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Scottish Government
Riaghaltas na h-Alba

Audrey Nicoll MSP
Convenor,
Criminal Justice Committee

Via e-mail:

08 October 2025

Dear Audrey,

Inquiry into the harm caused by substance misuse in Scottish prisons

I am writing to you following the Criminal Justice Committee evidence session on 24 September 2025, which was attended by the Cabinet Secretary for Justice and Home Affairs and myself.

This letter addresses the points on which the Committee requested further information from each of our portfolios. The Cabinet Secretary for Justice and Home Affairs has been copied into this response. The requested information comprises the following:

- An update on the delivery of the Target Operating Model for prison healthcare
- The NHS Toolkit on responding to deaths in prison custody
- Recent data on waiting times for toxicology results (Katy Clark MSP)
- Statistics on the use of Buvidal in prison settings, and an outline of the Scottish Medical Consortium's assessment of its role in therapy (Rona MacKay MSP)
- Details of specific prisons where the Scottish Recovery Consortium are undertaking delivering recovery projects
- Data on the use of Drug Treatment and Testing Orders by sheriffdom (Liam Kerr MSP)
- Information on specific procedures in place for when prison staff come into contact with substances, particularly through vapes (Sharon Dowey MSP)

I hope the Committee will find this information helpful in its inquiry into the harm caused by substance use in prisons.

Kind regards,

MAREE TODD MSP
Minister for Drugs and Alcohol Policy and Sport

ANNEX A

The Target Operating Model for prison healthcare

1. The Target Operating Model (TOM) for prison healthcare is a framework for a nationally consistent service model for healthcare delivery in prisons. Developed by National Prison Care Network (NPrCN) in collaboration with key partners (NHS/IJBs, SPS, SG) and individuals living in prison, it is currently 18 months into the implementation phase, with an estimated timetable for completion of 3 years.

2. The collaborative approach to developing the TOM generated over 90 change ideas which the development group carefully prioritised under Governance/Leadership, Workforce, Education and Training, and Services.

3. The key priorities identified for Services were:

- *Health Improvement:* Promotion of wellbeing support that mitigates against impact of custody; self-care/hygiene, nutrition, mental wellbeing self-management strategies.
- *Emergency Response*: Clear roles and responsibilities of nursing staff responding to emergencies.
- *Admissions:* Consider improvements to existing initial assessment in order to identify mental health concerns.
- *Mental Health:* Clear referral/access criteria for mental health services.
- *Mental Health:* Develop clear processes for community-based staff to support prison teams, e.g. virtual consultations, access for visiting health professionals.
- *Admissions*: Review admissions process to identify immediate.
- ***Addictions***: Implementation of Medication Assisted Treatment (MAT) Standards. concerns on admissions and longer-term healthcare needs.
- ***Addictions***: Development of new guidance for management of those suspected of intoxication.
- *Health Improvement:* Flexibility in regime to provide appropriate time for Health Improvement core services e.g. Quit Your Way and harm reduction activities.
- *Mental Health:* Second mental health screening, when person in better placed to engage in discussion.

4. To understand how each health board is progressing towards the full implementation of the TOM, they provide the NPrCN with a self-assessed 6-monthly report against each of the nine service areas of the TOM.

5. The most recent 6-monthly update (Apr–Nov 2024) indicates that 71% of all service elements identified in the TOM were considered, by NHS Boards/HSPCs, to be fully implemented.

6. An important role of the self-assessment process is highlighting those areas where the NPrCN can support further improvement on a national basis, current examples of these include:

- Supporting six uni-disciplinary peer support forums: GPs; Primary Care Nurses; Mental Health, Addictions and Learning Disability Nurses; Allied Health Professionals (AHPs); Sexual Health; Clinical Psychology.
- Establishing a short-life working group to share best practice on the first 24 hours of admission into prison; and,
- Providing 12 learning webinars in response to identified learning needs (which have been accessed 1000+ times since being made available).

7. To monitor the implementation of the TOM services, the self-assessed updates are collated into a dashboard and shared with Scottish Health in Custody Oversight Board (SHiC OSB) which

meets quarterly. At which point, any issue of concern can be escalated to NHS Board Chief Executives and the Strategic Leadership Group for Prison Health and Social Care.

8. The implementation dashboard is also regularly shared with the Cross Portfolio Ministerial Group (CPMG) for Prison Health and Social Care, as well as national prison healthcare Peer Support Forums and the National Executive Leads Collaborative (NELC) as mechanisms for taking forward any associated improvement initiatives.

9. A limitation of the robustness of the current approach of measuring implementation is that it is based on self-assessment carried out by NHS prison healthcare staff. Therefore, in order to ensure the TOM has maximum impact and can support improvement in the longer term, it is being embedded within established, more objective, assessment processes, of the prison inspection programme undertaken by Healthcare Improvement Scotland (HIS).

National Prison Care Network's Death in Prison Custody NHS Support Toolkit

10. The Toolkit, which has been attached separately at **Appendix B**, has been developed in response to the recommendations outlined in the Independent Review to Deaths in Prison Custody . The aim of this Toolkit is to outline steps that NHS professionals should take in response to a death in prison custody. It is also hosted on SPS' SharePoint site for officers to access.

11. The Toolkit aims to support staff working within the prison environment, improve consistency and ensure that families are informed and involved in NHS processes following a death of a relative in prison where appropriate. This toolkit sets out:

1. Roles and responsibilities across agencies; NHS, SPS, Police Scotland in response to a death in prison, with clear process for NHS staff.
2. Education and training for Registered Nurses to undertake confirmation of death.
3. Expectations in relation to reviews, documentation and learning relating to each death.
4. Support to provide improved communication with families following a death in prison.
5. Resources to support NHS staff wellbeing following a death in prison.
6. Resources to embed trauma informed practice across healthcare in prison teams to support people in prison and all NHS staff working in prison.

12. As the Toolkit has now been live for 2 years, NPrCN are currently undertaking a review, and are seeking feedback from operational staff who have used the Toolkit following a death in custody. Healthcare Improvement Scotland has also noted the Toolkit as an area of best practice found during inspections at the National Executive Leads Collaborative.

Delays in Toxicology Reporting

13. The Scottish Government are currently working with colleagues to try and understand where the delays in toxicology reporting are and the reasons for these. We will update Committee with further information when we have it.

Statistics on use of Buvidal in prisons

Data is on ScotPHO - Prescribing for drug use - ScotPHO

14. OST Drug Prescribing – Prisons

- The National Prisoner Healthcare Network collects data on the number of prisoners prescribed Opioid Substitution Therapy drugs by prison establishment. The latest data can be found in the PHS Prison Health Information Dashboard.

Key points:

- On 14 July 2021, approximately 30.8% of prisoners in Scotland were receiving Opioid Substitution Therapy, an increase compared to previous years (26.3% on 9 February 2020, and 22.0% on 6 June 2018)
- Methadone was prescribed to 22% (1,512) of prisoners, 6% (396) were prescribed Buprenorphine, 3% (214) were prescribed Buvidal, and 0.1% (five) were prescribed buprenorphine/naloxone on that day.
- The highest percentage of prisoners prescribed methadone was observed in HMP Greenock (37%), HMP Kilmarnock (32%) and HMP Edinburgh (29%). The lowest percentages of prisoners prescribed methadone were observed in HMP Polmont, HMP Castle Huntly, and HMP Dumfries (8%, 7% and 6% respectively).
- Prescribing of Buvidal in prisons in Scotland was introduced as a contingency measure response to the COVID-19 pandemic, as it is a sustained release injectable form of OST and available in 7-day or 28-day doses, compared to daily oral doses of methadone. HMP Cornton Vale, HMP Inverness and HMP Glenochil were the establishments with the highest percentages of prisoners prescribed Buvidal (11%, 7% and 6% respectively).
- The prison establishments with the highest percentage of prisoners prescribed Buprenorphine were HMP Perth (20%), HMP Castle Huntly (8%) and HMP Inverness (8%).
- Buprenorphine/naloxone was prescribed in just two prisons: HMP Inverness (3% of prisoners) and HMP Grampian (0.5%)

Previous findings can be found here:

- Prison Healthcare Snapshot of methadone prescribing figures per prison establishment June 2018
- Prison Healthcare Snapshot of methadone prescribing figures per prison establishment December 2017
- Prison Healthcare Snapshot of methadone prescribing figures per prison establishment August 2016
- Prison Healthcare Snapshot of methadone prescribing figures per prison establishment February 2016

Scottish Medicine Consortium (SMC) Assessment of Buvidal:

15. In August 2019, the SMC accepted buprenorphine prolonged-release solution for injection as a possible treatment within NHS Scotland. This acceptance is restricted to use in patients who are not suitable for treatment with methadone and where buprenorphine is considered appropriate.

16. The SMC defines Buprenorphine as a *'therapy for adults and adolescents (age 16 years and over) with a dependence on opioids such as heroin and morphine. Buprenorphine prolonged-release solution for injection is a long acting medicine which is used alongside medical, social and psychological support. It may enable patients to focus on recovery and return to normal routines without the need for daily visits to a pharmacy to receive oral treatment'*.

17. The SMC advises that *'Buprenorphine is a medicine that acts like an opioid but the effect is weaker than other opioids such as heroin or morphine. It is used to gradually reduce dependence whilst helping to decrease withdrawal symptoms. Buprenorphine prolonged-release solution for injection is injected under the patient's skin by a healthcare professional on a weekly or monthly basis'*.

18. Cost Implications & Economic Value:

- The Scottish Government has not made an assessment of any long-term economic benefits of replacing methadone with Buvidal for eligible patients.
- Public Health Scotland publishes a yearly report named the 'Prescription Cost Analysis' which outlines annual total expenditure on all prescriptions from community pharmacy in Scotland. British National Formulary chapter 4 includes methadone and buprenorphine (also known by its brand name Buvidal) and the cost of prescribing these drugs can be found on tab 4 of the PCA at Dispenser payments and prescription cost analysis - Financial year 2023 to 2024 - Dispenser payments and prescription cost analysis - Publications - Public Health Scotland.

Scottish Recovery Consortium projects in prisons

19. Scottish Recovery Consortium receives a total of £630,000 in core funding to deliver a service that meets the overall aims and objectives of the Drugs National Mission, and one of the main objectives of this funding is to support the development and integration of recovery-oriented support within Scottish Prisons.

20. Staffing costs and associated travel costs for recovery leads who deliver recovery café's in prison are included in this core funding.

21. For 2025-26, Scottish Recovery Consortium were awarded and additional £160,350 to upscale their recovery work in prisons, and they now have a presence in every prison in Scotland.

Drug treatment and testing orders (DTTOs) imposed in Scotland by sheriffdom, 2019-20 to 2023-24

Sheriffdom	2019-20	2020-21 [Note 1]	2021-22 [Note 1]	2022-23	2023-24
Glasgow and Strathkelvin	58	32	41	37	31
Grampian, Highland and Islands	36	24	40	38	32
Lothian and Borders [Note 2]	178	64	116	59	48
North Strathclyde	76	24	60	47	75
South Strathclyde, Dumfries and Galloway	83	50	61	77	65
Tayside, Central and Fife	85	34	49	44	29
Not assigned [Note 3]	0	0	1	1	0
Scotland	516	228	368	303	280

[Note 1]: There were significant public health measures, including two national lockdowns, in place during the 2020-21 and 2021-22 recording years due to the COVID-19 pandemic. This means that statistics for most areas of justice social work were impacted in 2020-21 and 2021-22. Caution is advised in comparing data from these two years to other years.
[Note 2]: The DTTO service in Edinburgh was suspended to new assessments/orders from June 2022 to February 2023 and then again from June 2023. During the suspensions, courts were able to impose CPOs with drug treatment requirements.
[Note 3]: The data is primarily collected at local authority level. A joining exercise is required to break numbers down by for sheriffdom reports, and not all data could be assigned.

