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24 March 2026

Dear Convener

Ministerial Accountability Board and the Independent Review of the Response to Deaths in Prison Custody (November 2021)

I wrote to you in December to update you on the Ministerial Accountability Board (MAB)'s work on deaths in custody and the publication of regular progress reports on delivering Fatal Accident Inquiry recommendations. In that letter I committed to providing Parliament with a further update in March 2026. As part of ensuring transparency across all oversight activity relating to deaths in custody, I am also taking this opportunity to update the Committee on recent progress made through the Deaths in Prison Custody Action Group (DIPCAG).

At its meeting on 19 January 2026, the DIPCAG reviewed progress on the remaining recommendations arising from the Independent Review of the Response to Deaths in Prison Custody. The meeting confirmed that 19 of the 26 recommendations and advisory points have now been implemented – a table is provided in the annex to this letter that provides an update on each point. It was also agreed that recommendations marked as implemented will continue to be revisited alongside the remaining outstanding actions. This reflects the Group's commitment to ongoing monitoring, continuous improvement and responding directly to feedback from families and stakeholders. Two further DIPCAG meetings have been scheduled for June and December 2026, and I will continue to keep the Committee informed as this work progresses.

This recent progress sits alongside the work taken forward through the Ministerial Accountability Board, which was established last year in response to the deaths of Katie Allan, William Lindsay (or Brown) and Jack McKenzie at HMP & YOI Polmont. These tragedies revealed significant and systematic failures within the prison and healthcare systems, and I established the MAB to strengthen transparency, scrutiny and system-wide learning by bringing together a range of prison, legal and health experts to provide robust

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challenge and hold senior representatives from the Scottish Government, the Scottish Prison Service and NHS Forth Valley to account. The MAB met formally five times since June 2025 and held their final meeting on 11 March 2026. Their final report was published today and can be viewed here: <https://www.gov.scot/isbn/9781807751593>

The MAB's final report provides an overview of the oversight undertaken in relation to the 43 recommendations and commitments arising from the deaths of Katie, William and Jack. It summarises the progress achieved, the challenges encountered, and the lessons learned, and sets out what the MAB expects to see demonstrated by the Scottish Government, the Scottish Prison Service (SPS) and the National Health Service (NHS).

Below is a list of the key commitments I made in my March 2025 statement to Parliament in response to Sheriff Collins's FAI determination, with short note to show where progress has been made:

- **Commitment:** Strengthen independent scrutiny, including through HMIPS oversight and the creation of a National Oversight Mechanism (NOM) that is evidence led, transparent, and independent of Government.
Action: A test of change prison only model of the NOM is now in development with an independent body.
- **Commitment:** Overhaul the SPS suicide prevention strategy, with a full evidence review completed by summer, and a new strategy and training package developed.
Action: Professor Graham Towl completed his review of Talk to Me last year, with his findings published in a [report](#) and a new strategy and training package is in development at SPS for implementation in early 2027.
- **Commitment:** Revise policy on possession of items that can be used as ligatures, supported by a new ligature audit toolkit.
Action: The SPS has revised its 'items in use' policy and removed high risk items such as belts and dressing gown cords in HMP & YOI Polmont and Stirling, while work continues on future options with targeted research on impacts for young people, and a trauma informed implementation approach that balances safety and wellbeing. A new ligature audit toolkit has also been piloted at HMP & YOI Polmont, and evidence from the pilot is now being considered to help inform next steps.
- **Commitment:** Address bullying and harmful behaviours through development of a new SPS anti-bullying strategy with external expertise.
Action: SPS are finalising a new bullying prevention strategy called CORE for piloting with young people in HMP & YOI Polmont in the coming months. The youth work service provided by Kinetic Youth within the prison has increased from 5 to 7 days a week.
- **Commitment:** Reform information sharing between courts and SPS, ensuring consistent and reliable transfer of critical information.
Action: A new process is in place to enable courts to share bail assessment reports and justice social work reports with prisons more easily. Work is continuing to check that the new process is being used properly, to bring justice partners together in a more formal way to drive quick improvements, and to commission independent research to guide future reforms.

