Independent Review of the Response to Deaths in Prison Custody

Follow up on progress report

December 2022

Scottish Government
Riaghaltas na h-Alba

1. Remarks from External Chair

In November 2019, the then Cabinet Secretary for Justice commissioned an independent review into the response to deaths in prison custody. The purpose of the review was to make recommendations for improvement to ensure appropriate and transparent arrangements for the immediate response to deaths in prison custody.

The Independent Review of the Response to Deaths in Prison Custody report was co-authored by HM Chief Inspector of Prisons; the Chief Executive of Families Outside and the Chair of the Scottish Human Rights Commission and was published on 30 November 2021. The review made one key recommendation, 19 other recommendations and six advisory points. All of the recommendations and advisory points were accepted in principle by the Scottish Government.

This progress report aims to provide an update one year on from the publication of the Independent Review of the Response to Deaths in Prison Custody (hereafter referred to as "the Review"). The data available show that deaths in prison are increasing. Last year (2021) saw a significant rise to 53 deaths, compared with 34 in 2020, 37 the year before (2019) and 32 the year before that (2018).

The initial Scottish Government response focused on how to achieve the key recommendation of the Review, namely that a separate independent investigation should be undertaken into each death in prison custody and should be carried out by a body wholly independent of the Scottish Ministers, the Scottish Prison Service or the private prison operator and the NHS.

To that end, the Cabinet Secretary for Justice chaired a roundtable event in February 2022, bringing together all the relevant stakeholders.

From these discussions, it was decided to appoint an external chair (Chair - Terms of Reference) to provide strategic leadership and oversight of the implementation of the recommendations and advisory points contained in the Review. I was appointed to this role in April 2022 on a part time basis, supported by one full time member of Scottish Government staff.

Reading the Review, I was struck by the opening statement of the Executive Summary:

"Two pillars of trauma-informed practice are choice and control. Our Review showed clearly that families bereaved through a death in prison custody have neither."

The first-hand experiences of family members contained in the Review's "Response from Families" Report made a powerful and compelling case for change.

I made it a priority to engage with families who had direct experience of losing a loved one through death in prison custody and to ensure their participation in the work to implement the recommendations of the Review. I was fortunate to be able to

benefit from the experience and network of Families Outside (a charity that works on behalf of families affected by imprisonment), who helped to establish a Family Reference Group.

The Family Reference Group has met on four occasions: 30 June; 23 August, 20 September and 15 November 2022. Some, but not all, of the group contributed to the original Review. Representatives of two families are bringing experience that has been gained from the death of loved one in prison custody after the Review was published. The accounts of families who have suffered more recent bereavement show the issues highlighted in the Review have not been resolved.

Trust is an issue for all of the families on the Family Reference Group, leading to a desire to be represented on all groups established to take forward the recommendations of the Review.

I spent the first few weeks after my appointment in April 2022 having individual discussions with a range of relevant stakeholders to find out the current position in terms of progress with work to implement the recommendations and advisory points of the Review.

It was clear that the Scottish Government had prioritised the key recommendation and various discussions had taken place leading to the establishment of a Working Group, which had its inaugural meeting in May 2022.

To provide oversight of the work to implement the recommendations and advisory points of the Review, I chair the Deaths in Prison Custody Action Group (DiPCAG). The membership of the group includes a representative of families bereaved by a death in prison custody; Scottish Prison Service; NHS National Prison Care Network; Crown Office Procurator Fiscal Service; Healthcare Improvement Scotland; Police Scotland; Families Outside and Scottish Government.

The DiPCAG (DiPCAG website page) met for the first time on 21 June 2022 and again on 27 September 2022. A high level work plan was produced, which shows the actions required to achieve the vision of a consistent, person-centred, trauma-informed response to all deaths in prison custody.

Formal updates were sought from all the relevant agencies for each meeting and an opportunity was given to provide evidence of further progress before the publication of this report. This progress report contains a summary of the work carried out so far under each of the recommendations and advisory points. This progress report focuses on the changes that have been made since publication of the Review in November 2021.

Whilst it is clear that some effort has been made to make progress, particularly with the key recommendation, I am disappointed to find that one year on from publication of the Review, only three have been completed and one is partially complete.

Family representatives have been involved in the work to oversee progress, and their views and feedback on key processes and documents have been sought increasingly by the Scottish Prison Service and NHS via the Family Reference

Group. This is encouraging, albeit belated: there was nothing to stop colleagues engaging and consulting families when the Review was published.

From the updates it is clear that some of the issues are complex and will take longer than one year to resolve. Some will need investment of additional resources. However, others seem to be relatively straightforward and could be achieved at little or no additional cost.

In this vein, I would highlight the following recommendations, which in my opinion should have been completed soon after publication of the Review:

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

Recommendation 1.4
When someone is admitted to prison, the Scottish Prison Service and the NHS should seek permission that where prison or healthcare staff have significant concerns about the health or wellbeing of someone in their care, they are able to contact the next of kin

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. A Scottish Prison Service single point of contact other than the Chaplain should maintain close contact thereafter, with pastoral support from a Chaplain still offered

Recommendation 3.3
The family should be given the opportunity to raise questions about the death with the relevant Scottish Prison Service and NHS senior manager and receive responses. This opportunity should be spelled out in the family support booklet

None of the recommendations highlighted above seems to be difficult to achieve. Indeed I am pleased to note that after the draft of this progress report was circulated on 4 November 2022, two Governors' and Managers' Action notes were issued: one on 7 November 2022, which addresses Recommendation 3.1, the other on 17 November 2022, which address Recommendation 1.4. In my view these mandatory instructions could have been issued much earlier, however I welcome the fact that they have been issued now.

Many of the recommendations and advisory points require action from the Scottish Prison Service and the NHS. Out of 19 recommendations, 12 are owned jointly by the Scottish Prison Service and the NHS. Four out of six advisory points name both the Scottish Prison Service and the NHS. In April 2022, representatives of the Scottish Prison Service met with NHS colleagues (the National Prison Care Network) to decide which agency would lead on each shared piece of work.

