warm and engaging personal style. It is difficult to know the extent to which the revised DIPLAR process has contributed to improvements (having only been introduced at the end of August 2023) and how much can be attributed to the professional credibility and personality of one individual.

The recommendation 5.3 states that an independent chair should chair **all** DIPLAR meetings, providing assurance that all deaths in custody are considered for learning points. This includes deaths by natural causes in prison, which are currently being chaired by the Governor of the establishment where the death happened (apart from one establishment). It seems the SPS has decided it is content with this approach, however it does not meet the recommendation and in my view having the Governor chair the DIPLAR of deaths in his/her own establishment does not create the best conditions for learning.

Some of the advisory points also relate to the DIPLAR process.

Advisory point 3 asks that consideration be given by the SPS and the NHS to whether other people held in prison who knew the deceased may have relevant information and how best to include their reflections in the DIPLAR and SAER processes, in particular whether discrimination of any kind was perceived as a factor in the death. The SPS believes this point has been addressed by the revised DIPLAR template having a section for recording any intelligence that could be relevant. The guidance for completion of the paperwork refers to checking electronic or written records and makes no mention of seeking views from other prisoners who lived with and knew the deceased, nor is there any reference to finding out if discrimination featured as part of the death. I do not agree that the action taken has addressed the issues raised by this advisory point.

Advisory point 4 asks that the SPS and the NHS include a separate section where observed systemic or recurring issues are recorded by the independent chair to ensure holistic improvements to broader systems and processes are more easily recognised and addressed. Staff from SPS Health HQ attend all DIPLARs and support the independent chair in identifying learning and actions.

Given that about half of all deaths in prison are categorised as natural deaths and the independent chair does not chair these (contrary to recommendation 5.3 above), I cannot be confident that a consistent approach is being taken to identifying systemic issues that may have contributed to a death. This is the main reason why I

disagree with the practice of Governors chairing reviews into natural deaths that occurred in their own prisons.

That said, I am prepared to accept that this advisory point has been addressed through SPS HQ staff attending all DIPLAR and adding systemic or recurring issues to the national tracker. Crucially the HQ team take follow up action to share the learning across the prison estate. There is a need for scrutiny of the extent to which all establishments act on the learning from DIPLAR.

Advisory point 6 asks that the SPS develop clear protocols for memorial services, letters of condolence, and donations from people held in prison for families of the deceased. The information provided by the SPS emphasises their people-centred approach, where action taken varies depending on the individual circumstances and the wishes of the family. Various examples have been given of good practice in some establishments involving engagement with families, including attending memorial services, visiting the place where their loved one was found, and meeting people who knew the person.

The important point is that every family bereaved by a death in prison should be offered a choice of options for support, regardless of which establishment is involved. There should be a clear written guidance (a protocol) about the options that should be considered, even though each family will make different decisions.

My role as external chair will come to an end shortly but it is vital that the work to implement the recommendations and advisory points of the Review continues. My role did not extend to checking that the various changes have been put into practice nor to assessing their impact. To be sure that improvement has been achieved, there needs to be an ongoing programme of monitoring and inspection by the scrutiny bodies.

In conclusion, whilst the pace of implementation has been slow, there are signs of improvement. I am really grateful to everyone who has attended the various meetings associated with this work and those who have provided updates throughout the year.

I continue to be humbled by the contributions from families who have been bereaved through a death in prison custody, who are committed to using their experiences to help improve the situation for others in the future.

Gill Imery
External Chair
Oversight of implementation of recommendations
Independent Review of Response to Deaths in Prison Custody

January 2024

2. Summary of progress on implementation of recommendations of Review

Recommendation: 1
A separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator and the NHS.

Action Taken:

- The Scottish Government are leading on the implementation of this recommendation and are progressing it in conjunction with representatives from Scottish Prison Service (SPS), NHS, Crown Office and Procurator Fiscal Service (COPFS), Families Outside and bereaved relatives (who are members of Family Reference Group).
- The draft new process has been developed and refined in collaboration with partner agencies and representatives of bereaved family members.
- Key considerations in developing the draft new process have included: ensuring a focus on communication with bereaved families throughout the new process, with the aim of helping inform bereaved relatives and seeking to provide answers to questions they may have and adopting a trauma informed approach to all involved with associated challenges such as potential impacts on staff due to the potential for multiple interviews of them taking place for different investigations.
- A pilot of the new independent investigative process has begun and will take several months to complete. To test the process, the first phase of the pilot is a desktop exercise based on cases which have already reached a Fatal Accident Inquiry (FAI) determination and are fully anonymised so that individuals are unidentifiable. This phase of the pilot aims to test out the draft process in practice, how workable it is and to identify any issues. An investigation into more than one death will be undertaken as part of this phase in order to test the new process in a variety of circumstances.
- One desktop pilot exercise commenced in September 2023. An evaluation process is currently ongoing in respect of that exercise.

Next Steps:

- Evaluation of the first pilot exercise will be completed. The evaluation process aims to consider whether the independent investigation is workable in practice and meets the fundamental findings of the Independent Review. Careful evaluation will be undertaken to assess whether the proposed new process has meaningful outcomes and adds to current investigative processes. Consideration of resources will also be required.
- A second desktop pilot will take place in February 2024, following which a wider evaluation will take place. At that point, consideration will be given to whether another desktop pilot exercise is required to provide a thorough evidence base in which to evaluate.
- Following the evaluation, consideration will be given to whether the pilot should move to a further phase which it is intended would involve

consideration of the circumstances of a death shortly after it occurs, alongside existing investigative/review processes.

Status: In progress. This is a long term piece of work and timescales are partially dependent on how many pilot exercises require to be undertaken.

Recommendation: 1.1
Leaders of national oversight bodies (Healthcare Improvement Scotland, NHS boards, Care inspectorate, National Suicide Prevention Leadership Group and HMIPS) should work together with families to support the development of a new single framework on preventing deaths in custody.