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- **Commitment:** Make legal aid free, and non-means-tested, for families involved in deaths in custody FAIs, using ministerial powers from 7 April 2025 ahead of primary legislation.
Action: These powers remain in place, and further legislation will be required for the next Parliament to ensure that all families involved in FAIs related to deaths in custody have access to legal aid from day one of a bereavement. Between April 2025 and 3 March 2026, 25 grants of legal aid have been made to bereaved family members.
- **Commitment:** Provide new advocacy and trauma informed support services for families, shaped directly by family engagement.
Action: Work is underway to procure a third sector organisation to deliver a Family Advocacy role. The contract is expected to be awarded in May 2026, subject to approval of the next Government.
- **Commitment:** Commission an independent review of deaths in custody related FAIs, focusing on timeliness, trauma-informed practice, and barriers faced by families.
Action: Sheriff Principal Abercrombie completed and published the findings of his review in January 2026. His review made clear, practical recommendations to reduce delays and strengthen accountability, which will be valuable in shaping the next phase of work.

I noted in my March 2025 statement that all bunkbeds and doorstops of the type identified in the FAI determination have been removed from where young people are housed at HMP & YOI Polmont and Stirling. I also want to highlight that progress has been made in relation to the piloting of Signs of Life technology at HMP & YOI Polmont to provide additional safeguarding, and the introduction of a 72 hour enhanced observation process for young people on admission.

Overall, the MAB final report notes that 39 of the 43 recommendations and commitments have demonstrated measurable progress, and that action owners have provided assurance that they will be delivered as planned, or have already been completed. Full detail on the progress status of each recommendation can be found in the published [March progress report](#).

As the work of the Ministerial Accountability Board concludes, its lessons will inform the development of a National Oversight Mechanism to ensure continued accountability and sustained improvement across the justice system.

I would like to note on record my thanks to the members of the MAB for their time, expertise and candour in providing independent advice. I also thank staff across NHS Forth Valley, within SPS and Scottish Government for their continued work to support improvement. Most importantly, I extend my heartfelt appreciation to the families who have lost loved ones in custody for their tireless efforts to push for change.

Yours sincerely,



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<p>Recommendation 1 (Key Recommendation) <i>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.</i></p>	<p>A proposed model was developed and piloted twice, however the pilots identified that it could not deliver genuine independence, timely investigations, or effective family engagement. COPFS’ constitutional role meant the process could never be fully independent and investigations would be delayed until criminality was ruled out. The model risked duplicating the Fatal Accident Inquiry (FAI) process and confusing families. As a result, the Government decided not to progress the Independent Review’s key recommendation.</p> <p>Further recommendations were made and accepted by the Scottish Government in January 2025 following the FAI determination into the deaths of Katie Allan and William Lindsay. As a result of these recommendations, an independent review into the FAI system was undertaken by Sheriff Principal Abercrombie, with findings published in January 2026. The Scottish Government also committed to the development of a new National Oversight Mechanism to improve transparency, accountability, and learning and to introduce a new family advocacy support role for bereaved families. Whilst the decision was taken to not progress the Independent Review’s key recommendation, work in this area continues and these measures aim to deliver the underlying objectives to this recommendation more effectively.</p>
<p>Recommendation 1.1 <i>Leaders of national oversight bodies (Healthcare Improvement Scotland / NHS boards / Care inspectorate / National Suicide Prevention Leadership Group / HMIPS) should work together with families to support the development of a new single framework on preventing deaths in custody.</i></p>	<p>IN PROGRESS</p> <p>SG Justice Analytical Services (JAS) published their report in March 2025 which included comparisons with trends in general population. This work provides an agreed dataset and increased transparency. This analytical work only goes some of the way to achieving this recommendation and concern has been expressed regarding the focus on post-death processes rather than prevention.</p> <p>Next steps: The Scottish Government’s development and implementation of a National Oversight Mechanism (NOM) will involve further stakeholder engagement to ensure that prevention is embedded. The reporting from JAS will also contribute to the development of the NOM.</p>
<p>Recommendation 1.2 <i>The SPS and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.</i></p>	<p>IMPLEMENTED</p> <p>The National Prison Care Network (NPrCN) led on progressing this recommendation and was progressed in conjunction with recommendation 2.1. A Toolkit was developed to create a standard national process for use by both NHS and SPS staff on best practice response following a death in prison.</p>