The NHS National Prison Care Network is taking the lead on various actions, including:

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

The National Prison Care Network governance groups reached an early agreement that the Scottish Government's Confirmation of Death by Registered Healthcare Professionals Framework should apply in prisons as it does in community settings. All NHS Boards were asked to implement this framework for healthcare staff working in prisons, however delivery of the necessary training met with some challenges. Whilst the National Prison Care Network can encourage all NHS Boards to ensure the training is delivered and the framework implemented, it does not have the power to ensure compliance.

The quality of healthcare for people in prison is an issue for all NHS territorial boards, given that the prison population is made up of citizens from all areas of Scotland, however it has proved difficult to secure active participation from NHS Boards in the work to improve the response to deaths in prison custody. Whilst I have found the National Prison Care Network to be active in the work to achieve the necessary improvements, its success is limited by the need for NHS Chief Executives to prioritise and implement the changes. I have asked for a representative of NHS Chief Executives (territorial health boards) to attend meetings of the Death in Prison Custody Action Group and for a point of contact in each health board, to no avail.

Five of the recommendations and two of the advisory points relate to the Scottish Prison Service's internal Death in Prison Learning, Audit and Review (DIPLAR). Updates from the Scottish Prison Service rely heavily on the work being carried out by the DIPLAR Review Group, which was only set up in September 2022. Whilst some interim measures were introduced before the Group was established, it is not unreasonable to expect this work to have commenced shortly after the Review was published.

I mentioned that the Scottish Government had prioritised work to advance the key recommendation. A working group with representatives from Scottish Prison Service, NHS, Crown Office and Procurator Fiscal Service (COPFS), Families Outside and the Scottish Government was established that has met monthly since May 2022. I have been impressed by the way in which the key recommendation working group has engaged with families through the Family Reference Group, listening to and acting on their feedback. The group has mapped out the existing processes and sought to identify the gaps a new independent investigation should address.

The terms of reference for the original Review deliberately excluded the role of COPFS and the arrangements for Fatal Accident Inquiries. Similarly, the terms of reference for my role as external chair, explicitly state that it will not impinge on nor

undermine the role of the Lord Advocate as independent head of the system for the investigation of sudden or suspicious deaths.

In August 2016, HM Inspectorate of Prosecutions in Scotland carried out a thematic review of Fatal Accident Inquiries and made 12 recommendations. In August 2019, the Inspectorate published a Fatal Accident Inquiries - Follow Up Review which found the lack of progress in many areas was disappointing. In particular, there had been little progress in shortening the timeline for mandatory Fatal Accident Inquiries.

Whilst examining the Fatal Accident Inquiry (FAI) system and the role of COPFS is out with the scope of this work, I have been struck by the extent to which perceived shortcomings in the FAI process feature in discussions about how the response to deaths in prison can be improved. Families feel the length of time FAIs take to conclude is far too long and that communication between COPFS and relatives is inadequate.

Based on the feedback I have received from families and others in the course of my role as external chair, I have formed the opinion that the key recommendation of the Review is aimed at treating the symptoms (time delay and poor communication with families), rather than the problem itself, namely the FAI system.

Arguably the most important recommendations are aimed at understanding causes of deaths in prison and identifying trends with a view to preventing future deaths. Recommendation 1.1 states that leaders of national oversight bodies should work together with families to support the development of a new single framework on preventing deaths in custody. Recommendation 3.4 asks for a comprehensive review into the main causes of all deaths in prison custody.

I was surprised to find that no work had been commenced on either of these recommendations when I brought together the various scrutiny bodies for a meeting in July 2022. An Understanding and Preventing Deaths in Prison Working Group has now been established and has met twice. Comprehensive data on and analysis of deaths in prison custody are essential to this work, however there are significant gaps in publicly available information. The Scottish Prison Service publishes data on its website, including date of admission; date of death; age; gender; ethnic group; legal status, and medical cause of death (from 2019 onwards). There does not appear to be any published analysis of any trends, something I would expect the Scottish Government's Justice Analytical Services to produce on a regular basis. It is encouraging that Justice Analytical Services has recently (November 2022) agreed to assist the Understanding and Preventing Deaths in Prison Working Group.

The updates in this report include information on "next steps", and the relevant agencies have been asked repeated to provide timescales for completion. It has been a challenge to inject pace into the work required to make the necessary improvements. I am looking forward to seeing a draft new investigative process developed by the key recommendation working group with input from families, ready to be piloted early in the new year. At the end of January 2023, I hope to see the product of the Scottish Prison Service's DIPLAR review group's work, which will address a number of the issues identified by the Review. I also hope to see the NHS

accelerate the roll out of confirmation of death training for healthcare professionals working in a prison setting to ease pressure on the Scottish Ambulance Service.

The role of external chair is time limited for a maximum of 18 months (October 2023) and I would anticipate issuing a further update on progress prior to the conclusion of this post.

I am grateful to all those are participating in meetings to take forward the recommendations and advisory points of the Review and who have provided information for this Progress Report. I have been privileged to hear first-hand from families who have been bereaved through a death in prison custody and cannot thank them enough for sharing that painful experience, all with the motivation of preventing similar experiences for other families in the future.

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

November 2022

OVERSIGHT OF RECOMMENDATIONS OF REVIEW INTO RESPONSE TO DEATHS IN PRISON CUSTODY: CHAIR – TERMS OF REFERENCE

Purpose

1. The Independent Review of the Response to Deaths in Prison Custody was commissioned by the Cabinet Secretary for Justice on 7 November 2019. The Review was led by Wendy Sinclair-Gieben, Chief Inspector of Her Majesty's Prisons in Scotland (HMCIPS) and co-chaired by Professor Nancy Loucks, Chief Executive of Families Outside, and Judith Robertson, Chair of the Scottish Human Rights Commission.
2. The Review, which published on 30 November 2021, made 26 recommendations, which are relevant to the SPS, NHS, COPFS and the Scottish Government.
3. A Chair to drive forward and ensure rapid and robust responses and independent oversight of the Review recommendations is to be appointed.