Action Taken:

- Engagement has taken place with the national oversight bodies named in the recommendation seeking their leadership to progress this recommendation. A working group was established with representatives from Healthcare Improvement Scotland (HIS), Public Health Scotland (PHS), NHS National Prison Care Network (NPrCN), HMIPS, relevant Scottish Government policy area leads and a representative of bereaved families.
- The group consider progress on this recommendation to be inextricably linked to the need to undertake analysis of causes of deaths in prisons to better understand why deaths occur. This step is necessary to inform any prevention measures to be progressed, in addition to current policies and practices that directly or indirectly contribute to the prevention of deaths in prison custody.
- Chaired by the Head of the Scottish Government's Justice Analytical Service (JAS), a data and evidence working group which reports to the DiPCAG was established. The aim of the group is to explore the possibilities for further enhancement of data on deaths in prison custody, develop a workplan for deliver on these enhancements and provide peer review to analysis carried out by individual organisations.
- Scottish Government officials have been collaborating with SPS and NHS partners in a number of ways to improve the provision of healthcare in prisons, including the establishment of a network of health board leads in prison healthcare and creation of a short-life Strategic Leadership Group led by strategic leaders from across the health and justice system that aims to remove systemic barriers that impact the delivery of healthcare and positive outcomes for people in prison. As part of this, the NPrCN has developed a Prison Healthcare Target Operating Model (TOM). The TOM provides a framework for a nationally consistent approach to the delivery of the wide range of healthcare services required in a prison.
- The NPrCN are leading on progressing guidance on the clinical management of people suspected of intoxication in the form of revising the Management of Offender at Risk Due to any Substance (MORS) policy. This is being done in consultation with the Royal College of Emergency Medicine. The prisons GP Forum have provided feedback on the revised policy.
- The NPrCN is working alongside SPS to allow for in-cell telephony to be available for mental health and triaging appointments.

Next Steps:

- Implementation of the TOM is a longer term piece of work that it is hoped will be implemented in all health boards over the next 2-3 years.
- The NPrCN will work to agree the revised guidance within their governance structure by end of April 2024. Engagement will thereafter have to take place with NHS Health Boards to ensure it is embedded in practice.

- A revised version of the MORS policy, taking into account feedback from the GP Forum, has been shared more broadly with NHS Boards for further clinical input and feedback. To also be shared with the SPS for feedback, prior to sign off and implementation.
- Use of in-cell telephony for mental health and triaging appointments is expected to become available in early 2024. Guidance to support this has been developed and requires to be finalised.

Status: In progress. This is a long term piece of work.

Recommendation: 1.2
The SPS and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.

Action Taken:

- The NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when. By providing NHS staff with a single document containing all relevant information following a death in prison custody, the aim of the Toolkit is to ensure a trauma informed, compassionate response to families and staff and improve consistency in practice between prisons.
- This Toolkit was circulated to all NHS Boards and Prison Healthcare Centre Managers for them to adopt on 26 October 2023.
- The Toolkit is hosted on the NHS SharePoint platform that is accessible by all prison healthcare staff. The NPrCN have raised awareness of the Toolkit with primary care nurses in prison healthcare centres, prison GPs, the Prison Adult Nurses Forum, Prison Healthcare Managers, NHS Board Leads, NHS Executive Board Leads, members of the Network's Core Steering Group and Oversight Board, NHS Education for Scotland (NES), HIS, members of the Criminal Justice Voluntary Sector Forum and wider partners.
- The aim of this document is to help support NHS staff working within the prison environment, improve consistency and ensure that families are informed and involved in processes following the death of the relative in prison.
- The Toolkit includes:
    - Roles and responsibilities across agencies; NHS, SPS, Police Scotland in response to a death in prison, with clear process for NHS staff.
    - Education and training for Registered Nurses to undertake confirmation of death.
    - Expectations in relation to reviews, documentation and learning relating to each death.
    - Support to provide improved communication with families following a death in prison.
    - Resources to support NHS staff wellbeing following a death in prison.
    - Resources to embed trauma informed practice across healthcare in prison teams to support people in prison and all staff working in prison.
- NPrCN representatives engaged with the family reference group to provide them with an overview and opportunity to feedback on the Toolkit.
- Scottish Government officials are supporting the implementation of this Toolkit nationally. The Toolkit has been circulated to NHS Board Chief Executives and the newly established network of health board leads in prison healthcare, that provides a mechanism for raising awareness and promoting widespread implementation of the Toolkit.

Next Steps:

- The NPrCN are putting in place reporting arrangements with NHS Boards on some aspects of the Toolkit under five key themes:
    - Deaths to be confirmed by Nurses in prison to reduce reliance on Scottish Ambulance Service. This data will be collected in January 2024.
    - Robust documentation in relation to each death with clear actions and learning points. This data will collected in April 2024.
    - Improved communication with families following a death in prison.
    - Greater wellbeing support for NHS staff following a death in prison.
    - Embed trauma informed practice across the prison estate to support people in prison and all staff working in prison.
- The timescale for reviewing the final three themes is at the discretion of the NHS Board.
- The NHS Scotland Delivery Planning Guidance 2024/25 requires NHS Boards to set out how they will progress delivery in the priority areas of reducing health inequalities by improving custody healthcare through participation in the Executive Leads network and ensuring that the deaths in custody toolkit is implemented.
- HIS as part of their role in the HMIPS inspection process will also monitor implementation of the Toolkit. They will seek evidence of applied learning from adverse events and how that is shared with staff. HIS will also consider how healthcare information is provided to families and recording of next of kin details in clinical records.
- Ongoing monitoring of implementation of the Toolkit will be monitored through the NHS Annual Delivery Plan 2024/25 process in collaboration with sponsorship teams within the Scottish Government.

Status: In progress – product has been created that requires to be adopted and implemented in each NHS Health Board. No clear timescales for that to be completed.

Recommendation: 1.3
The SPS should develop a more accessible system so that where family members have serious concerns about the health/wellbeing of someone in prison, these views are acknowledged, recorded and addressed with appropriate communication back to the family.

Action Taken:

- A process is in place where whereby key stakeholders, including Families Outside, HMIPS and Prison Monitor Co-Ordinators can make referrals with concerns about the wellbeing of someone in prison by way of submission of an Electronic Concern Form. In the 2022 calendar year, Families Outside submitted 32 electronic concern forms to SPS.
- A decision made that rolling out the use of electronic concern forms for use by family members would not provide the necessary reassurance that SPS were acting responsively without any unnecessary delay.
- SPS thereafter decided to implement a direct access 24 hour phone line in every establishment. The phones will be situated in areas where there is full cover and have a different ring tone to alert staff to the need to prioritise answering. The first option on the updated answer machine message will be to raise a concern.
- SPS representatives attended the family reference group to provide them with an update on new telephone system to report concerns.
- Installation of the required technology was completed in all SPS run establishments in December 2023. The need to install some additional data points and cabling in some establishments impacted the speed of this roll out.
- SPS have guidance on processing and recording of concerns. An Establishment Concern Form Assurance Log has been introduced. This requires all concerns to be logged along with confirmation of adherence to the process outlined in the guidance. Duty Managers in establishments will have responsibility for assurance locally. SPS Headquarters have responsibility for assurance nationally.
- SPS have provided assurances to the NPrCN that any concerns raised relating to healthcare will be communicated to the prison healthcare team in a timely manner.

