Criminal Justice Committee

31st Meeting, 2023 (Session 6), Wednesday 22 November 2023

Deaths in custody: correspondence received

Note by the clerk

Background

1. At its meeting on 20 September, members took evidence from Gill Imery, Chair of the Deaths in Custody Review Group.

2. After consideration of her evidence, the Committee agreed to write to a number of bodies asking for an update on the progress of delivering on the recommendations from the Independent Review of the Response to Deaths in Prison Custody report. Ms Imery had reported that as of September 2023, five recommendations (out of 20) had been completed.

3. Letters were sent by the Convener on 25 September to:

    - NHS Scotland;
    - The Scottish Prison Service; and
    - The Cabinet Secretary for Justice and Home Affairs and the Cabinet Secretary for NHS Recovery, Health and Social Care

4. Responses have been received from NHS Scotland, the Scottish Prison Service and the Scottish Government. Additionally, both HM Inspectorate of Prisons for Scotland and the Scottish Human Rights Commission wrote to the Committee on this subject (see **Annex**).

Action/recommendation

5. **Members are asked to consider the correspondence and decide what, if any, further action is required. Members may wish to defer detailed consideration until all responses have been received**.

Clerks to the Committee
November 2023

ANNEX – Letters received

Scottish Government

17 November 2023

Dear Convener

Thank you for your letter dated 25 September 2023 regarding Gillian Imery's appearance at the Justice Committee on 20 September 2023 in her role as external chair with oversight of implementation of the recommendations of the Independent Review of the Response to Deaths in Prison Custody ("Independent Review").

I would like to acknowledge the distress caused when a death occurs in prison custody and my thoughts are with every family tragically bereaved by such a death.

The death of a loved one is stressful at any time. When someone dies in a community or custodial setting, it is crucial that services work together in a coordinated way to manage the death appropriately whilst ensuring people who have died are treated with dignity and respect. I fully understand the desire of bereaved families to get answers following the death of a loved one.

As you are aware, the Lord Advocate is constitutionally responsible for the investigation of sudden, unexpected and suspicious deaths, including all deaths in prison custody in Scotland. These functions are exercised independently of government, within a legislative framework enacted by the Scottish Parliament in 2016. At this time, we have no plans to revisit the legislation.

We have increased the Crown Office and Procurator Fiscal Service (COPFS) budget in recent years to support a range of its improvement work, including modernising processes for investigating deaths. As a result of successive increases, the resource allocated to the investigation of deaths has increased by 60% since 2018/19.

COPFS has over the last few years significantly reformed its processes to reduce the time taken to investigate deaths and to bring Fatal Accident Inquiries (FAI) to court more quickly. These reforms have already resulted in reductions in the duration of death investigations and it is expected that they will continue to do so. COPFS has also established a Specialist Casework Death Investigations Improvement Programme. Its purpose is to oversee all ongoing pieces of work and new proposals to achieve greater public confidence, to improve the service delivered to bereaved relatives and to deliver increased efficiencies in the investigation of deaths.

Investigation into deaths in prison custody involve both the consideration of possible criminality and preparation for Fatal Accident Inquiry. For this reason, a specialist custody deaths investigation team "Custody Deaths Unit" (CDU) was established by COPFS last year. CDU investigates all deaths occurring in prison (excluding covid deaths) and brings together the specialisms from across the death investigation teams in the Scottish Fatalities Investigation Unit and the Health and Safety Investigation Unit.

I have also noted comments relating to FAI's in the recent annual report from HM Inspectorate of Prosecution in Scotland. The inspectorate considered that of the 15 recommendations from the last review in 2016 relating to death investigations, ten had been achieved, two were superseded by Act of Sederunt (Fatal Accident Inquiry Rules) 2017 and three were still in progress, with substantial progress having been made in relation to one of them. Whilst I was pleased to see the recognition of the substantial progress which had been made since the 2016 report, I am conscious that there is still work to be done to further improve performance.

The Committee may wish to write directly to the Lord Advocate in her independent capacity as head of the system of deaths investigations in Scotland for further information about ongoing improvement work.

Turning to the implementation of the recommendations of the independent review themselves.

Firstly, I want to emphasise our commitment to working with partners such as the Scottish Prison Service (SPS) and NHS to implement the recommendations of the Independent Review of the Response to Deaths in Prison Custody.