Chair –Appointment and Status

4. The Chair will be appointed and report to the Cabinet Secretary for Justice and Veterans for a fixed term of eighteen months in the first instance, on terms which would recognise the need for operational independence from Ministers in how the work of the action group is undertaken, balanced with giving the Chair an authoritative mandate to act on behalf of the Justice Secretary in some aspects of work.
5. As an independent appointment, the Chair will provide strategic leadership to and oversight of the delivery of recommendations as set out in the HM Chief Inspector of Prisons for Scotland's Independent Review of the Response to Deaths in Prison Custody, published on 30 November 2021. The Chair will meet regularly with and report to, the Cabinet Secretary for Justice and Veterans (at least quarterly) to discuss progress.

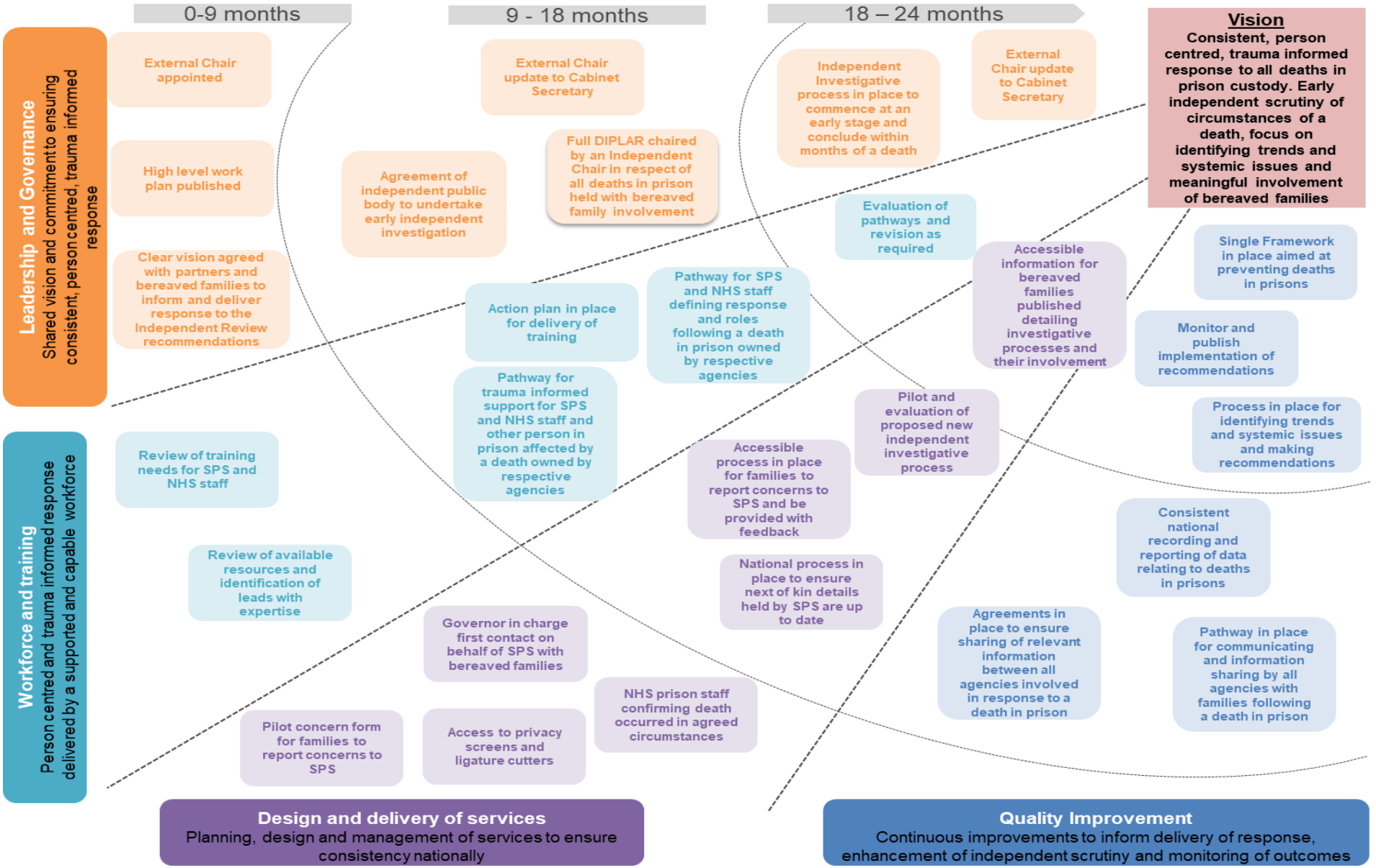
Role and Responsibilities

6. The Chair will be responsible for the provision of strategic leadership and oversight of the delivery of all recommendations set out in the HM Chief Inspector of Prisons for Scotland's Independent Review of the Response to Deaths in Prison Custody.
7. The Chair may appoint a death in prison custody action group (DiPCAG) of stakeholders from the Scottish Government, NHS Health Boards, the Scottish Prison Service (SPS) and the Crown Office of the Procurator Fiscal Scotland (COPFS) and others as required, which will be led by the Chair, supported by a policy co-ordination and secretariat function.
8. A DiPCAG may oversee the programme of work necessary to make suggested improvements and meet the recommendations, so as to improve the response to all deaths in prison custody by relevant agencies.
9. The Chair, with the secretariat, will be responsible for the development of an action plan of identified actions and priorities to achieve the recommendations in practice.
10. The Chair will initiate and drive engagement with all relevant stakeholders, including but not limited to Scottish Government, COPFS, Scottish Prison Service, Police Scotland and NHS Health Boards as required.