Next Steps:

- The new phone line system requires to be tested with the aim of going live early in 2024.
- Work requires to be undertaken to align the phone systems in the two privately run establishments with SPS run establishments.
- A 'Raising a Concern Booklet' is being developed and requires to be finalised following consultation with Families Outside. This will be made available electronically on SPS and Families Outside website and in hard copy in visitor centres and in establishment entry area.
- A standard operating procedure for the new telephone system is being developed that will address issues such as: how to deal with calls; advice on dealing with misuse and formalising how feedback is shared with NHS (or

other colleagues where identified) and the process for thereafter following up with the caller. A bespoke package of formal support for staff to manage difficult conversations is also being considered as part of the SOP.

- SPS website is being updated and is scheduled to go-live by end of January 2024. It has been designed to be make information for families more accessible. When the website is available, SPS will offer to engage with the Family Reference Group to test accessibility and seek their feedback on the available information.

Status: In progress. Due to be implemented by end of January 2024.

Recommendation: 1.4
When someone is admitted to prison, SPS and the NHS should seek permission that, where prison or healthcare staff have serious concerns about the health or wellbeing of someone in their care, they are able to contact the next of Kin. If someone is gravely ill and is taken to hospital, the Next of Kin should be informed immediately where consent has been given. This consent should be recorded at every admission to prison to allow for cases in which someone is unable to give consent.

Action Taken:

- On 17 November 2022, SPS issued a Governors' and Managers' Action Notice (GMA) to all prisons requesting a statement of assurance to SPS Headquarters by 30 November 2022 that there is a process in place to ensure that up to date next of kin details are recorded electronically, along with a record of whether or not that individual has given consent for their next of kin to be contacted in an emergency. This GMA also serves as a reminder of the relevant Prison Rules.
- SPS Headquarters have been provided with assurance that processes exist within each prison to ensure that next of kin details are recorded on admission to prison. To improve on these processes prisoners are now also asked to confirm up to date next of kin details annually or on every new admission to prison and this is recorded by SPS.
- The Prison Rules require the GiC to ask a prisoner who is unwell, injured or transferred to hospital if they wish anyone to be contacted to be informed.
- A review of SPS's Death in Prison Learning and Audit Review (DIPLAR) held over the proceding 12 months from the date of the issue of the GMA has provided assurance that next of kin details are being recorded and kept up to date. Challenges remain in ensuring that SPS hold accurate next of kin details for reasons such as those in prison failing to identify next of kin or identifying a person as next of kin that family members may not recognise as such.

Status: Implemented

Recommendation: 2.1
SPS and NHS should jointly develop enhanced training for prison and healthcare staff in how to respond to a potential death in prison, including developing a process for confirmation of death.

Action Taken:

- As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.
- The Toolkit sets out roles and responsibilities of the NHS, SPS and Police Scotland in response to a death in prison custody.
- The Toolkit includes confirmation of death education and training guidance, including links to other resources and flowchart.
- The update provided under recommendation 2.3 also provides further information relevant to this recommendation.
- The NPrCN facilitated its first FAI Training session in September 2023. This training was open to GPs, Nurses and Managers working within the Scottish Prison Estate and Police custody. The following topics were discussed:
    - Why FAIs are held
    - Court Procedure and Providing Evidence
    - Practitioner Perspective and Duty of Candour
    - NHS Central Legal Office Role and Support
    - Prison and Police FAI scenarios
- The NPrCN has developed a “Attending court for a Fatal Accident Inquiry (FAI)” support resource for staff.
- Scottish Government officials are supporting the implementation of this Toolkit nationally. The Toolkit has been circulated to NHS Board Chief Executives and the newly established network of health board leads in prison healthcare, that provides a mechanism for raising awareness and promoting widespread implementation of the Toolkit.

Next Steps:

- The NPrCN is putting in place reporting arrangements with health boards on some aspects of the Toolkit, including:
    - Deaths to be confirmed by Nurses in prison to reduce reliance on Scottish Ambulance Service. This will be reviewed in January 2024.
    - Robust documentation in relation to each death with clear actions and learning points. This data will be collected in April 2024.
- The NHS Scotland Delivery Planning Guidance 2024/25 requires NHS Boards to set out how they will progress delivery in the priority areas of reducing health inequalities by improving custody healthcare through participation in the Executive Leads network and ensuring that the deaths in custody toolkit is implemented.
- HIS as part of their role in the HMIPS inspection process will seek evidence of mandatory training compliance around the confirmation of deaths training.

- SPS are developing documents on support for staff attending FAIs that will be made available to Human Resource (HR) Teams on SPS SharePoint platform once finalised following advice from their legal team.
- The NPrCN is liaising with speakers to support further FAI training, this is likely to be held May 2024.

Status: In progress – product has been created that requires to be adopted and implemented in each NHS Health Board. No clear timescales for that to be completed.

Recommendation: 2.2
SPS should improve access to equipment such as ligature cutters and screens to save vital time in saving lives or preserving dignity of those who have died.

Action Taken:

- As of September 2022, all establishments had in place screens that can be utilised to preserve the dignity of someone who has died. Each prison has local arrangements in place to ensure staff are aware of the purpose of these screens and how to access them.
- Following a scoping exercise a new model of ligature cutter was identified that was considered to be more effective than the model previously available within prisons.
- All establishments had supplies of the new model of ligature cutter delivered over April – June 2023 (noting HMP Stirling opened in June). They were all confirmed as being deployed by 23rd June 2023.
- In the majority of establishments the new ligature cutters have been placed in crash packs (similar to a first aid pack) in residential areas of each establishment as well as being issued to all patrol staff working in residential areas during lock-up periods. In some establishments due to security risks, instead of the new ligature cutter being placed in a crash pack nominated staff carry them in residential areas at all times.
- A national Risk Assessment has been completed and staff briefings have been provided to allow familiarisation with the new tool and mitigate the risk of personal injury along with safe and effective use. A staff information sheet was also distributed.
- A training video has been produced by SPS College (SPSC) to supplement the staff briefings and has been available on SPS internal staff training platform since July 2023. Uptake of the training has been high amongst staff.
- Guidance and processes for both sanitisation and re-sharpening have been developed.