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	HIS noted consistent implementation of Toolkit as an area of good practice as part of inspections.
<p>Recommendation 1.3 <i>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.</i></p>	<p>IMPLEMENTED A process is in place where whereby key stakeholders, including Families Outside, HMIPS and Prison Monitor Co-Ordinators can make referrals with concerns about the wellbeing of someone in prison by way of submission of an Electronic Concern Form. In the 2022 calendar year, Families Outside submitted 32 electronic concern forms to SPS.</p> <p>A decision was made that rolling out the use of electronic concern forms for use by family members would not provide the necessary reassurance that SPS were acting responsively without any unnecessary delay.</p> <p>SPS thereafter decided to implement a direct access 24-hour phone line in every establishment. The phones will be situated in areas where there is full cover and have a different ring tone to alert staff to the need to prioritise answering. The first option on the updated answer machine message will be to raise a concern.</p>
<p>Recommendation 1.4 <i>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.</i></p>	<p>IMPLEMENTED In November 2022, SPS instructed all prisons to confirm that they record up-to-date next of kin details electronically, including consent for contact in an emergency. SPS has since received assurance that this information is taken at admission and is now also confirmed annually or at each new admission.</p> <p>Prison Rules require the Governor in Charge (GiC) to ask unwell or hospital-transferred prisoners whether they want someone informed.</p> <p>A review of DIPLARs from the following year shows that next of kin details are generally being kept current, though challenges remain when prisoners do not identify a next of kin or name someone family members do not recognise.</p>
<p>Recommendation 2.1 <i>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.</i></p>	<p>IMPLEMENTED This recommendation was progressed in tandem with 1.2. Confirmation of Death training uptake remains high, with plans in place for new starts who have not yet completed the training.</p> <p>Currently working with NHS Education for Scotland (NES) to discuss feasibility of creating completion certificate.</p>

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<p>Recommendation 2.2 <i>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.</i></p>	<p>IMPLEMENTED</p> <p>As of September 2022, all establishments had in place screens that can be utilised to preserve the dignity of someone who has died. Each prison has local arrangements in place to ensure staff are aware of the purpose of these screens and how to access them.</p> <p>Following a scoping exercise a new model of ligature cutter was identified that was considered to be more effective than the model previously available within prisons.</p> <p>All establishments had supplies of the new model of ligature cutter delivered over April – June 2023 (noting HMP Stirling opened in June). They were all confirmed as being deployed by 23rd June 2023.</p> <p>In the majority of establishments, the new ligature cutters have been placed in crash packs (similar to a first aid pack) in residential areas of each establishment as well as being issued to all patrol staff working in residential areas during lock-up periods. In some establishments due to security risks, instead of the new ligature cutter being placed in a crash pack nominated staff carry them in residential areas at all times.</p> <p>A national Risk Assessment has been completed, and staff briefings have been provided to allow familiarisation with the new tool and mitigate the risk of personal injury along with safe and effective use. A staff information sheet was also distributed.</p> <p>A training video has been produced by SPS College (SPSC) to supplement the staff briefings and has been available on SPS internal staff training platform since July 2023. Uptake of the training has been high amongst staff.</p> <p>Guidance and processes for both sanitisation and re-sharpening have been developed.</p>
<p>Recommendation 2.3 <i>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.</i></p>	<p>IMPLEMENTED</p> <p>A ‘Confirmation of Death for Prison Healthcare’ webinar training product has been developed that is to be completed by all Registered Nurses working within a prison. This has been available since 5 July 2023. The training covers: Legal and Regulatory Frameworks; Clinical Scenarios in the context of Prison Healthcare; Demonstration of the Confirmation of Death in Scotland Process and Perspectives of a nurse in Prison Healthcare.</p>