Source: SG Justice Social Work DTTO datasets.

Specific procedures in place for when prison staff come into contact with substances, particularly through vapes

22. Scottish Prison Service were contacted to provide a response on what policies and procedures are in place to protect staff who come into contact with substances. They shared the following:

We continue to advise staff on safety and risk assessment processes in conducting their duties to minimise the impact and risk of exposure to any unknown hazardous substance.

23. SPS also highlighted a staff notice **[NTS 053/17)** which sets out the following guidance for staff who have been exposed to an unknown substance:

- *Where staff believe that they have been exposed to an unknown substance and report feeling unwell their Fist Line Manager should be informed immediately and their colleagues in the immediate area. Medical advice should be sought where necessary.*
- *Staff who feel unwell should be placed in a quiet area and encouraged to drink small sips of water and provided with support.*
- *Where symptoms have not alleviated after 15 - 20 mins, staff should not drive either for work or domestic purposes, travel or return home alone if there is no one to assist them and in such cases advice from a GP should be sought.*
- *In order to prevent further incidents and where symptoms allow, all the evidence possible should be presented to the First Line manager such as sights, smells and sounds at the time of exposure.*

- *All incidents that relate to an unknown hazardous substance or secondary exposure should be recorded as an incident on PR2; All staff who have been exposed to an unknown hazardous substance should record this as an Accident at work (as a near miss) and submit this to the establishment Health & Safety Coordinator for following on to the investigating Manager.*
- *Staff exposed to an unknown substance should be contacted by their line manager no later than one week after exposure to provide any additional support required. In all cases, a full investigation should be conducted by management in order to prevent, reduce and mitigate the risk of future occurrences.*

Deaths in Prison Custody

NHS SUPPORT TOOLKIT

SCOTTISH HEALTH IN CUSTODY NETWORK
PRISON CARE

National Prison Care Network
NATIONAL SERVICES DIVISION | NHS NATIONAL SERVICES SCOTLAND

Change Log

Document Control

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1.0	26/10/2023		N

Contents

Acronyms

Acronym	Meaning
BMA	British Medical Association
BMJ	British Medical Journal
CHI	Community Health Index
CIRS	Critical Incident Response & Support
COPFS	Crown Office Procurator Fiscal Service
CYP	Children and Young People
DIPLAR	Death in Prison Learning, Audit Review
DNACPR	Do not attempt cardiopulmonary resuscitation
FAI	Fatal Accident Inquiry
GIC	Governor in Charge
HCM	Healthcare Manager
HIS	NHS Healthcare Improvement Scotland
HMIPS	His Majesty Inspectorate Prison Service
HRBA	Human-Rights Based Approach
LAER	Local Adverse Event Review
NES	NHS Education for Scotland
NOK	Next of Kin
NSD	National Services Division
NSS	National Services Scotland
OOH	Out of Hours
OPCAT	Optional Protocol to the Convention Against Torture
PANEL	Participation, Accountability, Non-Discrimination and Equality, Empowerment and Legality.
RTA	Road Traffic Accident
SAER	Significant Adverse Event Review
SAS	Scottish Ambulance Service
SOCO	Scene of Crime Officers
SPS	Scottish Prison Service
VBRP	Value Based Reflective Practice

1. Introduction

The aim of this Death in Prison Custody NHS Support Toolkit is to provide an overview of steps that should be taken in response to a death in prison custody, by who and when. It is anticipated that this will help support staff working within the prison environment, improve consistency and ensure that families are informed and involved in processes following a death of a relative in prison.

This toolkit focuses on steps NHS staff should take following a death in custody, the reviews they can expect to be involved with and the support that is available.

A lack of family engagement at every step of the journey following a death in custody was recognised as a major gap for both the NHS and the Scottish Prison Service (SPS) in The Independent Review of the Response to Deaths in Prison Custody. The review also observed that humanity and compassion were at times compromised.

Two pillars of trauma-informed practice are choice and control, the review demonstrated that families of the bereaved felt they had neither. Whilst implementing the guidance within this toolkit, consideration of communication with families should be at the forefront of all practice following a death in prison custody.

To address the **19 recommendations** made in the review, this toolkit is structured into six themes:

1. Guidance and training to support multiagency response to a death in prison, with a clear and consistent role for NHS staff across NHS Boards and establishments.
2. Timely confirmation of death by a Registered Nurse.
3. Robust documentation in relation to each death with clear actions and learning points.
4. Improved communication with families following a death in prison.
5. Greater wellbeing support for NHS staff following a death in prison.
6. Embed trauma informed practice across the prison estate to support people in prison and all staff working in prison.

This toolkit has been developed and approved by the National Prison Care Network's Oversight Board to provide advice to NHS Prison Healthcare Teams. The National Prison Care Network is hosted in National Services Division (NSD) within NHS National Services Scotland (NSS).

The aim of the Network is to work across geographical and organisational boundaries to support a 'Once for Scotland 'approach in the planning, design and delivery of an integrated, holistic, person-centred care for those in the criminal justice system.

The toolkit represents the view of the National Prison Care Network, arrived at after careful consideration of the evidence available. When exercising their clinical judgement, healthcare professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values that the person may have expressed before they died, and those of their families.

2. Strategic and Policy Context

Independent Review of the Response to Deaths in Prison Custody

In 2019, Wendy Sinclair-Gieben, Chief Inspector of His Majesty's Prisons in Scotland (HMIPS) was tasked by the then Cabinet Secretary for Justice to undertake an independent review of the response to deaths in prison custody[1].

In 2021, Wendy Sinclair-Gieben, Professor Nancy Loucks, Chief Executive of Families Outside, and Judith Robertson, Chair of the Scottish Human Rights Commission co-produced the Independent Review of the Response to Deaths in Prison Custody[1]. The report makes several recommendations for improving processes following a death in custody, as outlined in appendix A. The recommendations made in the report were accepted by Scottish Government.

The purpose of the review was to make recommendations for improvements to ensure appropriate and transparent arrangements for the immediate response to deaths in Scottish prisons, as well as deaths of people in the care of SPS when the death occurs in a location outside of prison (e.g. hospital or hospice)[2].

It was acknowledged in the review there was a wide variation in practices and experiences relating to deaths in custody across the prison estate. The recommendations, and this toolkit aim to address this variation.

Duty of Care of State

For all deaths in prison custody, there is possible State responsibility for a death. There is a duty to carry out an effective investigation into the death, to establish if there was any State failure to safeguard the right to life and ensure accountability where State responsibility arises[3].

Under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) and HMIPS' Inspecting and Monitoring Standards for Inspecting and Monitoring Prisons in Scotland, Governors are required to have processes to create and maintain an environment where prisoners in their care are safe. It is essential to have systems in place to protect prisoners from abuse and neglect and to facilitate reporting and investigation of any suspected incidents[4].

HMIPS has a statutory duty to inspect and monitor the conditions in which prisoners are held and the treatment they receive. While in prison, healthcare should be equitable to community services.

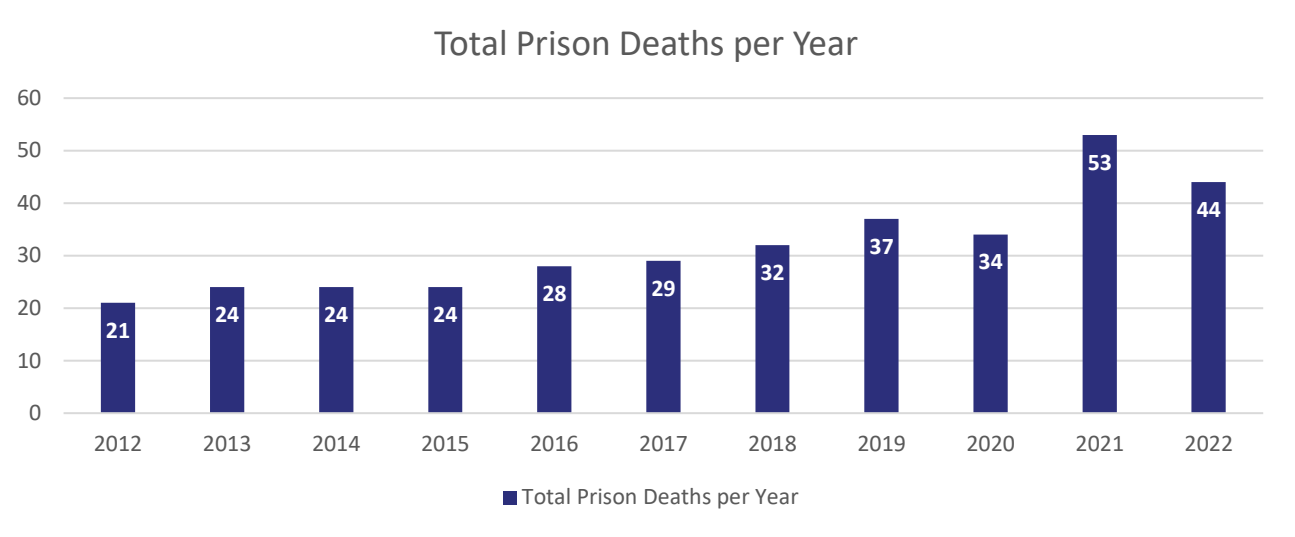
Following a death in prison custody, staff are involved in several reviews, details of which are within chapter 6 of this toolkit.

[1] Independent Review of the Response to Deaths in Prison Custody (2021)
[2] Independent Review of the Response to Deaths in Prison Custody: Follow up on progress report (2022)
[3] Guide on Article 2 of the European Convention on Human Rights: Right to Life (2022)
[4] Prison Reform Trust Safety in Prison

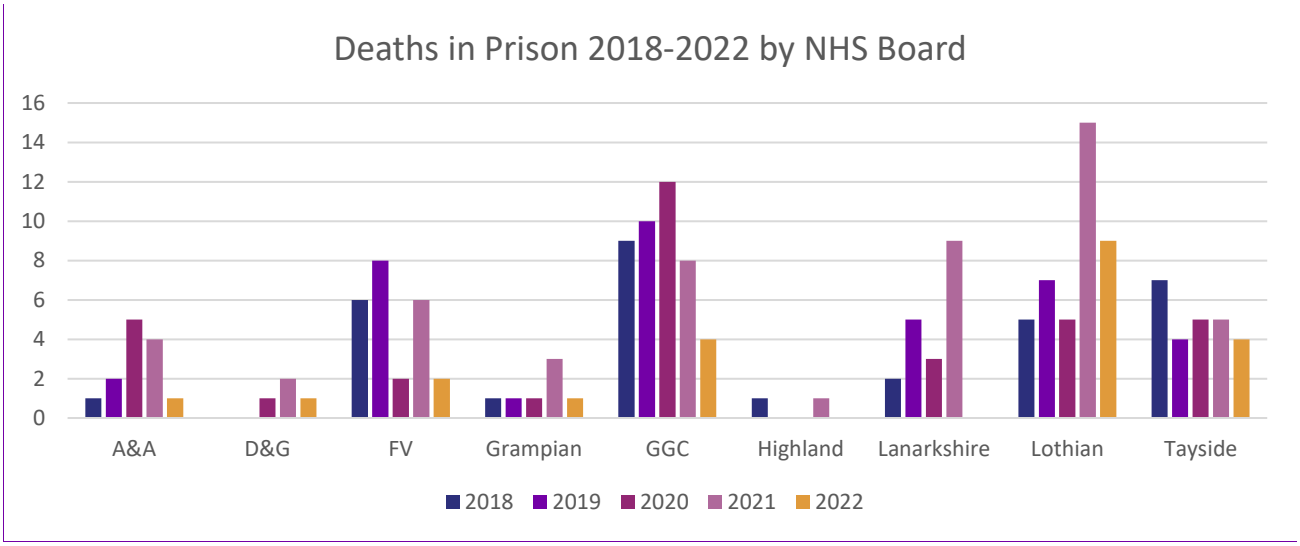
Death in Prison Custody Data

Scotland has one of the highest imprisonment rates of Northern European countries with 143 people in prison per 100,000 population[5]. In 2019, it also had a higher-than-average mortality rate in Europe, with a mortality rate per 10,000 people in prison of 39 compared with a median of 28 across all countries[6].