Status: Implemented

Recommendation: 2.3
NHS and SPS should address the scope to reduce unnecessary pressure on the Scottish Ambulance Service when clinical staff with appropriate expertise attending the scene are satisfied they can pronounce death.

Action Taken:

- A 'Confirmation of Death for Prison Healthcare' webinar training product has been developed that is to be completed by all Registered Nurses working within a prison. This has been available since 5 July 2023. The training covers: Legal and Regulatory Frameworks; Clinical Scenarios in the context of Prison Healthcare; Demonstration of the Confirmation of Death in Scotland Process and Perspectives of a nurse in Prison Healthcare.
- As described under recommendation 1.2, a Death in Prison Custody NHS Support Toolkit has been developed. This includes confirmation of death guidance, links to other resources and flowchart.
- A Confirmation of Death Pocket card for reference has been made available in all prison healthcare centres.

Next Steps:

- The confirmation of death training should feature within the Registered Nurse's induction process and be completed every 2 years to maintain competence.
- Completion of the training will be monitored – the aim is to have 100% completion by staff in post at that time by January 2024. Feedback from some establishments indicates a high level of completion, however there are other NHS Boards which have still to commence training of their staff. These NHS Boards have provided assurances that the training will be completed by end of January 2024.
- NHS Boards require to agree a process to ensure they have robust processes in place to enable confirmation of death to be carried out, during out of hours when there are no prison healthcare staff on site and where there is a 'Do not attempt cardiopulmonary resuscitation' decision in place and the Sottish Ambulance Service are not at the scene.
- HIS as part of their role in the HMIPS inspection process will seek evidence of mandatory training compliance around the confirmation of deaths training.

Status: In progress – product has been created that requires to be adopted and implemented in each NHS Health Board. Due to be implemented by end of January 2024.

Recommendation: 2.4
SPS should review the DIPLAR proforma to ensure they evidence how the impact of a death on others held in prison is assessed and support offered.

Action Taken:

- A DIPLAR Review Group was established in September 2022 with the purpose of progressing all of the recommendations and advisory points relating to the DIPLAR process. The Group was made up of representatives from SPS Suicide Prevention Co-ordinators, Prison Chaplaincy, Governor in Charge (GiC), NHS Prison Healthcare Teams and NPrCN.
- The DIPLAR Review Group have produced a revised DIPLAR Report template and guidance document to be used when someone dies in prison custody. Part of this process included wide consultation, including with the Family Reference Group. Testing and modification was undertaken on the revised documentation.
- On 31 August 2023, a GMA was issued to all prisons to advise that the revised DIPLAR Report template and guidance document are to be implemented with immediate effect.
- The DIPLAR process will now be fully owned by SPS, however revised documentation ensures NHS involvement throughout including in agreeing the shared action plan, roles and responsibilities.
- The revised DIPLAR Report template documentation includes a specific section that requires to be completed to evidence the impact of the death on staff, the establishment and on other people in custody. Any action to provide support should also be recorded, including who provided immediate and longer term support and how the death was communicated to staff and other people in custody.
- SPS Chaplaincy team will remain a key support both immediately and in the longer term following a death.

Next Steps:

- A further presentation and engagement session with GiC is scheduled for the 25 January 2024
- The revised DIPLAR Report template and guidance document will be formally reviewed in February 2024.

Status: Implemented

Recommendation: 2.5
The SPS and NHS must ensure that child-friendly policies and practices are introduced and applied to all children, aged under 18 , in accordance with the UNCRC. Reviews of deaths in custody involving a child or young person must include an assessment of whether or not the particular rights of children were fulfilled, with child-friendly policies and procedures followed in practice

Action Taken:

- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR report template includes a specific section that requires confirmation that an assessment of whether the rights of the child have been adhered to, if the death involves an individual under the age of 18 years.
- Where the death of an individual under the age of 18 years occurred, their Lead Professional or Named Person must also attend the DIPLAR.
- As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.
- The section of the Toolkit that addresses expectations in relation to reviews, documentation and learning relating to each death, details the need in relation to individuals under the age of 18 to give consideration to the United Nationals Convention on the Rights of the Child (UNCRC).
- HIS, in collaboration with the Care Inspectorate, co-host the National Hub for Reviewing and Learning from the Deaths of Children and Young People. This was launched in October 2021. Reviews will be conducted into the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of continuing care or aftercare at the time of their death. Where a care leaver, who was in receipt of continuing care or aftercare provision immediately prior to their detention or imprisonment dies in prison custody, consideration should be given as to whether the young person meets the criteria for inclusion in the National Hub review process. The criteria reflects the shift in policy, practice and culture as set out in UNCRC and the principles of the Promise.
- The overarching purpose of the National Hub is to ensure that data generated from these reviews informs national policy, education and learning and contributes to the prevention of child deaths in the future. The National Hub does not carry out individual child death reviews but has developed guidance for reviewing the deaths of children and young people in Scotland. The National Hub aims to ensure that the death of every child in Scotland is subject to a quality review by:
    - improving the quality and consistency of existing reviews;
    - improve the experiences and engagement with families and carers;
    - sharing learning from current review processes across Scotland that could direct action to help reduce preventable deaths.

Next Steps:

- Formal connections to be established between SPS, leads in the NHS and lead Scottish Government officials to identify others ways in which

compatibility with the UNCRC can be embedded into policies, strategic frameworks, action plans and other key initiative.

Status: Implemented

Recommendation: 3.1
The Governor in Charge should be the first point of contact with families (after the Police) as soon as possible after a death. An SPS single point of contact (other than the chaplain) should maintain close contact thereafter, with pastoral support from a Chaplain still offered.

Action Taken:

- On 7 November 2022, SPS issued a GMA formalising the process of the GiC contacting a family following a death. The GMA provides that:
    - The name and contact details of the Duty Manager should be shared with Police Scotland so that this can be passed to families to make immediate contact if they wish to do so;
    - The GiC (or Deputy Governor in their absence) should contact the family the next day and offer support from the Chaplaincy Team;
    - These actions must be recorded within the DIPLAR paperwork.
- The revised family support booklet (the update under recommendation 3.3 provides more information on this) contains details of the support available from within the prison including contact details for the GiC, Prison Chaplain and healthcare team.
- The revised DIPLAR guidance details that the responsibilities of the Chaplain include offering emotional and pastoral support; assisting with returning property to the next of kin and assisting with the arrangement of funeral service, memorial services and tributes.
- An audit of the 31 DIPLAR held since the GMA was issued revealed that 28 evidenced compliance with the GMA. In the 3 where this was not recorded, SPS headquarters are following this up with the establishments concerned to identify reasons for this not being done.