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	<p>As described under recommendation 1.2, a Death in Prison Custody NHS Support Toolkit has been developed. This includes confirmation of death guidance, links to other resources and flowchart.</p> <p>A Confirmation of Death Pocket card for reference has been made available in all prison healthcare centres.</p> <p>HIS as part of their role in the HMIPS inspection process will seek evidence of mandatory training compliance around the confirmation of deaths training.</p>
<p>Recommendation 2.4 <i>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.</i></p>	<p>IMPLEMENTED</p> <p>A DIPLAR Review Group was established in September 2022 with the purpose of progressing all of the recommendations and advisory points relating to the DIPLAR process. The Group was made up of representatives from SPS Suicide Prevention Co-ordinators, Prison Chaplaincy, Governor in Charge (GiC), NHS Prison Healthcare Teams and NPrCN.</p> <p>The DIPLAR Review Group have produced a revised DIPLAR Report template and guidance document to be used when someone dies in prison custody. Part of this process included wide consultation, including with the Family Reference Group. Testing and modification was undertaken on the revised documentation.</p> <p>On 31 August 2023, a GMA was issued to all prisons to advise that the revised DIPLAR Report template and guidance document are to be implemented with immediate effect.</p> <p>The DIPLAR process will now be fully owned by SPS, however revised documentation ensures NHS involvement throughout including in agreeing the shared action plan, roles and responsibilities.</p> <p>The revised DIPLAR Report template documentation includes a specific section that requires to be completed to evidence the impact of the death on staff, the establishment and on other people in custody. Any action to provide support should also be recorded, including who provided immediate and longer-term support and how the death was communicated to staff and other people in custody.</p> <p>SPS Chaplaincy team will remain a key support both immediately and in the longer term following a death.</p>

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<p>Recommendation 2.5 <i>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</i></p>	<p>IMPLEMENTED</p> <p>As described under recommendation 2.4, a review of the DIPLAR has taken place. The revised DIPLAR report template includes a specific section that requires confirmation that an assessment of whether the rights of the child have been adhered to, if the death involves an individual under the age of 18 years. Where the death of an individual under the age of 18 years occurred, their Lead Professional or Named Person must also attend the DIPLAR.</p> <p>As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.</p> <p>The section of the Toolkit that addresses expectations in relation to reviews, documentation and learning relating to each death, details the need in relation to individuals under the age of 18 to give consideration to the United Nations Convention on the Rights of the Child (UNCRC).</p> <p>HIS, in collaboration with the Care Inspectorate, co-host the National Hub for Reviewing and Learning from the Deaths of Children and Young People. This was launched in October 2021. Reviews will be conducted into the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of continuing care or aftercare at the time of their death. Where a care leaver, who was in receipt of continuing care or aftercare provision immediately prior to their detention or imprisonment dies in prison custody, consideration should be given as to whether the young person meets the criteria for inclusion in the National Hub review process. The criteria reflects the shift in policy, practice and culture as set out in UNCRC and the principles of the Promise.</p> <p>The overarching purpose of the National Hub is to ensure that data generated from these reviews informs national policy, education and learning and contributes to the prevention of child deaths in the future. The National Hub does not carry out individual child death reviews but has developed guidance for reviewing the deaths of children and young people in Scotland. The National Hub aims to ensure that the death of every child in Scotland is subject to a quality review by:</p> <ul style="list-style-type: none"> • improving the quality and consistency of existing reviews; • improve the experiences and engagement with families and carers;
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	<ul style="list-style-type: none"> • sharing learning from current review processes across Scotland that could direct action to help reduce preventable deaths.
<p>Recommendation 3.1 <i>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.</i></p>	<p>IMPLEMENTED</p> <p>On 7 November 2022, SPS issued a GMA formalising the process of the GiC contacting a family following a death. The GMA provides that:</p> <ul style="list-style-type: none"> • The name and contact details of the Duty Manager should be shared with Police Scotland so that this can be passed to families to make immediate contact if they wish to do so; • The GiC (or Deputy Governor in their absence) should contact the family the next day and offer support from the Chaplaincy Team; • These actions must be recorded within the DIPLAR paperwork. <p>The revised family support booklet (the update under recommendation 3.3 provides more information on this) contains details of the support available from within the prison including contact details for the GiC, Prison Chaplain and healthcare team.</p> <p>The revised DIPLAR guidance details that the responsibilities of the Chaplain include offering emotional and pastoral support; assisting with returning property to the next of kin and assisting with the arrangement of funeral service, memorial services and tributes.</p> <p>Chaplaincy Advisors conducted trauma informed communication sessions with members of senior management team who feel they can benefit from this input. This was formed of two sessions, “Reflection on Experience” and “Developing Skills”. These sessions commenced in late November 2022.</p> <p>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.</p>