11. The role of the Chair will not impinge on, nor undermine the roles of the Lord Advocate, who has responsibility for COPFS and is the independent head of the system for the investigation of sudden and suspicious deaths.
12. The independent Chair should ensure that where appropriate, advice is sought from the Lord Advocate throughout the life of the group and will ensure that the work of the group is informed by that advice.
13. As well as group engagement with stakeholders, the main operational role will be in chairing the action group, which will meet quarterly or as agreed by the group. The secretariat will provide the Chair with policy co-ordination and strategic secretariat support and will coordinate a series of early introductory meetings with key partners.
14. The Chair will be responsible for reporting regularly to the Cabinet Secretary for Justice and Veterans on progress, so as to ensure Ministers can report on/ outline initial progress to Parliament by Summer 2022.
15. Ministers would like to announce the appointment of a Chair by March 2022, with an immediate start. The Chair will be expected to remain in place until September 2023, or until all recommendations have been implemented/ and are underway. Members of the action group will not be remunerated but expenses such as travel and subsistence will be paid at normal Scottish Government rates, unless this is already covered by attendees regular working arrangements.

Resources
16. To support the Chair and the action group, we will have a secretariat of 1 C-Band staff member from within the SG Justice Directorate. The secretariat will co-ordinate the programme of work, liaising with stakeholders to ensure implementation of the recommendations, as well providing secretariat support at meetings.

Accountability, Decision Making and Reporting
17. The Chair or action group is not established on a statutory basis. It is therefore not subject to the formal public appointments process and the requirements of the Code of Practice for Ministerial Appointments to Public Bodies in Scotland.
18. The Chair is an independent and time-limited oversight resource. It has no executive functions. It will report to Scottish Ministers on progress.


0-9 months
9 - 18 months
18 – 24 months
Vision
Consistent, person centred, trauma informed response to all deaths in prison custody. Early independent scrutiny of circumstances of a death, focus on identifying trends and systemic issues and meaningful involvement of bereaved families
Leadership and Governance
Shared vision and commitment to ensuring consistent, person centred, trauma informed response
Workforce and training
Person centred and trauma informed response delivered by a supported and capable workforce
External Chair appointed
High level work plan published
Clear vision agreed with partners and bereaved families to inform and deliver response to the Independent Review recommendations
External Chair update to Cabinet Secretary
Agreement of independent public body to undertake early independent investigation
Full DIPLAR chaired by an Independent Chair in respect of all deaths in prison held with bereaved family involvement
Independent Investigative process in place to commence at an early stage and conclude within months of a death
External Chair update to Cabinet Secretary
Evaluation of pathways and revision as required
Accessible information for bereaved families published detailing investigative processes and their involvement
Single Framework in place aimed at preventing deaths in prisons
Monitor and publish implementation of recommendations
Process in place for identifying trends and systemic issues and making recommendations
Action plan in place for delivery of training
Pathway for SPS and NHS staff defining response and roles following a death in prison owned by respective agencies
Pathway for trauma informed support for SPS and NHS staff and other person in prison affected by a death owned by respective agencies
Pilot and evaluation of proposed new independent investigative process
Accessible process in place for families to report concerns to SPS and be provided with feedback
Review of training needs for SPS and NHS staff
Review of available resources and identification of leads with expertise
National process in place to ensure next of kin details held by SPS are up to date
Consistent national recording and reporting of data relating to deaths in prisons
Governor in charge first contact on behalf of SPS with bereaved families
Agreements in place to ensure sharing of relevant information between all agencies involved in response to a death in prison
Pathway in place for communicating and information sharing by all agencies with families following a death in prison
NHS prison staff confirming death occurred in agreed circumstances
Pilot concern form for families to report concerns to SPS
Access to privacy screens and ligature cutters
Design and delivery of services
Planning, design and management of services to ensure consistency nationally
Quality Improvement
Continuous improvements to inform delivery of response, enhancement of independent scrutiny and monitoring of outcomes

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. A working group with representatives from Scottish Prison Service (SPS), NHS, COPFS, Families Outside and the Scottish Government was established that has met monthly since May 2022 to progress this recommendation.
- The group held a roundtable discussion with organisations responsible for the investigation of deaths in other jurisdiction, i.e. England and Wales, Northern Ireland and Ireland, to gain knowledge about processes and practices in those jurisdictions to learn lessons from their experiences.
- A mapping exercise has been undertaken to set out all current investigative processes and how they interact with each other.
- An options appraisal has been initiated setting out the advantages and disadvantages of creating a new investigative body and framing existing public bodies which might have the necessary expertise and legislative framework to undertake the role of conducting the independent investigation.
- A draft version of the new investigative process has been created. It is being refined and tested in a series of workshop exercises by the working group.
- The family reference group have been engaged with to obtain their views on some aspects of how the new investigative process should communicate with families and what gaps in the needs of families the new investigative process should seek to address.

Next Steps:

- Further workshops are planned to continue to refine the draft new investigative process until there is agreement from the working group that the process is ready to be piloted.
- Agreement to be reached on which organisation will conduct a pilot.
- The aspiration is that the pilot will commence in early 2023.
- Engagement with the family reference group to obtain their feedback and views on how the new investigative process should interact with bereaved families to ensure their needs are met.

Status: In progress

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:

- A working group has been established with representatives from Healthcare Improvement Scotland (HIS), Public Health Scotland, NHS National Prison Care Network (NPrCN), HM Inspectorate of Prisons for Scotland (HMIPS), relevant Scottish Government policy area leads and a representative of bereaved families. The group first met in July 2022.
- The group is progressing this recommendation in conjunction with recommendation 3.4.
- The group has mapped any policies or programmes of work currently ongoing that directly or indirectly contribute to the prevention of deaths in prisons.
- The group have considered what data is publicly available in respect of deaths in prisons and gaps in that data with a view to gaining a better understanding of causes of deaths in prisons.
- The NPrCN has established a General Practitioner (GP) forum for all prison GPs. A key agenda item for the forum is best practice in relation to safe prescribing.
- The NPrCN is developing guidance on the clinical management of people suspected of being under the influence of drugs within prisons.