Status: Implemented

Recommendation: 3.2
SPS & NHS should review internal guidance documents, processes and training to ensure that anyone contacting family is clear on what they can and should disclose. SPS should work with COPFS to obtain clarity as to what can be disclosed to family without prejudicing any investigation, taking due account of the need of the family to have their questions about the death answered as soon as possible.

Action Taken:

- COPFS and SPS are seeking to agree the terms of a Data Sharing Agreement (DSA). This DSA provides a framework to support the lawful processing of personal data and to allow SPS and COPFS to comply with their own legal and professional obligations. The agreement relates to how and when information is shared between SPS and COPFS. The agreement will include agreed timescales for the provision of information from SPS to COPFS.
- COPFS are coordinating their input to this DSA with separate ongoing work to improve the quality, consistency and timeliness of information provided by the NHS, specifically Significant Adverse Event Review (SAER).
- COPFS and SPS are separately undertaking discussions to provide clarify about the information that SPS can disclose to families.
- As described under recommendation 1.2, a Death in Prison Custody NHS Support Toolkit has been developed. Included in the Toolkit is guidance on duty of confidentiality in respect of deceased patients and how to consider requests for information by relatives of deceased patients. The Toolkit also signposts to training resources to support with this.
- Healthcare staff should record any discussions that take place with family members and the information shared as part of the individual's electronic record.

Next Steps:

- Following the revision of the DIPLAR paperwork and guidance, COPFS and SPS to progress discussions to facilitate the earlier sharing of information from the DIPLAR report by SPS to COPFS. It is anticipated that this process will form part of the DSA.
- COPFS will continue to work with Scottish Government, HIS and Health Boards in an ongoing programme of improvement in 2024 aimed at supporting a more consistent approach to the SAER process across the country and the information provided to bereaved relatives at an earlier stage.

Status: In progress. DSA due to be formally agreed between SPS and COPFS by the end of February 2024.

Recommendation: 3.3
The family should be given the opportunity to raise questions about the death with the relevant SPS and NHS senior manager and receive responses. This should be spelled out in the family support booklet jointly created and reviewed by the SPS and the NHS.

Action Taken:

- The family support booklet was redrafted by SPS Chaplaincy team in partnership with the NHS and Families Outside and following consultation with the Family Reference Group and made available to all establishments for their use.
- The revised booklet contains details of the support available from within the prison including contact details for the GiC, Prison Chaplain and healthcare team and contact details for support organisations. The booklet also contains information about the investigative and review process that will take place, including the DIPLAR, NHS SAER and FAI.
- A template letter for the GiC to send to the family has also been produced. The GiC should personalise the letter with their contact details and anything else they may wish to add from the phone call with the family (which should have taken place within 24 hours of the death) and send this to be family along with the family support booklet.
- The family support booklet has been published on the website of SPS and Families Outside. This contains a link to the revised DIPLAR guidance.
- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.
- The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to:
    - ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR;
    - agree and record responses to any questions or concerns and be clear about who is provided feedback to the family;
    - have an identified point of contact who will provide feedback following the DIPLAR, who with the agreement of the family, will meet with them in person and provide responses to questions and also provide a written copy of responses.
- As described under recommendation 1.2, a Death in Prison Custody NHS Support Toolkit has been developed. Included is a chapter on family engagement to support improve communication. It highlights the need for healthcare staff to invite family members to contribute to and be kept informed throughout any review process. It includes guidance on how families can be involved following a death using compassionate communication skills.

- The Toolkit includes links to HIS's Learning Adverse events framework and links to resources to support communications with bereaved relatives.

Status: Implemented

Recommendation: 3.4
To support compliance with the state's obligation to protect the right to life, a comprehensive review involving families should be conducted into the main causes of all deaths in custody and what further steps can be taken to prevent such deaths.

Action Taken:

- On 30 August 2023, Gillian Imery published an initial analytical report in respect of deaths in prison custody containing a high level analysis of the data published by SPS on deaths in prisons.
- This work was led by a data and evidence working group chaired by the Head of the Scottish Government's Justice Analytical Service (JAS), which comprised Scottish Government Justice and health analysts and policy officials, analysts and operational colleagues from SPS, Community Justice Scotland and the NHS.
- The report looked at deaths in the period between 2012 and 2022.
- The analysis included information on the number of deceased, causes, prison establishment of death, as well as personal characteristics of the individuals deceased.
- The report contained a number of key findings and observations on how deaths in custody have changed over the course of the period analysed.
- Led by the SPS Head of Data and Analysis a review has been undertaken of more than 200 completed DIPLAR for the period 2016 to 2022, with a view to identifying trends in areas such as learning points, good practice and areas for improvement.

Next Steps:

- Following the development and agreement of data sharing, the data and evidence working group had begun further work with the National Records Scotland which will examine cause of death in prison custody in greater detail including providing comparisons to trends in the general population accounting for the age distribution. Data will be analysed in the same way as official death statistics. This report is expected to be published in early spring.
- Analysis of the review of completed DIPLAR to be concluded and consideration to be given to potentially publishing these findings.

Status: In progress. A further report is expected to be published in early spring.

Recommendation: 4.1
NHS and SPS should develop a comprehensive framework of trauma informed support with the meaningful participation of staff, including a review of Critical Incident Response and Support policy, to ensure accessibility, trained facilitators, and consistency of approach. This should ensure staff who have witnessed a death always have opportunity to attend and that a system of regular and proactive welfare checks are made.

Action Taken:

- A SPS HR led review of the Critical Incident Response and Support policy (CIRS) is being undertaken. This has included a review of other models of support available in organisations such as Scottish Fire and Rescue Service and Police Scotland, a literature review, engagement with prison services in other European countries to learn best practice and engagement with Lifelines Scotland to discuss the potential for a bespoke SPS resource. A questionnaire has been issued to former CIRS responders, GiC, HR staff and First Line Managers seeking view on the new policy and proposal for change.
- Whilst the review is ongoing, an interim CIRS process was introduced in May 2023.
- This can be accessed by staff via SPS SharePoint platform and includes details of practical support and access to 24/7 Employee Assistance Programme (EAP) post trauma service and other self-help support options. The EAP workplace wellbeing portal included a section with dedicated advice on trauma related matters. Virtual mental health clinics are available to all staff.
- SPS Employee Wellbeing Policy was revised in May 2023 and contains a section for staff on being a witness at a FAI.
- A Trauma Support booklet has been developed; one each for staff, managers and peer support colleagues. It is intended that this booklet is given to the person at the time and thereafter followed up. This covers the signs of Trauma to look out for and the levels of support available.
- SPS's Young Person's and Women's Strategy were introduced in 2021 and outline new approaches for care in custody underpinned by providing support that is trauma informed. All new recruits to SPS receive a one-day introductory session on trauma that includes information about the NHS trauma framework and encourages consideration of how SPS practices could be carried out in a trauma informed manner. Other training sessions, such as searching and equality have trauma informed practice embedded into them and trauma informed practice is discussed within a number of operational training sessions.
- SPS training for staff working with women and young people pays particular focus to trauma informed training. This includes stand-alone training (5-day for new staff, 2-day for existing staff) as well as embedded training that focuses on carrying out operational duties in a trauma informed manner.
- As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.