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<p>Recommendation 3.2 <i>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.</i></p>	<p>IN PROGRESS The Deputy Chief Executive and Director of Policy have attended a meeting with the Family Reference Group and meetings with COPFS have also been held.</p> <p>In terms of information sharing with families, work was undertaken on whether or not the DIPLAR could be shared. The legislative framework makes this overly restrictive and on discussion with the FRG, it was agreed that this was not a solution.</p> <p>Further to that, the DIPLAR process includes detail on engagement with families, when and how this happens. Governors are offering to meet with families, they also provide (where required) a written update to questions that are raised at the DIPLAR.</p> <p>There is ongoing work to ensure that information is shared appropriately and compassionately.</p> <p>This work is subject to ongoing review to improve engagement and support for families, including ensuring understanding of the various reviews (DIPLAR / SAER), this can be a confusing landscape to navigate. The Director of Policy is leading work on family engagement that also responds to the recommendations contained within the FAI outcomes.</p> <p>Next Steps: On-going focus on engagement with families to ensure continued progress on this recommendation.</p>
<p>Recommendation 3.3 <i>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.</i></p>	<p>IMPLEMENTED The family support booklet was redrafted by SPS Chaplaincy team in partnership with the NHS and Families Outside and following consultation with the Family Reference Group and made available to all establishments for their use.</p> <p>The revised booklet contains details of the support available from within the prison including contact details for the GiC, Prison Chaplain and healthcare team and contact details for support organisations. The booklet also contains information about the investigative and review process that will take place, including the DIPLAR, NHS SAER and FAI.</p> <p>A template letter for the GiC to send to the family has also been produced. The GiC should personalise the letter with their contact details and anything else they may wish to add from the</p>

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	<p>phone call with the family (which should have taken place within 24 hours of the death) and send this to be family along with the family support booklet. The family support booklet has been published on the website of SPS and Families Outside. This contains a link to the revised DIPLAR guidance.</p>
<p>Recommendation 3.4 <i>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.</i></p>	<p>IN PROGRESS – SEE 1.1 FOR LINKED UPDATE</p> <p>NHS have highlighted related activity including the publication of the SAER network with a strong focus on patient and family engagement, noting the Cabinet Secretary's direction to embed this approach and ongoing evaluation work. A wider "state of the nation" report is expected in March 2026 as the model shifts towards assurance.</p>
<p>Recommendation 4.1 <i>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.</i></p>	<p>IN PROGRESS</p> <p>NHS Scotland has embedded structured wellbeing checks within prison healthcare teams, with 100% compliance reported for regular one-to-one meetings with line managers, including following deaths in custody. Staff wellbeing support is now clearly set out within the NHS Support Toolkit, strengthening consistency and visibility of care for healthcare staff. SPS has made substantial progress on staff wellbeing through the launch of a Senior Leader Wellbeing Support Programme in November 2025, informed by UK prison leadership research and delivered in partnership with NHS Lothian's Rivers Centre. Early uptake has been positive, with one-to-one support already underway and group sessions scheduled for early 2026. In parallel, significant progress has been achieved on the Post Trauma and Resilience Policy, which has been agreed with trade unions and professional associations and is on track for launch in February/March 2026. This includes a new digital reporting system, automated management notifications, follow-up processes, a self-assessment tool, and expanded access to trauma, resilience and wellbeing resources for staff and their families.</p> <p>Next Steps: Key next steps focus on implementation, embedding and sustainability. A dedicated SharePoint landing page will be launched to host guidance, training and resources, supported by wider staff engagement activity, including advocacy through staff stories, podcasts and drop-in sessions to encourage uptake and cultural change</p>

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<p>Recommendation 4.2 <i>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</i></p>	<p>IMPLEMENTED</p> <p>Over the past two years, SPS and NHS have made joint progress in embedding trauma-informed support for people held in prison following a death in custody. A key development has been the national rollout of trauma-informed practice training through the Trauma-Informed Toolkit, delivered collaboratively across SPS and NHS services. The toolkit has recently undergone a comprehensive review to assess its effectiveness and ensure alignment with current best practice, with agreement in place to continue evaluation and learning from its implementation.</p> <p>Access to trauma-informed training is now available to staff across all establishments, and expectations around completion have been embedded within local Personal Development Plans (PDPs). This has helped reinforce trauma-informed practice as a core professional requirement rather than an optional add-on. SPS confirmed that staff continue to have access to the toolkit, supporting greater consistency in how trauma-informed approaches are understood and applied across custodial settings.</p>
<p>Recommendation 5.1 <i>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</i></p>	<p>IMPLEMENTED</p> <p>There is a requirement on the GiC (or Deputy Governor in their absence) to contact the family the next day following a death. Following that call, the GiC should write to the family and send them the family support booklet which provides information about the DIPLAR process. The onus is on the GiC to ensure that the DIPLAR process is explained to the family, including ensuring they are provided with opportunities to raise any questions or concerns they wish to have answered and making them aware of when they will receive feedback.</p> <p>The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.</p> <p>The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to: ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR and to agree and record responses to</p>