Next Steps:

- The group are working with the SPS, Justice Analytical Services and NPrCN to obtain further data in relation to deaths in prisons in order to analysis this in an attempt to identify trends to inform the work of the group.
- A draft action plan to be developed to support the creation of a framework on preventing deaths which will identify priorities and gaps in current policies and strategies.
- The group are going to explore the possibility of academic involvement in undertaking analysis of trends in deaths in prisons.
- The aspiration is that the draft of guidance on the clinical management of people suspected of being under the influence of drugs within prison will be available for consultation in December 2022.

Status: In progress

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 are leading on progressing this recommendation. This recommendation is being progressed in conjunction with recommendation 2.1. A Toolkit is being developed to create a standard national process for use by both NHS and SPS staff on best practice response following a death in prison.
- A mapping exercise has been undertaken of existing processes in NHS Boards following a death in prison. The SPS process for responding to a death has also been considered by the NPrCN.
- The Toolkit will provide clarity around roles and responsibilities throughout the prison estate and improve consistency of practice between prisons. It will also address training needs.
- The Toolkit will include:
    - a flowchart, supported by Standard Operating Procedures (SOP) of the steps to be followed following a death. This will provide clarity around roles and responsibilities throughout the prison estate. The Toolkit will cover the steps in the immediate aftermath of a death, in addition to longer term actions including the review process and associated learning from any findings.
    - links to training modules, webinars and resources. This will include subjects such as confirmation of death and delivering trauma informed care.

Next Steps:

- The aspiration is that the flowchart process will be agreed by the NHS and SPS late November/early December 2022.
- Following consultation with NHS Boards and SPS, the Toolkit will be disseminated via the NPrCN's governance groups.

Status: In progress

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:

- SPS staff complete a written concern form when either they have or they have been made aware of concerns about the wellbeing of someone in prison. The intention is to extend the accessibility of this written concern form to enable family members or other persons concerned about someone in prison to complete and submit this electronically to SPS. This is to supplement existing methods that a family member can use to raise concerns with SPS including telephoning a prison directly or telephoning SPS headquarters.
- It is recorded on the form any action taken as a result of the concerns being raised by the family member and how feedback was provided to the person who raised the concerns.
- A pilot using the electronic concern form whereby key stakeholders, including Families Outside, HMIPS and Prison Monitor Co-Ordinators could make referrals with concerns about the wellbeing of someone in prison was undertaken in late 2021. The pilot was evaluated in February 2022. Overall feedback was positive, in particular as it provides a written record of concerns submitted and allows for assurance checks to be carried out on responses and actions. Some minor amendments were made to the form and guidance updated on when it could be used. The process of Families Outside, HMIPS and Prison Monitor Co-Ordinators being able to submit electronic concern form has remained in place.
- Feedback on the current methods of raising concerns and the electronic concern form have been provided to the SPS by the Family Reference Group.

Next Steps:

- Feedback from the family reference group will be considered by SPS which may result in further amendments to the form and consideration of ways in which the SPS can improve awareness of the different ways in which family members can raise concerns about someone in prison with the SPS.
- SPS will establish a single point of contact/mailbox within each prison for the submission of the electronic concern forms by February 2023 and standardised processes will be in place from March 2023.
- SPS are developing broader means of ensuring access to and sign posting to the electronic concern form, such as on the SPS website, on key stakeholder websites and by alternative methods such as in family centres/prison visitor centres.
- SPS will develop an audit and review process to ensure compliance and timely response and engagement with persons raising concerns.

Status: In progress

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:

- 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 and this is recorded by SPS.
- A consultation with each prison carried out in September 2022, confirmed that these processes were being followed. It also highlighted that 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.
- The Prison Rules require the Governor to ask a prisoner who is unwell, injured or transferred to hospital if they wish anyone to be contacted to be informed.

Next Steps:

- 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.

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:

- The NPrCN are leading on progressing this recommendation. This recommendation is being progressed in conjunction with recommendation 1.2. A Toolkit is being developed to create a standard national process for use by both NHS and SPS staff on best practice response following a death in prison.
- A mapping exercise has been undertaken of existing processes in NHS Boards following a death in prison. The SPS process for responding to a death has also been considered by the NPrCN.
- The Toolkit will provide clarity around roles and responsibilities throughout the prison estate and improve consistency of practice between prisons. It will also address training needs.
- The Toolkit will include:
    - a flowchart, supported by Standard Operating Procedures (SOP) of the steps to be followed following a death. This will provide clarity around roles and responsibilities throughout the prison estate. The Toolkit will cover the steps in the immediate aftermath of a death, in addition to longer term actions including the review process and associated learning from any findings.
    - links to training modules, webinars and resources. This will include subjects such as confirmation of death and delivering trauma informed care.

Next Steps:

- The aspiration is that the flowchart process will be agreed by the NHS and SPS late November/early December 2022.
- Following consultation with NHS Boards and SPS, the Toolkit will be disseminated via the NPrCN's governance groups.

Status: In progress

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:

- By September 2022, all prisons 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.
- A scoping exercise has been undertaken to explore other models of ligature cutters and the use of them in other settings including by Police Scotland and HM Prison and Probation Service.
- A model of ligature cutter has been identified that was considered to be more effective than the model currently available within prisons. Currently ligature cutters are held at staff desks in all residential areas of each prison within crash packs (similar to a first aid pack) with standard processes in place for them to be brought promptly to the scene of any incident.

Next steps:

- The new preferred model of ligature cutter has been purchased. It will replace the existing model in all crash packs at staff desks and will also be carried by all patrol staff during nightshift and lock up periods across the prison estate by the end of January 2023.
- A process will be put in place to evaluate the use of the new model of ligature cutters in practice and consideration given to any further ways in which they can be made more accessible within prisons. This will take place at 6 months and 12 months following commencement of their introduction to prisons.