Between 2012-2022, 350 people have died in Prison. During this time, there has been an increase in deaths in prison custody, as demonstrated in the graph below[7]:



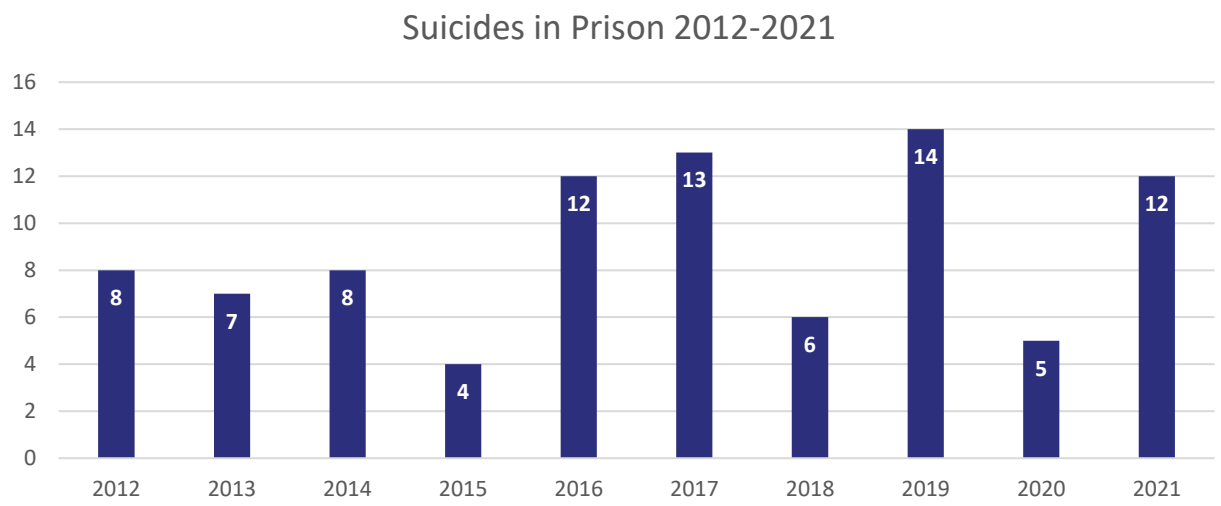
Due to the number of prisons, differing prison populations, size and healthcare needs there is variation between NHS Boards in the number of deaths in prison custody, as shown below:



Between 2012-2022, the leading cause of death was natural causes. With an ageing prison population, the number of deaths by natural causes in prisons is likely to continue to increase.

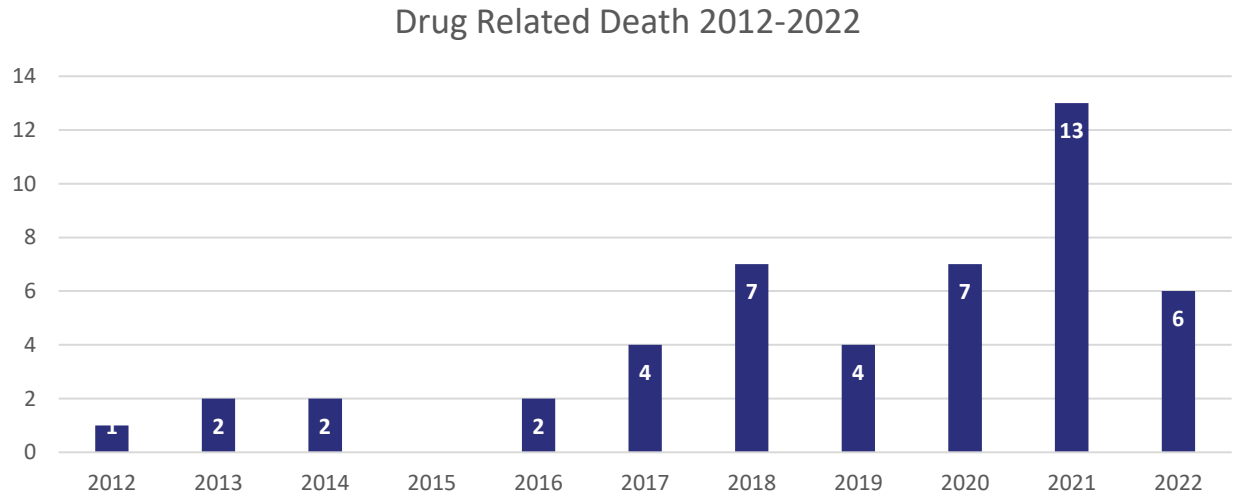
[5] SCCJR Scotland's prison population
[6] Council of Europe Prisons and Prisoners in Europe 2019: Key Findings of the SPACE I report (2019)
[7] SPS Prisoner Deaths

The second highest cause of death is self-inflicted death. This has long been a cause for concern, with death by suicide the leading cause of death of young people (aged 21 or under) in prison in Scotland. Approximately **71%** of male suicides happened within their first year of being in prison.



According to publicly available data on the SPS website, between 2012-2022, there have been 48 drug related deaths, this equates to 14% of all deaths in this timeframe. Of those who died of a drug related death, 79% were convicted, with the remaining 21% either on remand or recall.

An annual breakdown of these deaths is shown in the graph below:



Human Rights

Article 2 of the Human Rights Act protects your right to life. This means that nobody, including the Government, can try to end your life. Public authorities should consider the right to life when making decisions that might put you in danger or that affect your life expectancy. If a member of your family dies in circumstances that involve the State, you may have the right to an investigation. The State is also required to investigate suspicious deaths and deaths in custody[8].

SPS Standards of Professional Conduct[9] also state that staff should always treat prisoners, prisoners' families and all visitors with fairness, respect and humanity, safeguarding their legal rights and entitlements.

The Human Rights Based Approach (HRBA) is a conceptual framework directed towards promoting and protecting human rights, based on international human rights standards. It puts human rights and corresponding state obligations at the heart of policy and can be used by institutions as a tool to empower the most vulnerable people to participate in decision-making processes and hold duty-bearers accountable. The HRBA is underpinned by five key human rights principles, also known as PANEL: Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality:

Participation	Everyone is entitled to active participation in decision making processes which affect the enjoyment of their rights.
Accountability	Duty-bearers are held accountable for failing to fulfil their obligations towards rights-holders. There should be effective remedies in place when human rights breaches occur.
Non-discrimination and equality	All individuals are entitled to their rights without discrimination of any kind. All types of discrimination should be prohibited, prevented and eliminated.
Empowerment	Everyone is entitled to claim and exercise their rights. Individuals and communities need to understand their rights and participate in the development of policies which affect their lives.
Legality	Approaches should be in line with the legal rights set out in domestic and international laws.

[8] Equality and Human Rights Commission Article 2: Right to life
[9] SPS Code of Conduct (2010)

Scottish Government's Vision for Justice in Scotland

The four core principles outlined as part of the Vision for Justice in Scotland are:

The need for the principles to be founded in equality and human rights was highlighted as key. Justice services aim to eliminate discrimination, advance equality, and foster good relations while taking a right's-based approach, ensuring those most vulnerable and facing the biggest barriers can understand and realise their rights[10]. Trauma informed care is expanded on within chapter 7 of the toolkit.

The importance of embedding person-centred and trauma informed practices to ensure a person's needs and views are respected, provide clear communication and ensure understanding in areas of complexity was highlighted within the Vision for Justice in Scotland.

The Vision also expresses the importance of including individuals and their families' decisions which affect them, with a recognition that people are the 'experts' in their own lives.

Embedding trauma-informed practice will ensure that justice services and health services provided in justice settings, recognise the prevalence of trauma and adversity, realise where people are affected by trauma and respond in ways that reduce retraumatising.

Useful resources:

- Independent Review of the Response to Deaths in Prison Custody
- Scottish Government Caring for people in the last days and hours of life Guidance
- Marie Cure – National guidelines for end-of-life care
- Scottish Human Rights Commission, *A Human Rights Based Approach, an Introduction* leaflet.

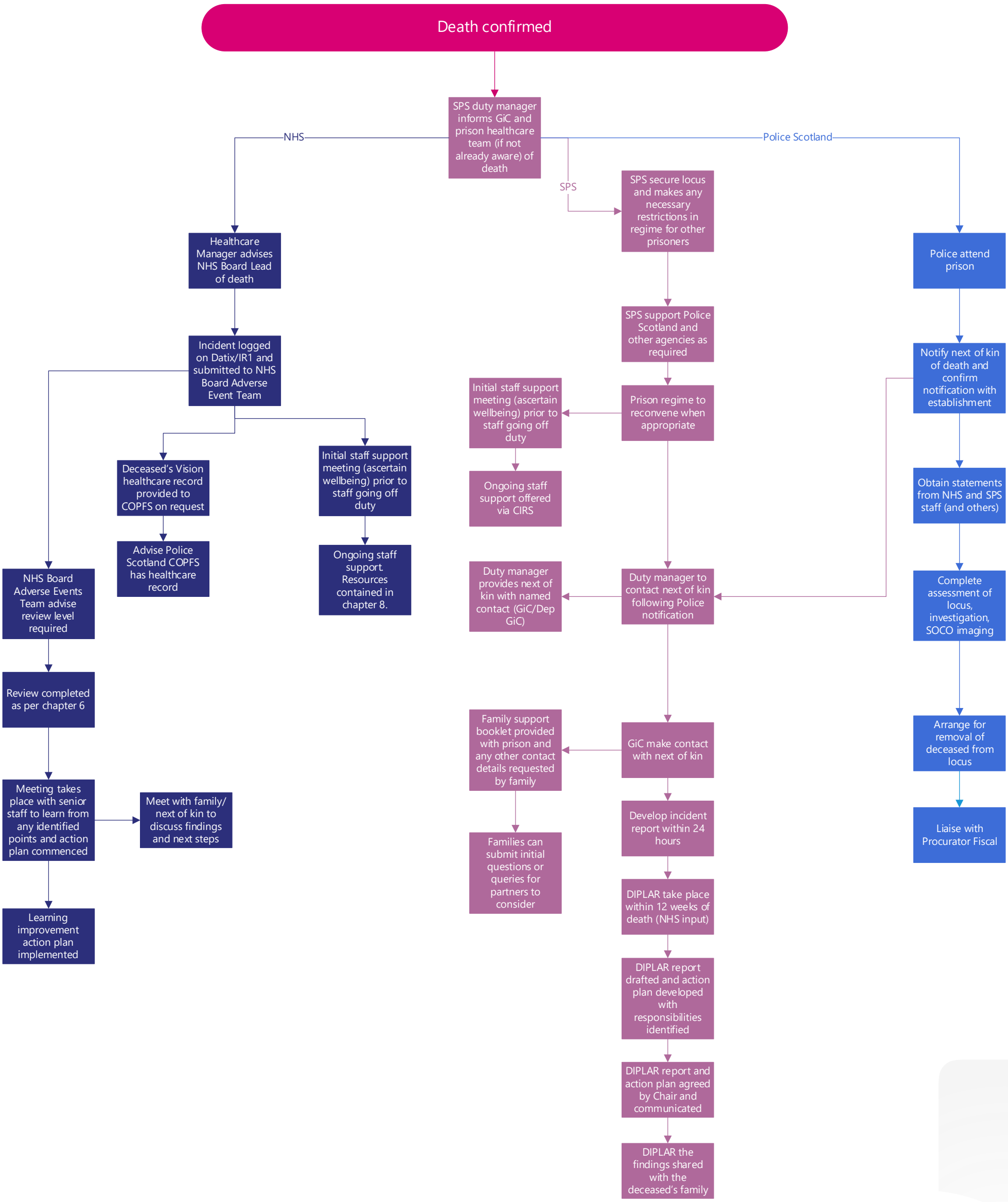
[10] Scottish Government the Vision for Justice in Scotland (2022)