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	<p>any questions or concerns and be clear about who is provided feedback to the family.</p> <p>As described under recommendation 1.2, a Death in Prison Custody NHS Support Toolkit has been developed. Included is a chapter on family engagement to support improve communication. It highlights the need for healthcare staff to invite family members to contribute to and be kept informed throughout any review process and to share the outcome of the review.</p> <p>The Toolkit contains a more detailed flowchart setting out NHS processes and provides more detail on the steps that should be followed to ensure families are included in any review process and informed of any findings. The Toolkit also includes guidance on how families can be involved following a death using compassionate communication skills.</p> <p>The Toolkit includes links to HIS's Learning Adverse events framework and links to resources to support communications with bereaved relatives.</p>
<p>Recommendation 5.2 <i>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</i></p>	<p>IMPLEMENTED</p> <p>As described under recommendation 3.3, the family support booklet has been redrafted. The revised booklet contains details of the support available from within the prison including contact details for the GiC, Prison Chaplain and healthcare team.</p> <p>As described under recommendation 2.4, a review of the DIPLAR has taken place.</p> <p>The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.</p> <p>The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to: ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR and to agree and record responses to any questions or concerns and be clear about who is provided feedback to the family.</p> <p>Over 90% of GiC and other members of the senior management team have completed face to face trauma informed</p>

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	<p>communication sessions with SPS Chaplaincy Team. This was in the form of two sessions, “Reflection on Experience” and “Developing Skills”. The objective of these sessions was to build confidence in having conversations with families following a death in custody, by recognising the importance of preparing for these conversations, highlighting existing skills and enhancing understanding of bereavement.</p> <p>As described under recommendation 1.2, the NPrCN have developed a Death in Prison Custody NHS Support Toolkit that provides an overview of steps that should be taken in response to a death in prison custody, by whom and when.</p> <p>Included in the Toolkit is guidance on duty of confidentiality in respect of deceased patients and how to consider requests for information by relatives of deceased patients.</p>
<p>Recommendation 5.3 <i>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.</i></p>	<p>IMPLEMENTED</p> <p>SPS has fully implemented this recommendation through the recruitment of four independent DIPLAR chairs, each bringing a range of relevant professional experience across prison, health and social care settings. These independent chairs have been in post since September/October 2025 and are now actively chairing all DIPLAR meetings, strengthening independence and consistency in the consideration of deaths in custody. Robust governance arrangements have also been established, including the use of trackers and an assurance group to provide objective oversight and assurance that learning points are identified and followed up.</p>
<p>Recommendation 5.4 <i>The full DIPLAR process should be followed for all deaths in custody, with a member of staff from SPS Headquarters in attendance</i></p>	<p>IMPLEMENTED</p> <p>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.</p> <p>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.</p> <p>A DIPLAR Review Group has been established to progress all of the recommendations and advisory points relating to the</p>