Status: Partially completed

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:

- The NPrCN National Prison Care Network are leading on progressing this recommendation.
- Agreement has been reached by the National Prison Care Network's governance groups that the Scottish Government's Confirmation of Death by Registered Healthcare Professionals Framework is appropriate for implementation within prisons. This will align practice in prisons with community settings.
- All NHS Boards have been asked to implement this framework for healthcare professionals working within prisons. This will require health professionals working within prisons to undertake training to ensure they have the correct skills to undertake this role.

Next Steps:

- Staffing capacity has affected ability to attend training. Other modes of delivering training have been explored to improve access to training. NHS Education for Scotland (NES) have agreed to develop a webinar that will be tailored to prison specific confirmation of death training.
- The NPrCN will monitor NHS Boards for uptake of training and implementation of the framework.

Status: In progress

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:

- The current DIPLAR paperwork (in use since December 2020) has a specific section to record how the death impacted staff and other prisoners. An audit was undertaken of completed DIPLAR since publication of the Review which revealed that in over just half of DIPLAR it was recorded that support was offered to other prisoners following a death.
- 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 is made up of representatives from SPS Suicide Prevention Co-ordinators, Prison Chaplaincy, Governor in Charge (GIC) and NHS Prison Healthcare Teams. The aim is to make improvements to this process, including the recording of information.
- The Group are undertaking a review of a number of aspects relating to the DIPLAR process including: the content of the DIPLAR paperwork to ensure it properly reflects any engagement with families and any information shared by other prisoners; ensuring that it aligns with HIS and NES best practice in undertaking reviews; identifying any training needs; revising DIPLAR guidance to ensure consistency of completing paperwork; reviewing and clarify roles and responsibilities for those involved in the DIPLAR process and agreeing accountability and governance process to ensure compliance with actions identified following the DIPLAR process.
- In the interim, a checklist has been developed for SPS Health Headquarters staff to use when attending and reviewing DIPLAR to ensure all relevant information is discussed and recorded.
- Feedback on the current DIPLAR paperworks have been provided to the SPS by the Family Reference Group and will be considered as part of their review.

Next Steps:

- SPS will complete a consultation process on the current DIPLAR process and paperwork with those involved in the process, including SPS Suicide Prevention Co-Ordinators, NHS staff and Prison Chaplaincy by the end of November 2022.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023, with implementation from March 2023, subject to NHS also undertaking the requisite approval process.
- A process will be put in place to evaluate the revised DIPLAR process at 6 months and 12 months following implementation.

Status: In progress

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:

- The SPS is developing a corporate approach will places responsibility on all senior leads to ensure compatibility with the UNCRC in the development of their legislative considerations, policies, strategic frameworks, action plans and other key initiatives.
- 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 is made up of representatives from SPS Suicide Prevention Co-ordinators, Prison Chaplaincy, GIC and NHS Prison Healthcare Teams. The aim is to make improvements to this process, including ensuring than any death in prison custody of a child or a young person includes a specific assessment of whether the particular rights of the child were fulfilled and child friendly policies and procedures followed in practice.

Next Steps:

- SPS will complete a consultation process on the current DIPLAR process and paperwork with those involved in the process, including SPS Suicide Prevention Co-Ordinators, NHS staff and Prison Chaplaincy by the end of November 2022.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023, with implementation from March 2023, subject to NHS also undertaking the requisite approval process.
- A process will be put in place to evaluate the revised DIPLAR process at 6 months and 12 months following implementation.

Status: In progress

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:

- A consultation undertaken with GIC revealed that the majority of them were contacting families following a death in prison custody.
- On 7 November 2022, SPS issued a GMA formalising the process of GIC contacting a family following a death. The GMA provides that:
    - The name and contact details of the Duty Governor 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 Governor (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.
- Contact details of the senior management team point of contact are now included within the family support booklet that is provided to family members following a death.
- Chaplaincy contact details are now also included within the family support booklet. Chaplains will continue to offer pastoral support to families.
- An audit was undertaken of completed DIPLAR since publication of the Review which revealed that in nearly half of DIPLAR it was recorded that Chaplains have provided families with support.

Next Steps:

- Chaplaincy Advisors will conduct trauma informed communication sessions with members of senior management team who feel they can benefit from this input. This will be in the form of two sessions, “Reflection on Experience” and “Developing Skills”. It is intended that these sessions will commence in late November 2022.
- The trauma informed framework being put in place in respect of recommendation 4.1 will provide a mechanism to ensure that senior management team members are equipped with skills to communicate in an appropriate way with family members.

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 legal team are developing a Memorandum of Understanding between the two organisations. This will include guidance on the disclosure of information to families.
- A mapping exercise has been undertaken of training and communication tools to support NHS staff when communicating with bereaved family members. Links to relevant training will be including within the Toolkit being developed in response to recommendations 1.2 and 2.1.

Next Steps:

- Information sharing protocols will require to be development in respect of recommendation 1 and the establishment of a new independent investigative process. Sharing of information between organisations and with families will need to be considered as part of that process.

Status: In progress

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:

- A family support booklet was jointly drafted by Families Outside and SPS in 2020 to provide information for families following a death in prison. This is available on the website of Families Outside and is also provided in paper copy to bereaved families, primarily by prison chaplains.
- The current family support booklet provides that relevant information or questions about a death of someone in prison to be considered at a DIPLAR can be raised via the Chaplain, with a response to be provided by a member of the prison Senior Management Team.
- The booklet is being reviewed and revised to ensure it addresses the recommendations and meets the needs of families.
- SPS and NHS have engaged with the family reference group to obtain their feedback and views of the family support booklet.

Next Steps:

- SPS and NHS to consider any revisions to the family support booklet to address feedback from the family reference group.
- NHS will engage with equality and diversity colleagues on revised leaflet to ensure readability.
- Make the booklet more accessible to family members including placing it on SPS website.
- The family support booklet is to be further revised to include details for a single point of contact for the NHS healthcare team.