3. Initial Response

Following a death in prison custody, NHS, SPS and Police Scotland all play a pivotal role in ensuring that the death is dealt with in a respectful, timely manner. A key priority of following a death in custody is ensuring that families/next of kin are informed as soon as possible, by a Police Scotland representative. This chapter provides an overview of what steps partners and NHS staff should take in the immediate aftermath of a death.

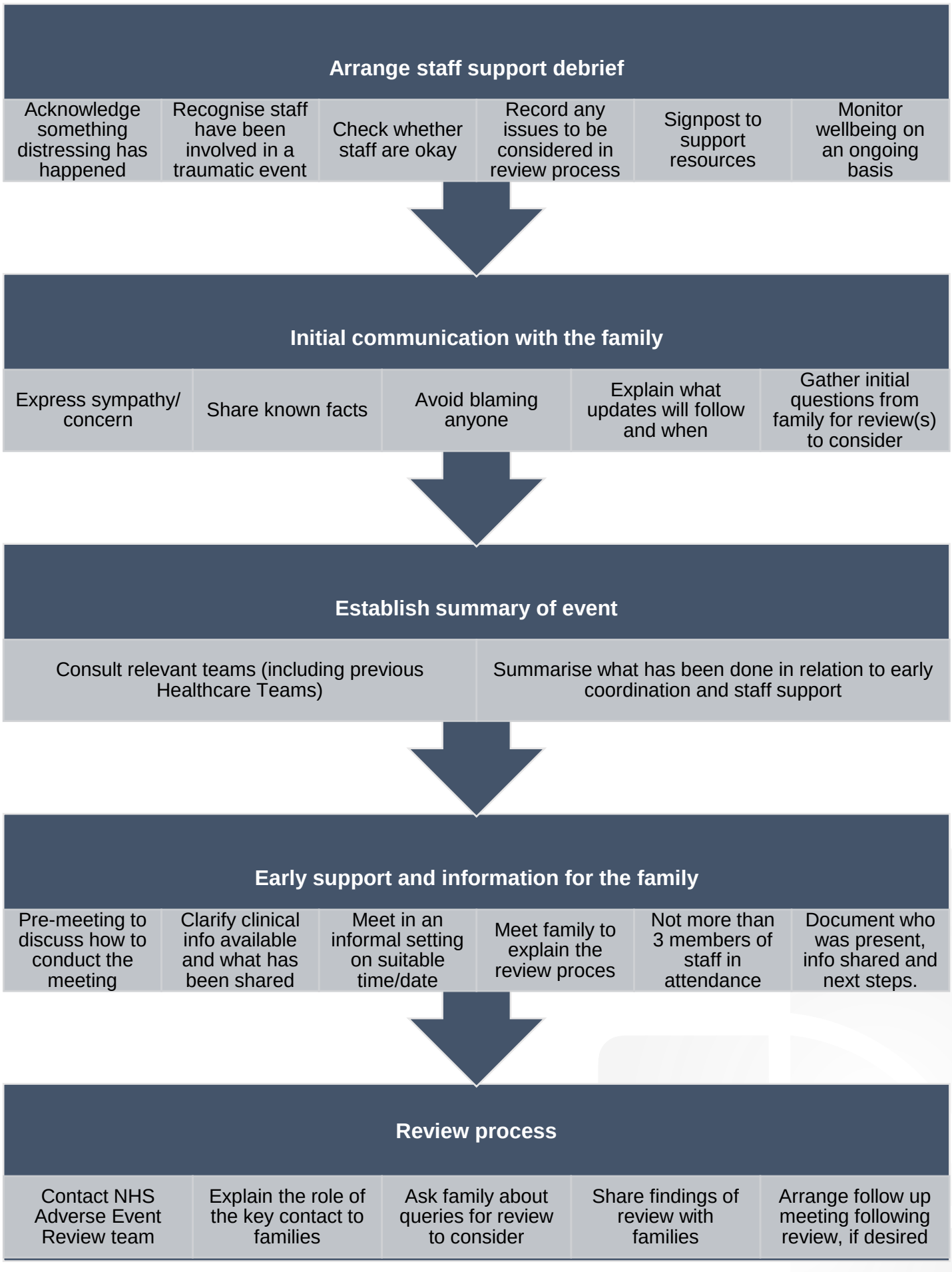
NHS, SPS and Police Scotland Initial Response Flowchart

The flowchart below has been developed by the NHS, in collaboration with SPS and Police Scotland, to ensure all partners are aware of roles and responsibilities following a death in prison custody:



NHS Process

Following a death in custody, there are steps that NHS Prison Healthcare staff are required to take. These are to ensure that staff are supported in the immediate aftermath, families are considered and involved on an ongoing basis. Initial steps that should be taken by NHS staff are detailed below:



4. Confirmation of Death Guidance

This chapter focuses on the implementation of the confirmation of death by registered healthcare professionals framework within NHS Prison Healthcare Teams. This training allows for Registered Nurses to carry out a timely confirmation of death within the prison environment, in any circumstances, without the need for involvement of a medical practitioner. This training has been developed to support the delivery of **recommendation 2.3** within the review:

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

When providing confirmation of death, the Registered Nurse is only confirming that the patient is deceased and providing a time that this assessment was made. The Registered Nurse is not asked to provide any opinion as to the potential cause of death.

Following a death in prison custody, the deceased becomes the responsibility of the Procurator Fiscal. Police Scotland, who are called to attend every death in prison, take possession of the deceased. **Police Scotland are responsible for advising SPS when the deceased can be moved from its locus**. To begin this process, there is a requirement that confirmation of death is made by an appropriate healthcare professional. Further information and considerations can be found within the confirmation of death by registered healthcare professionals: framework.

Training for Registered Nurses

All Registered Nurses working within a Prison should complete the Confirmation of Death for Prison Healthcare training. The training can be accessed via this link. This training covers:

- Legal and Regulatory Frameworks
- Clinical Scenarios in the context of Prison Healthcare
- Demonstration of the Confirmation of Death in Scotland Process
- Perspective of a nurse in Prison Healthcare

This training should feature within Registered Nurse's induction process and be completed every 2 years to maintain competence.

Process following a death in Prison

The NHS prison healthcare team will be notified via radio from Prison Officer whether it is a "code red" or "code blue" and the location of the incident.

To confirm a death, the Registered Nurse will carry out observations and examination over a minimum of 5 minutes to confirm death following the five steps below. These are outlined in the online Confirmation of Death Pocket card. Physical copies are available from the prison health centre:

- Absence of carotid pulse over one minute, and
- Absence of heart sounds over one minute, and
- Absence of respiratory sounds over one minute, and
- No response to painful stimulus (trapezium squeeze, orbital pressure), and
- Fixed dilated pupils unresponsive to bright light.

The guidance and supporting resources for practitioners undertaking the Confirmation of Death procedure in Scotland template provides guidance to support healthcare practitioners completing the recording template is outlined in appendix B, along with frequently asked questions.

Out of Hours Process

There may be circumstances where SPS are alerted that someone is deceased and there is no Prison Healthcare Staff on site. Normally, the Scottish Ambulance Service (SAS) will be called, as there is a duty to preserve life and will therefore be in attendance to confirm death. There may however by circumstances where a DNACPR is in place and SAS are not on scene to confirm the death. In these circumstances, NHS Boards need to have robust processes in place to enable confirmation of death to be carried out.

The agreed process for each NHS Board area needs to be shared with SPS colleagues within the establishment so that SPS operational staff are aware of who they should contact to arrange for confirmation of death to be carried out.

In these circumstances, it is essential that communication is made with the prison, informing both SPS and NHS staff, so that appropriate steps are taken following the death and that families are kept informed and offered support.

Unexpected Events

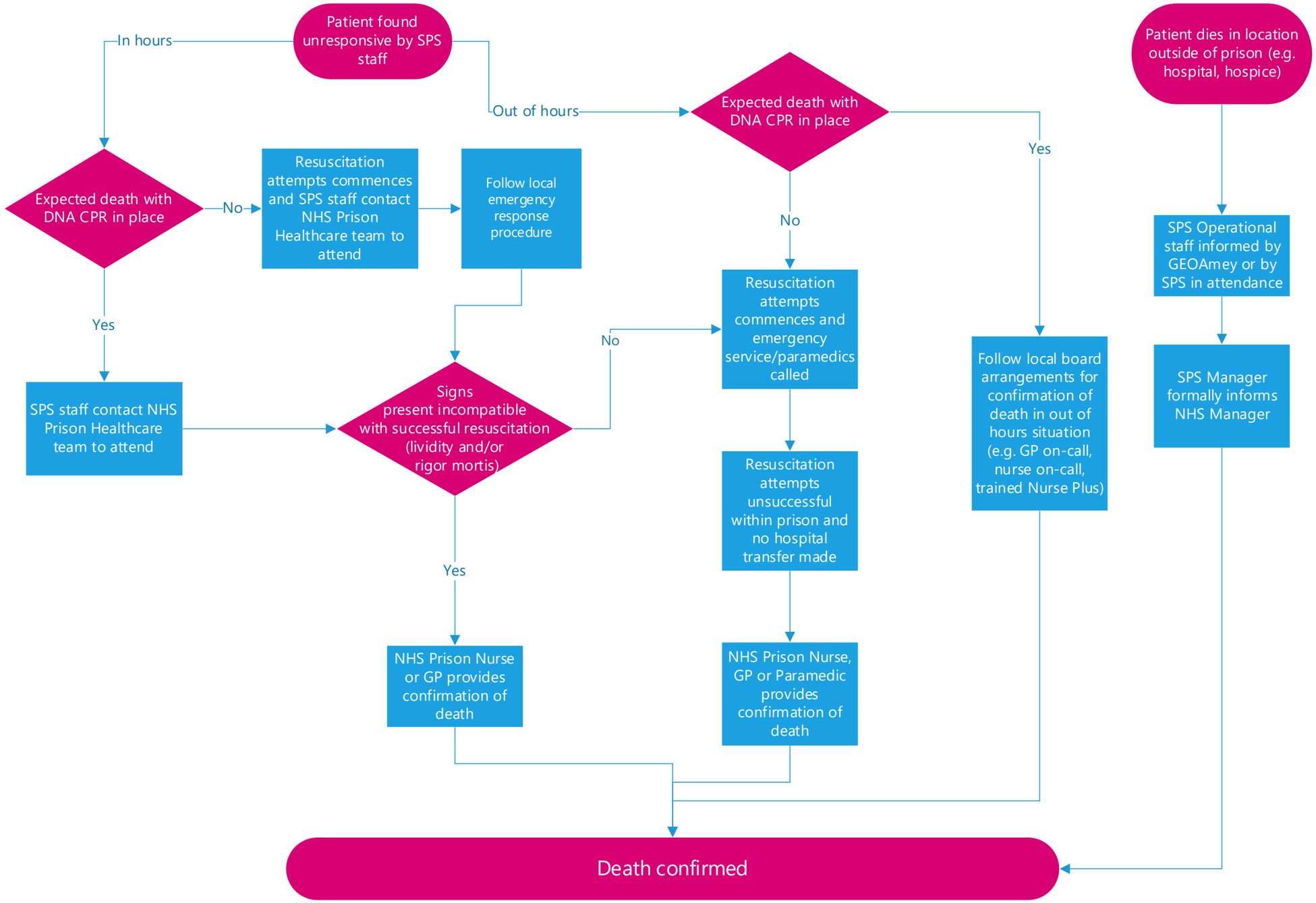
All unexpected events should be reported to the appropriate Prison Healthcare Manager or equivalent.