- Included in the Toolkit are resources to support NHS staff wellbeing following a death in prison. Topics covered are line manager support, values-based reflective practice, essentials of psychologically informed care and NHS national wellbeing support for people working in health and social care. Also included are links to online resources and organisations where additional support can be sought.
- Highlighted is the need to carry out wellbeing checks on any staff member directly involved in a death in custody, information about proactive strategies to protect the wellbeing of teams and how and when to respond effectively to concerns about an individual's mental health. Links are including to a number of NES resources to support this approach.
- Included in the Toolkit is a recommendation that trauma informed practice should be embedded across the prison estate to support people in prison and all staff working in prison. To support this, all NHS staff should complete National Trauma Training Programme "Trauma Informed" module.

Next steps:

- A final proposal as to what will be introduced to replace the interim CIRS process is to be agreed and approved by SPS Executive Management Team. This will require the various options to be costed. The timeframe in which this is due to be done is by the end of March 2024.
- SPSC are working on a learning agreement with NES to make available on the internal SPS staff training platform three e-learning trauma modules that focus on staff wellbeing and trauma. The anticipated timescale for this is 3 months.
- The NPrCN is putting in place reporting arrangements with health boards on some aspects of the Toolkit, including:
    - Resources to embed trauma informed practice across healthcare in prison teams to support people in prison and all staff working in prison.
- The NHS Scotland Delivery Planning Guidance 2024/25 requires NHS Boards to set out how they will progress delivery in the priority areas of reducing health inequalities by improving custody healthcare through participation in the Executive Leads network and ensuring that the deaths in custody toolkit is implemented.

Status: In progress. New model for the CIRS is likely to be developed and approved by April 2024 and will then require implementation.

Recommendation: 4.2
SPS and NHS should also develop, with the meaningful participation of people held in prison, a framework of trauma informed support for people held in prison to ensure their needs are met following a death in custody

Action Taken:

- A SPS Trauma Delivery Group has been progressing the work required to implement this recommendation. To date, SPS, supported by the NES have held four Scottish Trauma Informed Leadership Training (STILT) sessions for senior staff. In each establishment either the GiC or Deputy Governor has attending this training, along with the majority of senior staff.
- In partnership with NES, four e-learning trauma awareness modules were made available at the end of September 2023 on SPS internal staff training platform. These modules aim to develop trauma informed skilled practice by enhancing understanding of: the impact of trauma and responding in a trauma informed way; trauma in children and young people; understanding the impact on mental health and evidence-based pathways to recovery and understanding the use of substances to cope with the impact of trauma. This training is not mandatory. GiC will actively encourage completion and rates of completion will be monitored.
- As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.
- Included in the Toolkit are resources and training to embed trauma informed practice across healthcare in prison teams to support people in prisons and all staff working across prisons. Education of vicarious trauma is included.

Next steps:

- SPSC will work with NHS and Psychology partners to adapt the STILT training to allow it to be delivered to senior management teams locally. The anticipated timescale for this to be rolled out is 6-9 months.
- There is a longer term plan that SPSC will create a learning and development strategy and phased plan for trauma training roll out. This will include a number of different strands of work, including:
    - a mapping exercise across two establishments is underway to inform a detailed analysis of job roles matched to appropriate levels of trauma training. Work will then be undertaken with NES to adapt existing training into a bespoke product for SPS use;
    - a literature review of trauma training will be undertaken;
    - focus groups will be undertaken with staff and individuals in prison to inform an overarching organisational training needs assessment.

  It is anticipated that it will take 12-18 months for creation of this strategy and phased plan to be agreed and roll out to commence.
- A short-life working group chaired by chaplaincy has driven the revision of Exceptional Escorted Days Absence (EEDA) forms and guidance to promote a more compassionate and positive response and the development of a Bereavement Guidance resource for staff. Provisions for attending a funeral or terminally ill family member are included and the revised paperwork and

guidance will be piloted at HMP Low Moss, Shotts and Glenochil in January 2024, with the aim of full rollout to all establishments by March 2024.

- The NPrCN is putting in place reporting arrangements with health boards on some aspects of the Toolkit, including:
    - Resources to embed trauma informed practice across healthcare in prison teams to support people in prison and all staff working in prison.
- The NHS Scotland Delivery Planning Guidance 2024/25 requires NHS Boards to set out how they will progress delivery in the priority areas of reducing health inequalities by improving custody healthcare through participation in the Executive Leads network and ensuring that the deaths in custody toolkit is implemented.

Status: In progress. It is likely to be a further 12-18 months for a strategy and plan to be in place that will then require to be rolled out.

Recommendation: 5.1
SPS and NHS should ensure every family should be informed of the DIPLAR and if applicable, the SAER, process and their involvement maximised. This includes the family having the process (and timings) and their involvement clearly explained; being given the name and contact details for a point of contact; knowing when their questions and concerns will be considered by the Review and receiving timely feedback.

Action Taken:

- There is a requirement on the GiC (or Deputy Governor in their absence) to contact the family the next day following a death. Following that call, the GiC should write to the family and send them the family support booklet which provides information about the DIPLAR process. The onus is on the GiC to ensure that the DIPLAR process is explained to the family, including ensuring they are provided with opportunities to raise any questions or concerns they wish to have answered and making them aware of when they will receive feedback.
- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.
- The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to: ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR and to agree and record responses to any questions or concerns and be clear about who is provided feedback to the family.
- As described under recommendation 1.2, a Death in Prison Custody NHS Support Toolkit has been developed. Included is a chapter on family engagement to support improve communication. It highlights the need for healthcare staff to invite family members to contribute to and be kept informed throughout any review process and to share the outcome of the review.
- The Toolkit contains a more detailed flowchart setting out NHS processes and provides more detail on the steps that should be followed to ensure families are included in any review process and informed of any findings. The Toolkit also includes guidance on how families can be involved following a death using compassionate communication skills.
- The Toolkit includes links to HIS's Learning Adverse events framework and links to resources to support communications with bereaved relatives.