Status: In progress

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:

- A working group has been established with representatives from Healthcare Improvement Scotland (HIS), Public Health Scotland, NPrCN, HMIPS, relevant Scottish Government policy area leads and a representative of bereaved families. The group first met in July 2022.
- The group is progressing this recommendation in conjunction with recommendation 1.1.
- The group has mapped any policies or programmes of work currently ongoing that directly or indirectly contribute to the prevention of deaths in prisons.
- The group have considered what data is publicly available in respect of deaths in prisons and gaps in that data with a view to gaining a better understanding of causes of deaths in prisons.

Next Steps:

- The group are working with the SPS, Justice Analytical Services and NPrCN to obtain further data in relation to deaths in prisons in order to analysis this in an attempt to identify trends to inform the work of the group.
- A draft action plan to be developed to support the creation of a framework on preventing deaths which will identify priorities and gaps in current policies and strategies.
- The group are going to explore the possibility of academic involvement in undertaking analysis of trends in deaths in prisons.

Status: In progress

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:

- The NPrCN is developing a framework to support the implementation of NHS trauma informed care modules for all healthcare professionals working in prisons. The framework will include a tiered approach to training which is tailored to different roles and will detail training that should be undertaking in each role.
- A mapping exercise has been undertaken to ascertain available resources including those provided by NES that can be adapted to the prison setting regarding wellbeing training and support packages for staff. This included a consideration of Police Scotland debrief and wellbeing support mechanisms and Trauma Risk Management.
- SPS are undertaking a review of the Critical Incident Response and Support policy (CIRS). A paper has been submitted to the SPS Executive Management Team for their consideration on proposed changes to CIRS. It proposes that the CIRS process is replaced temporarily by an interim Employee Assistance Programme whilst research is being undertaken to review best practice and an options appraisal is initiated detailing possible future process. A CIRS group has been established to oversee this piece of work.
- A SPS Women's Estate and Young Person's Estate Learning and Development Strategy were introduced in late 2020. The intention of the strategy is to have all staff trained to a consistent skill set who work in prisons with either women or young persons. Contained within phase one is trauma training that will bring staff up to a 'trauma-aware' status. This is a half day course delivered by SPS College Team that is now completed by all new recruits in the SPS and those who work in residential care with woman or young persons. The course content includes an introduction to trauma and its causes, the NES trauma framework, impact of trauma on prisoners and staff and how to support/work in a trauma informed manner.

Next steps:

- Once finalised, the trauma informed practice tiered framework will require agreement through the NPrCN's governance structure and thereafter dissemination to NHS Boards.
- Further development of a national approach to provide wellbeing support to healthcare professionals working in prisons.
- Completion of the review of the CIRS process.
- SPS to roll out two day mandatory workshops on trauma informed leadership to senior leaders. The aspiration is that they will then be better able to support the development of a framework for SPS staff. The framework is to be

developed with the support of NES. The first cohort is scheduled for November/December 2022 with a following cohort scheduled for February/March 2023.

Status: In progress

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:

- The NPrCN are leading on progressing this recommendation in conjunction with the work being undertaken to progress recommendation 4.1.
- A mapping exercise has been undertaken to ascertain available resources, services and sources of support that are available within the community that could be adapted to be made available for people held in prison.

Next steps:

- Developing a leaflet containing support resources that can be made accessible to prisoners.
- Investigate the possibility of contact telephone numbers for support organisations being accessible on prisoner mobile telephones, to allow for privacy.
- SPS to roll out two day mandatory workshops on trauma informed care to senior leaders. The aspiration is that they will then be better able to support the development of a framework for SPS staff which will better equip those working with prisoners to provide them with support following a death in prison. The first cohort is scheduled for November/December 2022 with a following cohort scheduled for February/March 2023.
- SPS to undertake a review of their Bereavement Strategy that will include an update of the response to support those impacted by bereavement prior and during their time in prison custody.

Status: In progress

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:

- The current DIPLAR guidance provides that it is the role of the Chaplain to inform families of the DIPLAR process and make them aware of timescales.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process. The aim is to make improvements to this process, including reviewing and clarify roles and responsibilities for those involved in the DIPLAR process and making the process more accessible to families.
- There is a section on the DIPLAR paperwork where any concerns raised by families should be recorded.
- An audit was undertaken of completed DIPLAR since publication of the Review which revealed that in just over half of DIPLAR it was recorded that families had the opportunity to have questions raised at the DIPLAR meeting.
- A family support booklet currently in use that has been jointly created by the SPS and Families Outside contains information about the DIPLAR process and meeting, including timings.
- SPS and NHS have engaged with the family reference group to obtain their feedback and views of the family support booklet.
- The family support booklet has been revised to include details for a single point of contact for the GIC or other senior management team contact for the SPS and for Prison Chaplaincy.
- Variation in process between NHS Boards regarding the SAER process has been identified. There is ongoing work to develop a standard operating procedure to standardise this process, family engagement will be considered as part of this.
- A national programme of standardisation for all adverse events, including SAERs commenced in August 2022. This work is being led by HIS. The intention is to reach agreement on which events lead to the commissioning of a SAER leading to a national standard reporting, reviewing and sharing of learning. The roles of families will be considered as part of this programme of work.

Next steps:

- SPS will complete a consultation process on the current DIPLAR process and paperwork with those involved in the process, including SPS Suicide Prevention Co-Ordinators, NHS staff and Prison Chaplaincy.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any

learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023, with implementation from March 2023, subject to NHS also undertaking the requisite approval process.

- A process will be put in place to evaluate the revised DIPLAR process at 6 months and 12 months following implementation.
- The family support booklet is to be further revised to include details for a single point of contact for the NHS healthcare team.
- SPS and NHS to consider any revisions to the family support booklet to address feedback from the family reference group.
- The programme of standardisation of adverse events led by HIS is scheduled to take 2 years.