Audit

- Training uptake will be monitored via Turas.
- The Confirmation of Death recording template will be completed by the Registered Nurse and held within an appropriate place within the shared drive. These will be audited on a yearly basis.

Confirmation of Death flowchart

There may be circumstances where a prisoner dies out with the prison environment e.g. in a hospital or hospice. In these circumstances, it is essential that appropriate communication is made with the prison, informing both SPS and NHS staff, so that appropriate steps are taken following the death and the families are kept informed and offered support. The flowchart below illustrates the difference in the process of confirming death depending on if there is healthcare provision available on site and if the death happens out with the prison. Following confirmation of death, the flowchart contained on page 10 should be followed.



5. Family Engagement

The review highlighted that there is a lack of family engagement at every stage following a death in prison custody, with humanity and compassion sometimes being compromised.

This chapter will help to address **recommendation 3.3** by outlining why family engagement is so vital and how communication should be delivered:

> *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 opportunity should be spelled out in the family support booklet.*

Within **recommendation 5.2** it also states that:

> *The 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.*

Communication with Families

The Healthcare Improvement Scotland (HIS) Learning from adverse events through reporting and review framework notes that individuals involved in the adverse event (for example patients, family, carers, staff) **must be invited to contribute and kept informed** throughout the review process. This includes asking those involved if they have any questions that they would like to be explored during the review process. Within NHS Scotland, the current adverse event review process states that patients, service users and families are told what went wrong, why and receive an apology for any harm that has occurred.

The review highlighted that involvement of families varied, in some cases, patients and families were invited to submit questions in advance of the review, whilst in others, patients and families may be provided with a copy of the review findings. Less frequently, families were invited to share their observations surrounding the event, what mattered (and matters) to them, and how their perspectives could enhance learning. This means their issues and concerns were not always fully known to healthcare managers, with lost opportunity to address these, and the potential for vital learning missed.

Following a death in custody, family members are provided a copy of the revised SPS Family Support Booklet. This booklet has been designed to contain contact details and information about the help and support available.

To ensure that families can contact prison health centres, health centre phone numbers are contained with the booklet. It has been agreed that administrative staff will take the initial call and advise that the appropriate manager would then contact the family. This will provide the manager returning the call adequate time to collate appropriate information on the patient and ensure they are speaking to the family fully informed.

Death-related discussions are not easy. Families depend greatly on the level of communication skill used by staff. Poor communication can lead to long term emotional damage[11]. The Compassionate Friends website contains resources for professionals, and others, supporting bereaved parents and families.

[11] NHS NES Death Related Discussions

Do's and Don'ts of communication who those who are bereaved[12]

Do	Don't
Acknowledge their grief	Say you know how they feel - you can't
Take time to listen – attentively	Talk about your own experiences
Suggest a quiet place to sit together	Use platitudes like 'time is a great healer'
Use the name of the person who has died	Rush the conversation
Share resources - leaflets and contacts	Promise what you cannot deliver
Remember everyone is different	Forget that you need support too

It is important to be aware of some ways to sensitively approach these interactions; to have the confidence to talk or just listen. The talking and being with people who are bereaved video developed by NES aims to help health and social care professionals communicate with families in this situation. A downloadable leaflet which accompanies the video can be found here

The Irish Hospice Foundation delivering bad news video outlines a five-step process to breaking bad news. As this was not developed for a prison environment, not all the information contained within is directly applicable, however there are still key messages contained within.

The British Medical Journal (BMJ) "Adverse event reviews in healthcare: what matters to patients and their family? A qualitative study exploring the perspective of patients and family" outlines four key themes following interviewing 19 patients involved with Significant Adverse Event Reviews (SAERs)[13]:

1. **Communication**: the importance of feeling listened to and included – style and method of communication, communication in a human way.

2. **Trauma**: the challenges experienced during the review process – perceived inactivity during a lengthy review could impact negatively on mental health and lead to feelings of frustration and anxiety.

3. **Learning**: the importance of closing the loop and improving the healthcare system and patient safety - important to many participants that they knew what changes had been made following the adverse event.

4. **Litigation:** the opportunity to get answers where it was difficult to obtain answers elsewhere - used only when attempts to get answers and improvement had not been successful.

[12] Do's/ Don'ts produced by NHS Education for Scotland, content developed by Cruse Bereavement Care Scotland, © CBCS 2014

[13] McQueen, J.M., Gibson, K.R., Manson, M. and Francis, M. (2022). Adverse event reviews in healthcare: what matters to patients and their family? A qualitative study exploring the perspective of patients and family. BMJ Open, [online].

This study suggests eight recommendations for involving patients and families in adverse event reviews using the APICCTHS model:

APICCTHS Model: Involving patients and families in adverse event reviews: using compassionate communication skills[14]	
Apology	Say the words 'I am sorry, or I apologise'. This should be timely (soon after the event) and show empathy.
Person-centred	Ask what matters to the patient and family. Record this and respond to this as part of the review process (often it is not what clinicians or reviewers think might be important to patients and families).
Inclusive	Explain you are interested in finding out why the adverse event happened and ask the family for any insights they would like the review team to consider, actively listen and acknowledge these.
Communication	Remain empathetic, even in situations fraught with anger or frustration. Be open to hear personal criticisms without withdrawing or becoming defensive
Closing the loop	Share learning with families 'what we have learned from this is 'or 'here is what we will do to avoid this happening again'. This should be communicated in a way that fits family's needs (minimal use of jargon). Learning should be re-visited to ensure recommendations continue to be actioned.
Timing	Provide regular updates throughout the review explain what you are doing to find out what happened. Communicate what you know, include, and acknowledge suggestions made by the family.
Heart of review	Re-dress the power imbalance by putting patients and their families at the heart of reviews. Actively listen to their accounts, they may have vital pieces of information to enhance learning. Patient and families experience is their truth and should be represented as part of the review.
Support for staff	Create just culture and psychological safety for staff (as second victims) and patients. Focus on learning and not blame i.e., what was it in the system, environment, tools that contributed to the event.

NHS Central Legal Office (CLO) advised that an apology is a way of dealing with adverse events, complaints and duty of candour reporting. It is not an admission of liability or responsibility in the context of a litigation or a Fatal Accident Inquiry (FAI). However, it is possible that an apology may be referred to within the FAI process and therefore, if it is to be given, it should be considered carefully.

[14] NES Person Centred Care 2022 from McQueen et al: Adverse event reviews in health care What matters to patients and their families BMJ https://www.medrxiv.org/content/10.1101/2021.12.10.21267585v1

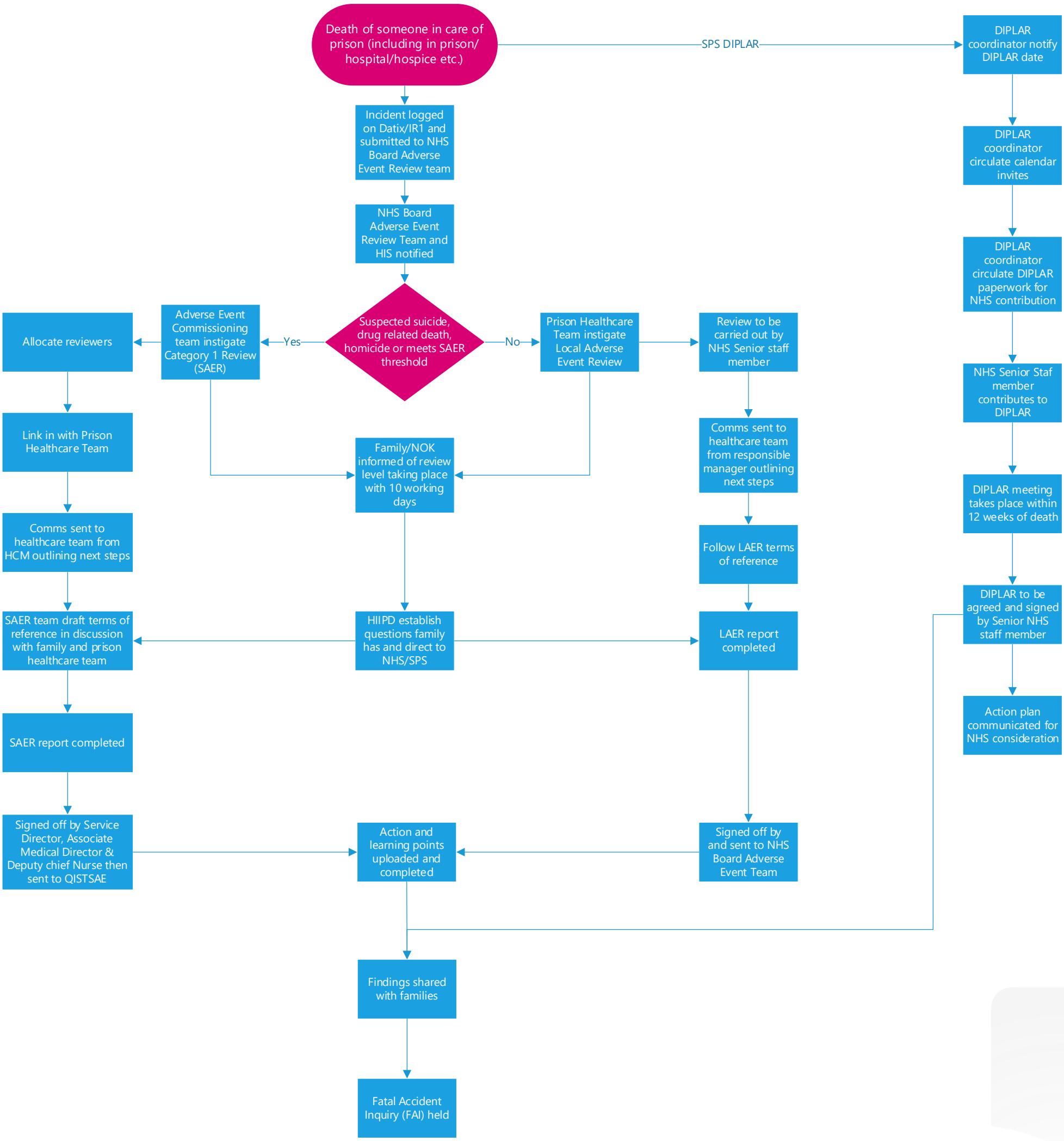
6. Scrutiny, Learning and Improvement

Following a death in prison custody, NHS staff will likely have to contribute to several reviews to ascertain circumstances surrounding deaths, consider queries raised by family members and to identify learning points/areas of good practice. **Recommendation 5.1** in the review highlighted the importance of ensuring families are involved and updated as part of these reviews:

> *The SPS and NHS should ensure that every family is informed of the Death in Prison Learning, Audit and Review (DIPLAR) and, if applicable, the SAER process, and their involvement maximised. This includes the family:*
> - *having the process (including timings) and their involvement clearly explained*
> - *being given the name and number of a single point of contact*
> - *knowing when their questions and concerns will be considered*
> - *receiving timely feedback.*

Learning Reviews Flowchart – SAER, LAER, DIPLAR and FAIs

The flowchart below demonstrates the various review process NHS staff are likely expected to feed into. These are likely the be the NHS SAER **or** NHS Local Adverse Event Review (LAER), SPS DIPLAR and FAI.



NHS Serious Adverse Event Reviews

All NHS Boards and NHS services are required to follow HIS learning from adverse events through reporting and review, a national framework for Scotland. This national framework was developed to provide an overarching approach to support care providers to effectively manage adverse events.

The principle of this framework is to learn from adverse events and support and build on the key values of care and compassion; dignity and respect; openness; honesty and responsibility; quality; and teamwork.

The framework incorporates the NHS statutory organisational duty of candour legislation, which came into force on 1 April 2018. The purpose of these provisions was to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm that is not related to the cause of the condition for which the person is receiving care.

SAERs are carried out following events that have resulted in unexpected death or harm. These are focused on analysing factors that have contributed to the circumstances of the adverse event. NHS Boards must inform HIS of any death where a category 1 SAER has been commissioned, this includes deaths in prison.

Determining whether a SAER is required

Following a death in prison, Prison Healthcare Teams are required log an IR1 incident on Datix. They should then contact their NHS Board Adverse Event Review team to carry out an assessment as to whether a SAER is required.

If a SAER is required:

All deaths where the person was in care of the prison at their time of death should be reported to the NHS Board Adverse Event Teams to review and decide whether a SAER is required.

Depending on the circumstances surrounding a death in prison, the NHS Board's Adverse Event Team will determine whether a SAER is required. A SAER would be required if:

- The event is or could be duty of candour i.e. serious harm and likely to be the organisation's responsibility.
- The event met the criteria for a Never Event (serious incident which is wholly preventable).
- There are multiple unanswered questions relating to what occurred and why it happened.
- There is complexity to the case that will require time to sort through the information to establish the facts.
- Staff will require to be interviewed to establish required information.
- The patient or their family are expecting an investigation report regarding the event.
- A significant clinical adverse event is converted from a complaint.
- A review group was required.
- The causation is likely to be 3 or 4 with serious harm indicated[15].
- The procurator fiscal is interested in the case.
- Significant learning/system changes has been identified and required to be shared.

In the prison context this means that the following, as a minimum, should automatically result in a SAER:

- Suicide
- Drug related death
- Homicide

[15] Causation codes:
1. Appropriate care/services: well planned and delivered/unavoidable outcome
2. Issues identified but they did not contribute to the event
3. Issues identified which may have caused or contributed to the event
4. Issues identified that directly related to the cause of the event

The SAER process must:

- Be transparent.
- Ensure engagement with all those involved in the adverse event.
- Incorporate thoughts and questions from families/next of kin.
- Ensure outcomes are shared with all of those who have contributed to the review.

If a SAER is deemed not to be required

If the death was expected, a SAER may not be deemed as necessary. In these circumstances:

- SPS will still carry out a DIPLAR which NHS staff provide clinical input into and establish if there are any learning points.
- NHS Prison Healthcare Teams should still contact families/next of kin to establish whether they have any questions regarding the healthcare provision in place and provide answers to these in a timely manner.

Local Adverse Event Review (LAER)

NHS Boards may have an adverse event that does not require a SAER. This happens when there is agreement by the NHS Board that the event was not preventable/avoidable.

A Local Adverse Event Review is acceptable if:

- No further information is required to make an assessment that a SAER is not required.
- Minimum extra information is required to make an assessment that a SAER is not required.
- Although there may be harm, the information on the briefing note provides assurance that the event was not preventable/avoidable.
- Information provided on the briefing note indicates no benefit by commissioning a SAER as most of the information has been gathered and either there is very low harm or there is a low causation code (1 or 2) with minimal recommendations.

The NHS Board may support a LAER by developing a briefing note detailing why a SAER was not required.

As detailed in the Communication with Families chapter of the toolkit, the HIS Learning from Adverse Events Through Reporting and Review Framework states that individuals involved in the adverse event (for example family, carers, staff) must be invited to contribute and informed throughout the review process. This includes asking them if they have any questions that they would like to be explored during the review process[9].

NHS Boards will have local processes for the review of reports and recommendations either through clinical governance structures and/or management team structures. It is expected that the lead director or manager who commissioned the review will be responsible for approving the report.

The review team and all staff involved in the adverse event should receive a copy of the final report. The organisation should also share this with families. A one-page learning summary should be completed to identify key learning points[16].

[16] Learning from adverse events through reporting and review A national framework for Scotland (2019)

SPS DIPLAR

Previously, the DIPLAR was the joint SPS & NHS process for reviewing all deaths in custody and provided a system for recording any learning and identified actions. NHS Prison Healthcare teams were included on DIPLAR paperwork as co-chair however, SPS now own and govern the DIPLAR process independently.

NHS staff can still provide valuable insight into an individual's care and so, a senior NHS representative should contribute to the DIPLAR.

The 2023 refreshed DIPLAR paperwork expects NHS staff to provide insight on:

- If there was NHS contact with the family/next of kin.
- Answering questions that pertain to healthcare that family/next of kin have raised.
- Relevant contact with healthcare including contact with mental health service etc.
- Requests or referrals for healthcare assistance.
- Details of any significant events in the months leading up to the death.
- Any other relevant information and intelligence.

A DIPLAR learning and action plan will be produced, this will be owned and monitored by SPS. If there are advisory points which pertain to healthcare these advisory points should be communicated to the senior NHS representative who attended the DIPLAR for their consideration.

Inspecting and Monitoring: Standard 9: Health and Wellbeing

Standard 9 is undertaken by HIS, as part of the HMIPS inspection process. The Quality Indicators under Standard 9 reflect a human rights approach and the National Health and Social Care Standards: My support, my life (2017) principles.

The guidance supporting Standard 9 also reflects HIS' Quality Framework which provides guidance to services, and to those externally quality assuring them, about what good quality care looks like and how this can be evaluated.

Using the quality-of-care approach principles, HIS aims to drive improvements in healthcare through consistent quality assurance and inspection activities. This includes inspecting NHS Boards/Health and Social Care Partnerships on their performance of how they implement governance and quality assurance processes, specifically for the Deaths in Custody recommendations.

HIS will ask/seek evidence of applied learning from adverse events and how this is shared with staff, how people are supported to implement changes and what support staff receive. HIS will also consider how healthcare information is provided for families and recordings of next of kin details in clinical records and information sharing/consent. They will seek evidence of mandatory training compliance around the confirmation of deaths training.

FAI

A FAI will be held following a death if the person was in legal custody. Legal custody can include the people in prison, police custody, those police custody in other premises such as courts.

The purpose of an FAI is to:

- establish the circumstances of the death.
- consider what steps (if any) might be taken to prevent other deaths in similar circumstances.
- establish the facts surrounding the death, rather than to apportion blame or to find fault.

To support NHS staff attending Court as part of a FAI, the FAI supporting resource, available here, has been developed. This resource covers the aim of a FAI, what is involved when attending court, court citations, witness oath/affirmation, the court room and an overview of others that may be involved in the process.

National Hub for Reviewing and Learning from the Deaths of CYP

The National Hub for Reviewing and Learning from the Deaths of Children and Young People (CYP) has been set up at the request of Scottish Government. The aim of this is to:

- ensure that the death of every child in Scotland is subject to a quality review, and
- that there is a consistent approach and coordinated process for all local review activity that is undertaken in relation to learning from the circumstances surrounding the deaths of all children and young people in Scotland.

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. Hosted by HIS and the Care Inspectorate, the National Hub ensures that from 1 October 2021, reviews are conducted on 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 aftercare or continuing care** at **the time of their death**.

National guidance sets out the processes for health and care professionals from NHS Boards, Local Authorities and Health and Social Care Partnerships when responding to, and reviewing, the death of a CYP. It outlines the review process and infrastructure required to support local systems and takes account of the need to consider how to keep families and carers at the centre of the review process.

A key part of the review process includes the completion of the National Hub core review dataset. This dataset information enables the consistent gathering and analysis of data on all child deaths across Scotland.

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.

Contact should be made with the National Hub team at his.cdrnationalhub@nhs.scot who can discuss this with you.

Should the young person meet the National Hub criteria, the National Hub team will signpost you to the relevant NHS Board area child death review group. It is important to agree locally the most appropriate review approach, including the completion of the core review dataset, and to optimise shared learning and avoid duplication.

More information about the National Hub can be found here.

For those under 18, consideration must be given to The United Nations Convention on the Rights of the Child to ensure respect and the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status[17].

[17] The United Nations Convention on the Rights of the Child Article 2

7. Trauma Informed Care and Wellbeing

This chapter sets out the rationale behind the development of the NHS National Trauma Training Programme led by NHS Education for Scotland and provides information on the training and education resources available.

The aim of this Programme is to support the skills and knowledge of the whole Scottish workforce to meet the vision of:

"A trauma informed and responsive nation and workforce, that is capable of recognising where people are affected by trauma and adversity, that is able to respond in ways that prevent further harm and support recovery and can address inequalities and improve life chances."

Trauma is everyone's business, and every member of the Scottish Workforce has a role to play in understanding and responding to people affected by trauma. This doesn't mean that everyone needs to be a trauma expert — different expertise and skills are required to support people's recovery — but all workers, in the context of their own role and work remit, have a unique and essential trauma informed role to play in responding to people who are affected by trauma[18].

The need for the principles to be founded in equality and human rights was highlighted as key. Justice services aim to eliminate discrimination, advance equality, and foster good relations while taking a right's-based approach, ensuring those most vulnerable and facing the biggest barriers are able to understand and realise their rights[19].

The Scottish Government's trauma-informed practice toolkit has been developed as part of the National Trauma Training Programme, to support all sectors of the workforce, in planning and developing trauma informed services.