Next steps:

- A presentation and engagement session with GiC is scheduled for the 25 January 2024

- The revised DIPLAR Report template and guidance document will be formally reviewed in February 2024.
- HIS to concluded an exercise they are undertaking to revise the adverse events framework and produce national guidance to be used alongside the framework . This includes:
    - a national SAER report template with associated guidance;
    - appropriate timeline for commissioning of reviews, the review process and sign off;
    - national guidance for patient, family and carer engagement, to ensure the review includes what matters to them and addresses any concerns along with providing the right information at the right time and in the right way;
    - Support for staff and the need for openness and psychological safety.
- HIS are also reviewing the notification system whereby health boards are required to notify HIS when they have commissioned a SAER, including those where there has been a death in prison custody.
- Publication of the revised adverse events framework is planned for December 2024. The framework is being revised in a phased format and the chapters on a national SAER Template and associated guidance for a good quality review along with the revision of appropriate timescales will be ready for comment by key partners in Spring 2024
- The NPrCN have recommended that NHS Boards should undertake an audit to monitor the number of families who are contacted following a SAER to have the findings explained to them.

Status: The aspects of this recommendation that relate to the DIPLAR have been implemented, whilst those relating to the SAER are still in progress. No clear timescales for completion.

Recommendation: 5.2
SPS and NHS should ensure a single point of contact for families. They should be a trained member of staff and this staff member should be fully briefed about what can be initially shared with the family and subsequently fed back, both during the process and once the DIPLAR has been concluded. These communications between the staff member and family should be recorded in the DIPLAR report.

Action Taken:

- As described under recommendation 3.3, the family support booklet has been redrafted.
- The revised booklet contains details of the support available from within the prison including contact details for the GiC, Prison Chaplain and healthcare team.
- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.
- The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to: ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR and to agree and record responses to any questions or concerns and be clear about who is provided feedback to the family.
- Over 90% of GiC and other members of the senior management team have completed face to face trauma informed communication sessions with SPS Chaplaincy Team. This was in the form of two sessions, “Reflection on Experience” and “Developing Skills”. The objective of these sessions was to build confidence in having conversations with families following a death in custody, by recognising the importance of preparing for these conversations, highlighting existing skills and enhancing understanding of bereavement.
- As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.
- Included in the Toolkit is guidance on duty of confidentiality in respect of deceased patients and how to consider requests for information by relatives of deceased patients.

Next Steps:

- An eLearning module is being developed based on the content of the trauma informed communication sessions conducted by the Chaplaincy Team to support changes in the senior management team. The target for completion of development of the module is March 2024.

Status: Implemented

Recommendation: 5.3
A truly independent chair, with knowledge of the prison, health and social care environments, should be recruited to chair all DIPLAR meetings providing the assurance that all deaths in custody are considered for learning points.

Action Taken:

- A non-executive member of SPS Advisory Board chairs all DIPLAR meetings for deaths that are confirmed as not being as a result of natural causes and at HMP Addiewell they chair all DIPLAR meetings irrespective of cause of death. The exception is that DIPLAR at HMP Kilmarnock are Chaired by SERCO's national lead and action plans are then shared with SPS Headquarters Health team.
- A decision was made by SPS Advisory Board in July 2023 not to extend the remit of the non-executive member of SPS Advisory Board to chair DIPLAR meetings for natural cause deaths and not to recruit a Chair external of SPS Advisory Board.
- The DIPLAR for natural cause deaths will continue to be chaired by the GiC of the establishment in which the individual died.

Status: Not implemented – action taken does not fully meet recommendation.

Recommendation: 5.4
The full DIPLAR process should be followed for all deaths in custody, with a member of staff from SPS Headquarters in attendance

Action Taken:

- On 14 June 2022, a GMA was issued to all prisons to remind them of the need to invite SPS Health Headquarters to be part of each DIPLAR meeting.
- They contribute by providing an overview of national policy and by taking forward any national action points.
- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR guidance sets out the requirement for a member of SPS Health Headquarters to attend all DIPLAR meetings.
- One of the key changes of the review was the introduction of a revised single DIPLAR report template for all deaths irrespective of the cause of death.
- The role of SPS Health Headquarters is detailed within the revised DIPLAR guidance and include ensuring a consistency in completion of DIPLAR reports, maintaining the National Learning and Action Plan and to share learning and recurring themes with SPS National Suicide Prevention Management Group and Governors.

Status: Implemented

Advisory Point: 1
A platform should be available for families to share and process their experiences such as a Bereavement Care Forum as previously recommended. The NHS and SPS should commission the independent development and support of such a platform.

Action Taken:

- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- An initial exploration meeting Families Outside took place in August. This included SPS, a member of the Family Reference Group and the NPrCN. Fundamental concerns were raised about the lack of agreement on the purpose of such a forum and the ability to moderate such a forum to ensure minimisation of risk of harmful content. This has not been progressed further at this stage.

Next Steps:

- No planned next steps currently. SPS have advised that they cannot commission national service and NPrCN have concerns about whether it is appropriate for NHS Boards to take ownership of this recommendation.

Status: Under consideration

Advisory Point: 2
The SPS should review the scope to place emergency alarms within reach of the cell bed to ensure the ability to raise the alarm when incapacitated.

Action Taken:

- Each prison cell is provided with a Cell Call Point that is located adjacent to the cell door. For cells designed for disabled prisoners an additional Cell Call Point is located beside the bed and the call point at the door placed at the relevant height for use by a wheelchair user. Additional emergency call points are installed as “pull cords” beside the bed and within the WC area and “push buttons” at a low level within shower areas.
- The Cell Call Points are tested daily. Any fault places the cell out of use until repairs are carried out.

Next Steps:

- No immediate plans to progress this advisory point. Would require a large estates project and significant budget implication which SPS is not currently resources to deliver.

Status: Not commenced – no plans to progress due to resources required

Advisory Point: 3
SPS and NHS to consider whether other people held in prison who knew the deceased may have relevant information to offer and how best to include their reflections in DIPLAR and SAER processes where appropriate, in particular whether discrimination of any kind was perceived as a factor in the death.