Status: In progress

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:

- Contact details of the GIC or other senior management team contact are now included within the family support booklet that is provided to family members following a death.
- A consultation was undertaken with GIC/members of senior management teams which identified a training need to ensure this role is undertaken in an effective way.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process. The aim is to make improvements to this process, including the recording of information and engagement with families.

Next Steps:

- Action taken in respect of recommendation 4.1 to create a framework of trauma informed support/training will be shaped to include the training needs identified.
- Information sharing protocols are likely to require development in respect of recommendation 1 and the establishment of a new independent investigative process. Sharing of information between organisations and with families will need to be considered as part of that process.
- The family support booklet is to be further revised to include details for a single point of contact for the NHS healthcare team.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023, with implementation from March 2023, subject to NHS also undertaking the requisite approval process.
- A process will be put in place to evaluate the revised DIPLAR process at 6 months and 12 months following implementation.

Status: In progress

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 the SPS Advisory Board chairs all DIPLAR meetings (other than DIPLAR at HMP Kilmarnock which are Chaired by SERCO's national lead and action plans are then shared with SPS Headquarters Health team) except for those confirmed as a result of natural causes, although will do so if requested.
- The current Chair has experience of health management and prison and is an independent appointed Safeguarder outwith SPS.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process. The aim is to make improvements to this process, including reviewing whether the role of the current Chair should be expanded.

Next Steps:

- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023.

Status: In progress

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:

- Whilst the DIPLAR review group work is ongoing, in the interim it was agreed that the full DIPLAR process is followed for all deaths. This includes the holding of a DIPLAR meeting for an expected natural cause death. This process has been in place since June 2022.
- Since June 2022, a process has been in place whereby a member of SPS Health Headquarters attends all DIPLAR meetings. They contribute by providing an overview of national policy, take forward any national action points and have developed a checklist for use in the interim to ensure all relevant information is discussed and recorded at the DIPLAR meeting.
- A GMA has been issued to all prisons to remind them of the need to invite SPS Health Headquarters to be part of each DIPLAR meeting.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process, including reviewing and clarify roles and responsibilities for those involved in the DIPLAR process including SPS health headquarters team.

Next steps:

- SPS have confirmed that the interim process put in place will continue to be standard practice and this will be made explicit in the revised guidance produced by the DIPLAR review group.

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:

- No action taken.

Next Steps:

- No update provided.

Status: Not commenced

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 recommendation. Would require a large estates project and significant budget implication which the SPS is not currently resources to deliver.

Status: Not commenced

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:

- This advisory point is being progressed in conjunction with recommendation 2.4 and the others that relate to the DIPLAR process.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process. The aim is to make improvements to this process, including the recording of information including the content of the DIPLAR paperwork to ensure it properly reflects any information shared by other prisoners.

Next Steps:

- Complete a consultation process on the current DIPLAR process and paperwork with those involved in the process, including SPS Suicide Prevention Co-Ordinators, NHS staff and Prison Chaplaincy by the end of November 2022.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023, with implementation from March 2023, subject to NHS also undertaking the requisite approval process.
- A process will be put in place to evaluate the revised DIPLAR process at 6 months and 12 months following implementation.

Status: In progress

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 an interim process, SPS Health Headquarters team use a tracker on which they are recording any learning points or recurring issues noted by the DIPLAR chair.
- Also recorded is any action taken to address the learning points on both a local and national level.
- Learning from all DIPLAR is shared via the Suicide Prevention Co-ordinators group that meets bi-monthly and includes the leads from all SPS and private prisons for onward dissemination to local prisons.
- This advisory point is being progressed in conjunction with recommendation 2.4 and the others that relate to the DIPLAR process.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process. The Group are undertaking a review of a number of aspects relating to the DIPLAR process, including the recording of information relating to any systemic or recurring issued noted by the Chair.

Next Steps:

- Complete a consultation process on the current DIPLAR process and paperwork with those involved in the process, including SPS Suicide Prevention Co-Ordinators, NHS staff and Prison Chaplaincy.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023, with implementation from March 2023, subject to NHS also undertaking the requisite approval process.
- A process will be put in place to evaluate the revised DIPLAR process at 6 months and 12 months following implementation.

Status: In progress

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:

- There is a section on the DIPLAR paperwork where impact of the death on family members and any concerns raised by families should be recorded.
- An audit was undertaken of completed DIPLAR since publication of the Review which revealed that in over just half of DIPLAR it was recorded that families had the opportunity to have questions raised at the DIPLAR meeting.
- This advisory point is being progressed in conjunction with recommendation 2.4 and the others that relate to the DIPLAR process.
- A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the DIPLAR process. The Group are undertaking a review of a number of aspects relating to the DIPLAR process including the content of the DIPLAR paperwork to ensure it properly reflects any engagement with families.

Next Steps:

- Complete a consultation process on the current DIPLAR process and paperwork with those involved in the process, including SPS Suicide Prevention Co-Ordinators, NHS staff and Prison Chaplaincy.
- Complete an initial revised draft of the DIPLAR paperwork addressing each of the related recommendations and advisory points, with a focus on making it more user friendly, ensuring that all key information is captured and that any learning points/recurring themes are clearly identifiable. The aspiration is that proposed amendments to the DIPLAR process and paperwork will be presented in a paper to SPS Executive Management Team for approval by the end of January 2023.

Status: In progress

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:

- An audit has been undertaken which revealed an inconsistency in practice across prisons in relation to the holding of memorial services and SPS attendance at funerals.
- SPS have developed an ‘Options for Support and Tributes’ document for local consideration to support families and others within prison who have been affected by a death. It includes guidance on matters such as memorial services and letters of condolence. Suicide Prevention Co-Ordinators have been asked to comment on this document

Next steps:

- The SPS Suicide Prevention Co-Ordination Group will consider this document when it next meets in mid-November.
- SPS to undertake a review of their Bereavement Strategy that will include an update of the response to support those impacted by bereavement prior and during their time in prison custody.

Status: In progress

Scottish Government
Riaghaltas na h-Alba

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