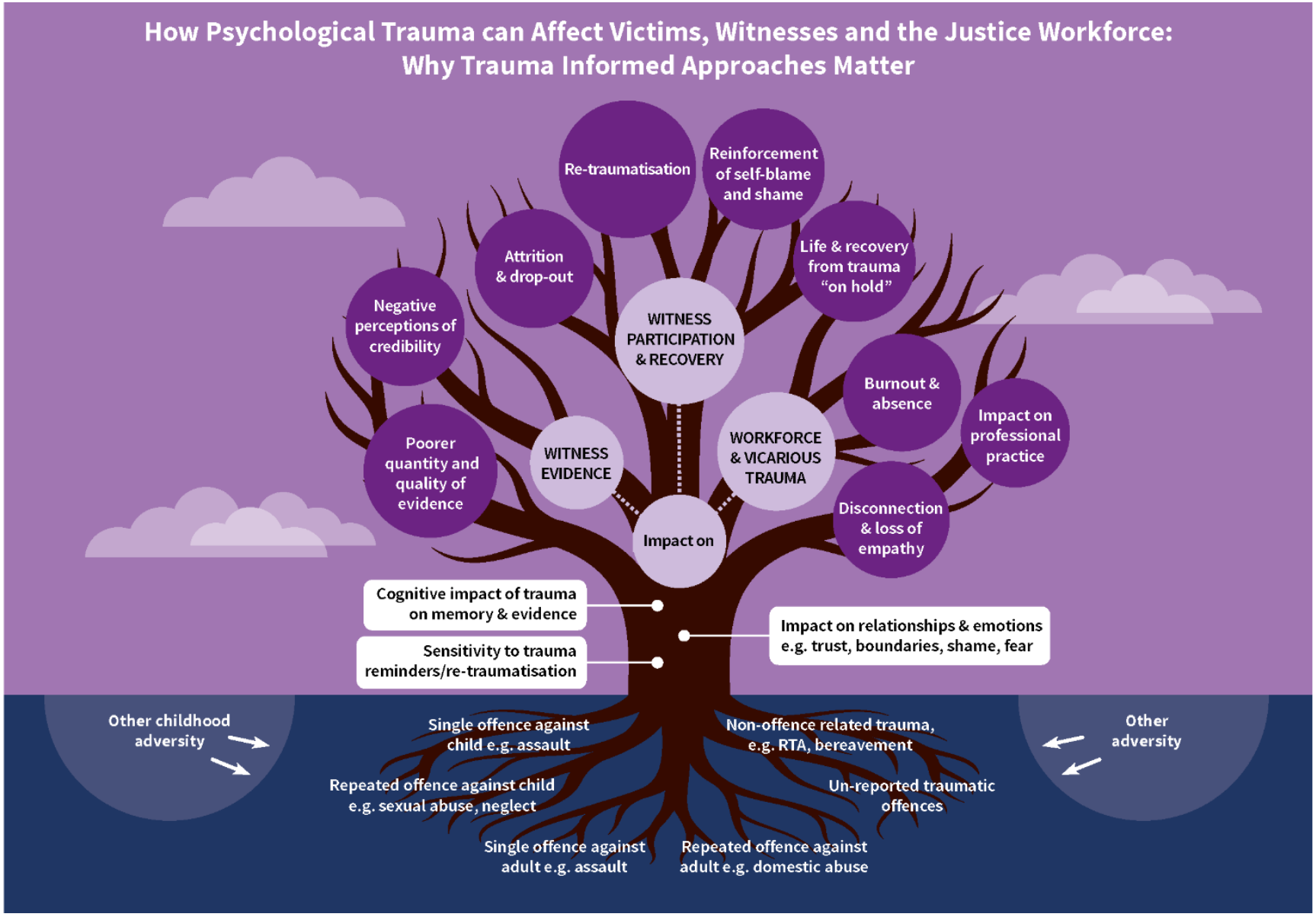
Being 'Trauma Informed' means being able to recognise when someone may be affected by trauma, collaboratively adjusting how we work to take this into account and responding in a way that supports recovery, does no harm and recognises and supports people's resilience. Being 'Trauma Informed' is underpinned by the 5 R's:

- **Realising** how common the experience of trauma and adversity is
- **Recognising** the different ways that trauma can affect people
- **Responding** by taking account of the ways that people can be affected by trauma to support recovery
- Opportunities to **Resist** re-traumatisation and offer a greater sense of choice and control, empowerment, collaboration and safety with everyone that you have contact with
- **Recognising** the central importance of relationships**.**

The NHS National Trauma Training Programme highlights that "whether an event(s) is traumatic depends not only on our individual experience of the event, but also how it negatively impacts on our emotional, social, spiritual and physical wellbeing. We are all affected by traumatic events in different ways.[12]"

The NES Trauma Informed Justice Framework's knowledge and skills apply to anyone working or volunteering in the justice system. Within Aim 5 of the framework, it states "support resilience of the workforce and reduce the potential impact of vicarious trauma".

[18] National Trauma Training Programme
[19] The Vision for Justice in Scotland (2022)


How Psychological Trauma can Affect Victims, Witnesses and the Justice Workforce:
Why Trauma Informed Approaches Matter
Re-traumatisation
Reinforcement of self-blame and shame
Attrition & drop-out
Life & recovery from trauma "on hold"
Negative perceptions of credibility
WITNESS PARTICIPATION & RECOVERY
Burnout & absence
Impact on professional practice
Poorer quantity and quality of evidence
WITNESS EVIDENCE
WORKFORCE & VICARIOUS TRAUMA
Disconnection & loss of empathy
Impact on
Cognitive impact of trauma on memory & evidence
Sensitivity to trauma reminders/re-traumatisation
Impact on relationships & emotions e.g. trust, boundaries, shame, fear
Other childhood adversity
Single offence against child e.g. assault
Non-offence related trauma, e.g. RTA, bereavement
Other adversity
Repeated offence against child e.g. sexual abuse, neglect
Un-reported traumatic offences
Single offence against adult e.g. assault
Repeated offence against adult e.g. domestic abuse

Vicarious Trauma

Vicarious trauma is a process of change resulting from empathetic engagement with trauma survivors.

Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals[20].

Unless the impact of vicarious trauma on the justice workforce, including healthcare professionals who work in the justice system, is properly responded to, and proactively managed, members of the workforce can experience burnout or traumatic stress, become disconnected and feel less empathy. Outcomes like these make it much harder to respond to others in a trauma informed way.

The British Medical Association (BMA) outlines the following strategies for reducing risk of vicarious trauma:

- Increase your self-observation - recognise and chart your signs of stress, vicarious trauma and burnout.
- Take care of yourself emotionally - engage in relaxing and self-soothing activities, nurture self-care.
- Look after your physical and mental wellbeing.
- Maintain a healthy work/life balance - have outside interests.
- Be realistic about what you can accomplish - avoid wishful thinking.
- Don't take on responsibility for your patients' wellbeing but supply them with tools to look after themselves.
- Balance your caseload - mix of more and less traumatised clients, victims and non-victims.
- Take regular breaks, take time off when you need to.
- Seek social support from colleagues, family members.
- Use a buddy system - particularly important for less experienced healthcare professionals.
- Use peer support and opportunities to debrief.
- Take up training opportunities.
- If you need it, take up time-limited group or individual therapy.
- There are also significant organisational factors that can increase the risk of a person being vicariously traumatised, which should be assessed and addressed.

As part of the National Prison Care Network's Prison Healthcare Target Operating Model and Training Needs Analysis, staff identified that they would like further training in relation to trauma informed care.

Due to this and the reasons noted above, it is recommended that all NHS staff working within prisons complete NES' Trauma Informed module of the National trauma training programme. As part of this, staff should watch the animations noted below:

- Looking after yourself wellbeing animation (7 mins)
- Opening Doors: Trauma Informed Practice for the Workforce Animation (9 mins)

[20] BMA Vicarious trauma: signs and strategies for coping

8. NHS Staff Wellbeing and Support

Responding to a death in custody can be traumatic for all those involved. It is essential that line managers and the wider workforce take cognisance of this and ensure that appropriate support is accessible. As a line manager, there is a duty of care to ensure team members wellbeing and ensure that they are adequately supported.

Recommendation 4.1:

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

Line manager support

Following a death in custody, the line manager of those who have been directly involved (e.g. responded to the code, attempted CPR or confirmed death) should carry out a wellbeing check with the staff member prior to them finishing the duties for the day. It is important to not re-traumatise the staff member by going into too many details.

Within NES' suite of psychosocial mental health and wellbeing support resources, there is a 30minute e-learning module titled "Protecting the psychological wellbeing of staff and teams for managers and team leaders". The aim of this is to help managers, planners and leaders of teams understand the evidence-based factors that support the wellbeing of teams through crisis events. It contains 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 during and after the crisis. This was originally developed in response to Covid-19 however it can be applied to any workforce where staff may routinely have their resilience challenges by working in high pressure environments.

The protecting the psychological wellbeing of staff and teams for managers and team leaders module recommends against offering formal psychosocial interventions too soon. Psychological and critical incident stress debriefings where staff are mandated to talk about their thoughts or feelings are also advised against, due to the possible detrimental effect. Instead it recommends to actively monitor and support staff through and beyond the crisis period.

This module includes a stepped model of care responding to staff distress, including:

- Basic practical needs
- Basic emotional needs
- Psychological First Aid
- Brief Psychological Support
- Formal Psychological Intervention

As part of monthly supervision meetings, line managers should ensure staff wellbeing is considered, especially following the involvement of a death in prison custody. Managers should signpost staff to the NES personal wellbeing plan and actively encourage them to consider the resources contained within this toolkit.

Values-Based Reflective Practice

The use of individual or team debrief, and reflection can be helpful following end of life events and bereavement situations. NES' Values-Based Reflective Practice® (VBRP). It is an intentional way of reflecting on past practice, in the present, in order to improve practice in the future.

VBRP® offers a structured, reflective method which is designed to help staff deliver the care they came into the service to provide. It promotes person-centred care, engages in dialogue between per sonal and organisational values, attitudes and behaviours. It enhances staff fulfilment and turns history (what we have done) into learning. It supports staff members to better manage their own wellbeing and resilience and helps them to develop increased reflexivity in their practice. A short video about VBRP® can be accessed via this link.

Essentials of psychologically informed care

This package has been developed to support a deeper psychological awareness and learn communication skills required for emotional wellbeing in the workplace. It explores strategies to enhance and maintain collaborative working relationships and develop an understanding of practical ideas to help look after yourself.

- **Module 1 – Introduction**: a brief overview of the further 4 modules which make up the essentials of psychological care learning suite. It sets the scene for the further learning and identifies who would benefit from completing them.
- **Module 2 - Emotions and wellbeing**: explore the concept of emotional wellbeing and consider its relationship with the work done in health and social care settings. This is done by considering the biopsychosocial and the cognitive behavioural models and looks at recovery resources available in Scotland.
- **Module 3 - Communication and active listening**: develop their communication skills which lie at the heart of psychological awareness and performing psychologically informed care. It considers the core conditions and other skills associated with good communication.
- **Module 4 – Good working relationships**: importance of good working relationships as an integral part of psychologically informed practice. This is done by looking at communication styles, collaborative relationships, and the importance of confidentiality and boundaries.
- **Module 5 - What about you**: people in caring services can sometimes feel difficult and stressful. This can give rise to negative feeling and can affect practitioners' well-being. Some helpful things people can do to look after themselves are considered.