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	<p>DIPLAR process, including reviewing and clarify roles and responsibilities for those involved in the DIPLAR process including SPS health headquarters team.</p> <p>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.</p>
<p>Advisory point 1 <i>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</i></p>	<p>IN PROGRESS</p> <p>Discussion of Advisory 1 has clarified that while there is broad support for the principle of a bereavement platform for families, there is currently no agreed owner. Both NHS and SPS have indicated that delivering a family-focused bereavement forum is not squarely within their remit, although SPS has highlighted existing bereavement-related activity that could align with or complement family support if scaled. The group has reinforced that the advisory is about <i>commissioning</i> an independent platform rather than direct delivery, with third-sector providers identified as potential options. There is also recognition that “forum” has not been clearly defined and that bereavement support may need to be offered through a range of formats, including in-person, online, or hybrid models, taking account of risks and accessibility.</p> <p>Next Steps: The group will need to agree a clearer definition of the intended bereavement platform, including its purpose, scope, and preferred delivery models. Further work will explore what commissioning would mean in practice, including whether the platform could be incorporated within the Family Advocacy (FA) service specification. If incorporation within FA is not feasible, this will be brought back to the group for further discussion and direction.</p>
<p>Advisory point 2 <i>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.</i></p>	<p>IN PROGRESS</p> <p>SPS has progressed a review of the scope for placing emergency alarms within reach of the cell bed and has identified that installing a bedside alarm alone would not adequately address the issue. As a result, a broader review is underway, considering digital solutions, the wider cell environment, and the need for robust, joined-up operational processes. This work is being taken forward through a short-life working group with representation from five NHS Boards and the Scottish Ambulance Service, and is progressing well, with completion targeted for Q2 2026. Consideration is also being given to enhanced support planning for individuals at higher risk of health incidents, with the expectation that these plans will remain under regular review.</p> <p>Next Steps: SPS will continue to progress the work of the short-life working group, including the evaluation of emerging technologies and digital monitoring tools, ensuring any solutions</p>

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	<p>are carefully assessed and proportionate to the underlying risks. Clarification will be required on the intended scope and applicability of any new technology, including whether pilots or future roll-out would apply to all cells or specific contexts. SPS will keep this work under review and provide updates as findings emerge, recognising that the advisory identifies an issue that may require a broader system-level response rather than a single technical solution.</p>
<p>Advisory point 3 <i>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.</i></p>	<p>IMPLEMENTED The DIPLAR process now includes the capturing of relevant relationships and insights from others in custody, and SPS are committed to ensuring this element is consistently considered in practice. The SAER is a standard NHS-wide process, applied uniformly across all settings including prisons, and therefore cannot be modified specifically for the prison context, though relevant information can still inform reviews within the existing framework.</p>
<p>Advisory point 4 <i>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.</i></p>	<p>IMPLEMENTED It is the responsibility of the DIPLAR chair to identify and record learning points, best practice and action.</p> <p>The revised DIPLAR Report template includes, under the Learning and Action Plan, a section to record if the establishment section in National DIPLAR Learning and Action Plan has been checked for recurring actions and if so whether any recurring actions were identified. If so, details of these are to be recorded. The GiC/Deputy Governor and NHS Leads are responsible for progress against actions on the Learning and Action Plan.</p> <p>Emerging issues and learning points are discussed at the Suicide Prevention Co-ordinator meeting, which meets quarterly. They are also shared at the National Suicide Prevention Strategy Group, which also meets quarterly and discussing all deaths.</p>
<p>Advisory point 5 <i>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</i></p>	<p>IMPLEMENTED The revised DIPLAR report template includes a section on family contact. There is a requirement to record in this section, whether the family support booklet was provided and if not, why not; whether the family were informed of relevant points of contact; whether the family raised any questions or concerns to be discussed at the DIPLAR and whether there was any contact between the NHS and the family.</p>

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<p><i>questions raised by the family and the response to them.</i></p>	<p>The revised DIPLAR guidance includes a section on family engagement which sets out the requirement to: ensure all contact with them is recorded, including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR and to agree and record responses to any questions or concerns and be clear about who is provided feedback to the family.</p> <p>The revised DIPLAR guidance also includes a Family Contact Record which should be used to keep a record of all contact with family members following a death, including any information provided to and by them.</p>
<p>Advisory point 6 <i>The SPS should develop clear protocols for memorial services, letters of condolence and donations from people held in prison for families of the deceased.</i></p>	<p>IMPLEMENTED</p> <p>Progress has been made in this area, with increased clarity on the importance of consistent and sensitive approaches to memorial services, letters of condolence and donations from people held in prison. There is a shared understanding of the need for clear communication with families about memorial arrangements, and SPS has highlighted that families' wishes are routinely taken into account. Experience to date demonstrates that complex circumstances, including the need for multiple or separate memorials for different family groups, have been handled sensitively in practice. Maintaining a respectful and consistent approach to memorials and related practices has been recognised as central to supporting families. The development and implementation of these protocols will remain under review to ensure they reflect good practice and respond appropriately to family needs in a range of circumstances.</p>

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