Action Taken:

- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR Report Template includes a section for recording any other relevant information and intelligence. The guidance on what should be recorded in this section includes; details of number of visits taken, phone calls and contact with solicitor and partner agencies and any recent relevant intelligence.
- No action has been taken by the NHS to ensure that as part of the SAER process, the views of others in prison are routinely taken into account.

Status: Not implemented – action taken does not fully meet recommendation

Advisory Point: 4
SPS and NHS to review DIPLAR report form to include a separate section where observed systemic or recurring issues are recorded by the independent chair to ensure holistic improvements to broader systems and processes are more easily recognised and addressed.

Action Taken:

- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- It is the responsibility of the DIPLAR chair to identify and record learning points, best practice and action.
- The revised DIPLAR Report template includes, under the Learning and Action Plan, a section to record if the establishment section in National DIPLAR Learning and Action Plan has been checked for recurring actions and if so whether any recurring actions were identified. If so, details of these are to be recorded. The GiC/Deputy Governor and NHS Leads are responsible for progress against actions on the Learning and Action Plan.
- Emerging issues and learning points are discussed at the Suicide Prevention Co-ordinator meeting, which meets quarterly. They are also shared at the National Suicide Prevention Strategy Group, which also meets quarterly and discussing all deaths.

Status: Implemented

Advisory Point: 5
SPS and NHS to consider developing a separate section in the DIPLAR document to ensure info on family involvement and the content of discussions is recorded, including any questions raised by the family and the response to them.

Action Taken:

- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.
- The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to: ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR and to agree and record responses to any questions or concerns and be clear about who is provided feedback to the family.
- The revised DIPLAR guidance also includes a Family Contact Record which should be used to keep a record of all contact with family members following a death, including any information provided to and by them.

Status: Implemented

Advisory Point: 6
The SPS should develop clear protocols for memorial services, letters of condolence and donations from people held in prison for families of the deceased.

Action Taken:

- As described under recommendation 2.4, a review of the DIPLAR has taken place.
- The revised DIPLAR Report template includes a section on funeral, memorial service and tributes. To be recorded in this section are details of any memorial service or tributes organised by the establishment and whether SPS staff attended the funeral.
- The DIPLAR guidance details that the role of the Chaplain includes assisting with the arrangements for funeral services, memorial services and tributes.
- The trauma informed communication sessions led by the SPS Chaplaincy Team with GiC and senior management team highlights the importance of providing an opportunity create a connection to the person who has died, such as family members visiting the room where their family member died, attending a memorial service and meeting with people who knew their family member.
- As described under recommendation 4.2 a short-life working work chaired by chaplaincy have revised EEDA forms and guidance. A Bereavement Guidance resource has also been developed which will include guidance on memorial opportunities.

Next Steps:

- The revised EEDA paperwork and guidance will be piloted at HMP Low Moss, Shotts and Glenochil in January 2024, with the aim of full rollout to all establishments by March 2024.

Status: In progress – due to be implemented by the end of March 2024

3. Other ongoing improvement work

Police Scotland:

- Members of the DiPCAG identified that there was a need to convene a national governance group to promote more effective working more generally across different organisations and consider the quality of investigations into deaths in prison custody.
- Chaired by the Police Service of Scotland, a Deaths in Prison Governance Group has been created that met for the first time in August 2023. Agencies represented on this group include Police Service of Scotland, SPS, COPFS and NHS. The group agreed a Terms of Reference and will meet quarterly in the future. The group shared areas of good practice and explored key aspects of future learning. The key aims of this group were agreed as:
    - develop effective processes, governance arrangements and communication to provide the optimum level of service in respect of investigations into all aspects of deaths in custody;
    - implement a national governance structure to promote and enhance the quality of investigation into death in custody through regular engagement, communication and sharing of best practice amongst key agencies;
    - ensure that relevant key recommendations from the 'Independent Review of Response to Deaths in Prison Custody' are successfully implemented in operational practice by respective organisations across Scotland;
    - consider and maximise joint training opportunities to raise awareness in relation to the requirements of death investigations and in particular obligations in terms of Article 2 ECHR.

Crown Office and Procurator Fiscal Service:

- COPFS have established a Custody Deaths Unit, bringing together the specialisms from across the death investigation teams of Scottish Fatalities Investigation Unit and the Health and Safety Investigation Team. The establishment of a dedicated unit aims to support improvements in the quality and effectiveness of such investigations, prosecutions and FAIs and consistency of process throughout the country. All death in custody investigation are now the subject of regular senior management oversight as part of a process of Case Management Panels.
- More efficient scheduling of FAI is supported by a system of regular liaison with the Scottish Courts and Tribunals Service, as part of which details of forthcoming Inquiries are provided to Sheriffs Principal.
- A Death Investigation Improvement Programme has been established to take forward measures to improve the service provided to bereaved relatives and deliver increased efficiencies in the investigation of deaths. COPFS have enhanced the information provided on their external website to include a fuller description of the death investigation system. This includes information about the potential stages of a death investigation including the report of a death, limited investigations, full investigations, FAI, and determination.

- COPFS undertook a small initial survey of a number of bereaved relatives and work is now underway to form a Lived Experience Advisory Panel, to provide COPFS with an important source of feedback and advice to help to shape improvements to the death investigation process in Scotland to ensure that investigations are thorough, occur in a reasonable timescale and have bereaved relatives at their heart.
- COPFS have established a Service Improvement Programme, one of the aims of which is to provide a consistently high-quality standard of service, designed to meet the diverse needs to the public we serve. A key part of that programme will be introducing the measures that support trauma informed practice across the organisation.

SPS

- SPS have piloted and now embedded a Harm Reduction Officer role across establishments with a remit for Support & Wellbeing. SPS have recruited 12 posts across the SPS run prison estate. These posts are additional to the existing Suicide Prevention roles already in place. The key areas of focus are:
    - Talk to Me & Self-Harm – to pro-actively champion best practice in case management and care planning for those deemed to be at risk; auditing and providing secondary assurance to senior management;
    - Support for local processes and compliance in relation to alcohol and drug use, including prescribed medication e.g. MORS;
    - Support for Recovery related activities and interventions – coordinating services; liaising with staff and internal and external partners;
    - Supporting the development of holistic care plans to support people in custody who are vulnerable taking into consideration causal factors such as bereavement, trauma, abuse, Adverse Childhood Experiences and disabilities.
- These officers will play a critical role within the establishment concerned with monitoring and supporting staff to manage and care for those at risk of self-harm or suicide, those involved in alcohol and drug use or any persons of concern.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-83521-915-7 (web only)

Published by The Scottish Government, February 2024

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1410954 (02/24)

w w w . g o v . s c o t