NHS National Wellbeing Support for People Working in Health and Social Care

The National Wellbeing Hub for People Working in Health and Social Care is partnership between national, local and professional bodies with a shared passion for looking after the emotional and psychological wellbeing of Scotland's health and social services workers.

The hub has been developed for everybody working in health, social care and social work in Scotland. It contains resources to promote mental wellbeing, financial wellbeing, physical wellbeing, psychologically safe workplaces, supporting staff wellbeing and responding to emergencies.

NHS Bereavement Co-ordinators and Spiritual Care Leads in NHS Boards can provide an important resource for healthcare staff regarding methods of accessing support and guidance. For more information go to their page on Resilience and Wellbeing.

Online resources

National Wellbeing Hub - mental wellbeing resources for health and social care workers.

NHS NES Support Around Death website aims to support health and social care staff working with patients, carers and families before, at, and after death. It provides key information on the clinical, legislative, and practical issues involved. The **TALK video** was designed to help health and social care professionals cope with death and bereavement.

The **ripples of grief video** provides tips for looking after those who are bereaved and your own wellbeing. This film explores how healthcare professionals can support people who are bereaved as well as look after their own wellbeing. It is structured around ten tips.

Clear Your Head - the Scottish Government's website to support your mental wellbeing.

NHS Scotland HR Connect Wellbeing

- Employee Assistance Programme
- Mental Health and Wellbeing
- Physical Wellbeing
- Stress and Mental Health at Work
- Wellbeing - Policy, Process & Guidance

HELP Employee Assistance provides a range of information and guidance to help you improve your wellbeing. Can be contacted **by phone via 0800 032 9849.**

NES developed a series of **Psychological Wellbeing podcasts** to help managers and staff during difficult times. The series of podcasts includes topics on, Psychological Wellbeing, Psychological First Aid, Resilience for Managers and Psychological 1st Aid in Action.

See Me is Scotland's national programme to end mental health stigma and discrimination. See Me in Work e-Learning Portal aims to support employers to create a working environment where people feel safe and able to talk openly about mental health.

BMA have a range of services such as. counselling, peer support, support directory available via their helpline on **0330 123 1245.**

Additional Support

NHS 24 Mental Health Hub Available 24/7 phone **111** and choose the mental health option, to be connected to psychological wellbeing practitioners. You can text **NHS 24 on 18001 111** or the **Relay UK app.**

Breathing Space free and confidential phoneline for anyone experiencing low mood, anxiety, depression or is in need of someone to talk to. **By phone: 0800 83 85 87 (Mon-Thurs 6pm-2am, Fri 6pm-Mon 6am)**

Samaritans provide confidential emotional support 24 hours a day, 365 days a year for people who are feeling distressed or need to talk to someone. **By phone: 116 123 or email: jo@samaritans.org**

Cruse Bereavement Care Scotland offers free bereavement care and support through one-to-one counselling or local support groups. To find out about the availability of services in your area, contact the National Office by **phone: 0845 600 2227 or email: info@crusescotland.org.uk**

CALM is for anyone who needs to talk confidentially about a tough. Calls are taken by trained staff who listen, support, inform and signpost to further information. **Phone: 0800 58 58 58** open from 5pm to midnight every day. CALM also offers a webchat.

Scottish Association for Mental Health (SAMH): Phone: 0141 530 1000 or **email: info@samh.org.uk**

Remploy's workplace mental health support service is free, confidential and available to employees with mental health issues affecting their work **0300 456 8114.**

Sleepio is a clinically evidenced sleep improvement programme that is fully automated and highly personalised, using cognitive behavioural techniques to help improve poor sleep.

Daylight is a smartphone-based app that provides help to people experiencing symptoms of worry and anxiety, using evidence-based cognitive behavioural techniques, voice, and animation.

9. Duty of Confidentiality

BMA Healthcare and Confidentiality toolkit – Chapter 5 - Deceased patients
This toolkit, developed for doctors, outlines that the obligation to respect a patient's confidentiality extends beyond death. However, this duty needs to be balanced with other considerations, such as **the interests of justice and of people close to the deceased person**. There may be circumstances where it is obvious that there may be some sensitivity about information in health records. In these circumstances, healthcare professionals may wish to consider speaking to their patients about disclosure after death with a view to soliciting their views.

There are other circumstances when information about a deceased patient must be disclosed. Separate to the access to health records legislation, information about a deceased patient must be disclosed:

- to assist a coroner or procurator fiscal investigation.
- For accurate completion of death certificates.
- to meet a statutory duty of candour.
- when the law requires disclosure.

Are relatives entitled to information about the deceased's last illness?
Whilst there is no legal entitlement other than the limited circumstances covered under access to health records legislation, healthcare professionals have discretion to disclose information to a deceased persons relatives or others when there is a clear justification.

A common example is when the family requests details of the final illness because of an anxiety that the patient might have been misdiagnosed or there might have been negligence. Disclosure in such cases is likely to be what the deceased person would have wanted and may also be in the interests of justice.

Refusal to disclose in the absence of evidence that this was the deceased patient known wish exacerbates suspicion and can result in unnecessary litigation. The balance of benefit to be gained by disclosure to the family, for example, of a hereditary or infectious condition, may outweigh the obligation of confidentiality to the deceased.

NHS Scotland Code of Practice - Protecting Patient Confidentiality
The ethical responsibility in terms of a patient's confidentiality extends beyond their death. However, the duty of confidentiality needs to be balanced with other considerations, such as the interests of justice and the interests of people who had close or emotional ties to that person. Confidentiality is an important ethical and legal duty, but it is not absolute.

Where appropriate, you should counsel your patients about the possibility of releasing information after death and get their views about this. This particularly applies if it is obvious that there may be some sensitivity surrounding the nature of the information in question. You also need to record these discussions in the patient's record.

Unless patients have asked for confidentiality while alive, their personal representative and any other person who may have a claim arising out of their death has a right of access to information in the patient's records, directly relevant to a claim. This applies under the terms of the Access to Health Records Act 1990. (A personal representative is defined under section 3 (1) (f) of the act as the executor or administrator of the person's estate).

If you are not aware of any instructions from the patient, when you are considering requests for information, you should take into account the following:

- If a parent asks for information about the circumstances and causes of their child's death.
- If a partner, close relative or friend asks for information about the circumstances of an adult's death, and you have no reason to believe that the patient would have objected to you telling them.
- If a person has a right of access to records under the Access to Health Records Act 1990.
- On death certificates.
- For public health surveillance (in these circumstances, the information in question should be made anonymous unless this would defeat the purpose).
- To help the Procurator Fiscal with an investigation or a FAI.
- For national confidential inquiries or for local clinical audit purposes.

Appendix A - Review of the Response to Deaths in Prison Custody Recommendations

Key Recommendation

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.

The other **19 recommendations** are grouped under the following themes:

1. Family contact with the prison and involvement in care.
2. Policies and processes after a death.
3. Family contact and support following a death.
4. Support for staff and other people held in prison after a death.
5. SPS and NHS documentation concerning deaths.

Family contact with the prison and involvement in care

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.

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

1.3 The SPS 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.

1.4 When someone is admitted to prison, the SPS and 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.

Policies and processes after a death

2.1 The 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.

2.2 The SPS should provide improved access to equipment such as ligature cutters and screens to save vital time in saving lives or preserving the dignity of those who have died.

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

2.4 The SPS should review the DIPLAR pro forma to ensure they evidence how the impact of a death on others held in prison is assessed and that support is offered.

2.5 The SPS and NHS must ensure that child-friendly policies and practices are introduced and applied to all children, 18 years or under, 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.

Family contact and support following a death

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

3.2 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.

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 opportunity should be spelled out in the family support booklet.

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.

Support for staff and other people held in prison after a death

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

4.2 The 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.

SPS and NHS documentation concerning deaths

5.1 The SPS and NHS should ensure that every family are informed of the DIPLAR and, if applicable, the SAER process, and their involvement maximised. This includes the family:

5.2 Having the process (including timings) and their involvement clearly explained

5.3 Being given the name and number of a single point of contact

5.4 Knowing when their questions and concerns will be considered

5.5 Receiving timely feedback.

5.6 The 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 the family should be recorded in the DIPLAR report.

5.7 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.

5.8 The full DIPLAR process should be followed for all deaths in custody, with a member of staff from Prison Service Headquarters in attendance.

Advisory Points

6.1 A platform should be available for families to share and process their experiences such as a Bereavement Care Forum as previously recommended (Nugent 2018). The NHS and SPS should commission the independent development and support of such a platform.

6.2 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.

6.3 Consideration should always be given by the SPS and NHS to whether other people held in prison who knew the deceased may have relevant information to offer and how best to include their reflections in both DIPLAR and SAER processes where appropriate, in particular whether discrimination of any kind was perceived as a factor in the death.

6.4 The SPS and NHS should review the 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.

6.5 The SPS and NHS should also consider developing a separate section in the DIPLAR document to ensure information on family involvement and the content of discussions is recorded, including any questions raised by the family and the response to them.

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

Appendix B – Confirmation of Death Recording Template

Confirmation of Death recording template			
Section 1 – Patient's details: Attach addressograph label or complete below			
Circle as appropriate: Consultant /hospital/GP practice:	**First name:**	**Last name:**	
	CHI number:	**Date of birth:**	
	Permanent address: (NB this may not be the place of death) **Post code:**		
Section 2 - Clinical signs - o**bservations and examination over minimum of 5 minutes**			Tick when absence is confirmed
Absence of carotid pulse over one minute confirmed AND			
Absence of heart sounds over one minute confirmed AND			
Absence of respiratory sounds/effort over one minute confirmed AND			
No response to painful stimuli (e.g. trapezius squeeze) confirmed AND			
Fixed dilated pupils (unresponsive to bright light) confirmed?			
Date and time clinical signs noted to be absent	**Date:** ...../...../.....		**Time**: .... : .....(24 hour)
Section 3 - Place of death and witness			
Place of death (address)			
Person present at death/person who found the deceased* (delete as appropriate).	Name: Contact details: Relationship to the deceased person:		Approximate time of death estimated by witness Date: ..... / ...../..... Time: ..... : ..... (24 hour)
Section 4 - Clinical information: to the best of your knowledge and belief			
Is there a potential risk of transmission of infection?			Yes /Unknown/ No
Is the use of a body bag required as per infection control policy?			Yes /Unknown/ No
Are there any known hazards, e.g. indwelling medical devices, or equipment remaining with the deceased?	Yes/Unknown/No		If Yes – give details:
Section 5 - **Communication** *(a summary can be provided here; more significant communication should be recorded in the patients notes)*			
Next of Kin present? - Yes/No	If not present, have they been informed? - Yes/No		
If Next of Kin not informed, detail reasons why:			
Name of Person Informed			Date: ...../...../..... Time: ..... : ..... (24 hour)
Relationship to Patient			
Contact Details (phone)			
Professionals informed: GP / Consultant / Out of hours / Community Team / Funeral Director /Other (Circle as appropriate)	Name/details of professionals informed:		Date: ...../...../..... Time: ..... : ..... (24 hour)
Are you aware of any factors that may indicate need to report this death to Police Scotland / Procurator Fiscal?	Yes/No	If Yes – Inform Dr and give details: Name of Dr informed: .....**Date..../..../..... Time ...:.....**	
Section 6 - Registered healthcare professional confirming death			
Name (Block Capital):		Designation:	
Signature:		Date: ...../...../.....	Time: .....: ..... (24 hour)