Several recommendations are now implemented or are close to being implemented which will improve support and sharing of appropriate information in a timely and sensitive manner with bereaved relatives. However, as Ms Imery acknowledged a number of the recommendations are complex and require resource, which means they will take time to implement. It is important to take that time to ensure the recommendations are implemented in a way that benefits bereaved relatives at a very difficult time.

I am pleased to confirm that the SPS have completed a thorough review of their Death in Prison Learning Audit and Review (DIPLAR) process, designed to improve their support for vulnerable people in their care. The new DIPLAR, introduced at the end of August 2023 and developed in collaboration with bereaved relatives, ensures there will be more focus on families and gives them the opportunity to raise questions on a range of issues. The next meeting of the Death in Prison Custody Action Group (DiPCAG), chaired by Ms Imery, will consider the changes introduced against the recommendations to consider which further recommendations and advisory points can now be said to be implemented.

The Scottish Government is also working closely with NHS Chief Executives who play a key role in providing leadership to ensure NHS-focussed recommendations are adopted. In July this year, NHS Chief Executives agreed to deliver all outstanding recommendations of the Independent Review for the NHS by the end of 2023.

Aware of the need to provide leadership around the challenges of prison healthcare, lead officials from Health & Social Care, Justice along with SPS and NHS leaders, are meeting regularly through a short-life Strategic Leadership Group, which reports to relevant ministers through a Cross-Portfolio Ministerial Group for Prisoner Health and Social Care. This approach is designed to help deliver an integrated approach to prisoner health, mental health and social care, within the context of shared and competing priorities.

As you know, Scottish Government are leading on the delivery of the key recommendation of establishing a new independent investigative process. That process has been developed working in partnership with key partners, including COPFS and bereaved relatives. A pilot of this new process commenced in September 2023. We will undertake a thorough evaluation of the pilot investigative process to assess resource requirements, whether it is workable in practice, has meaningful outcomes and meets the findings of the Independent Review. Whilst I am mindful of the comments Ms Imery made in respect of her view about whether there is a need for the key recommendation, it is important not to pre-empt the outcome of the pilot and evaluation process.

I met with Ms Imery on 25 October 2023, where we discussed the progress on the recommendations and options to increase pace of implementation whilst getting the best outcomes for those bereaved. I have another meeting scheduled with Ms Imery and Mr Mathieson on 21 November 2023.

Yours sincerely

ANGELA CONSTANCE

CJ/S6/23/31/1

NHS Scotland

11 October 2023

Dear Convener

Thank you for your correspondence dated 25 September regarding the evidence heard from Gill Imery, Independent Chair of the Deaths in Custody Review Group, at the Justice Committee meeting of 20 September.

I would like firstly to acknowledge the distress caused when a death occurs in prison custody and my thoughts are with those who have been tragically bereaved by such a death. I can assure you that we take delivery of the Deaths in Custody recommendations very seriously and we are taking forward a range of work aimed at improving prison healthcare as outlined below.

As Ms Imery noted at the Justice Committee there was no timescale set for the implementation of the recommendations and some of the more complex recommendations require resource and time to implement. Notwithstanding this, I was pleased to hear Ms Imery's acknowledgement of the work of the National Prison Care Network (NPrCN), which the Scottish Government funds, to bring together relevant partners from across health and justice to collaborate on improving the quality of life for people in prison.

Following publication of the Independent Review of the Response to Deaths in Prison Custody, we agreed with relevant partners that the NPrCN would lead on those actions primarily aimed at the NHS. Since then the NPrCN has carried out an impressive amount of work including development of a Deaths in Prison Custody: NHS Support Toolkit in consultation with a wide range of partners, including the Deaths in Prison Custody Family Reference Group. In July of this year, NHS Chief Executives agreed to implement outstanding NHS recommendations by the end of this year. Progress monitoring of this will be carried out by the NPrCN in partnership with Healthcare Improvement Scotland and NHS Boards. Chief Executives requested quarterly updates on progress as well as the broader improvement work being undertaken to improve prison healthcare through their regular meetings.

One aspect of the wider work we are taking forward with SPS and NHS partners to improve prison healthcare, is the introduction of custody healthcare considerations into the Annual Delivery Plan guidance for Health Boards in order to improve the visibility of, and accountability for, the provision of health services to those living in prison. Robust and regular scrutiny of Board performance against these plans is conducted by the Scottish Government.

Building on the additional planning requirement, and to further drive improvements in custody healthcare, we have established a network of Executive-level leads from all territorial Health Boards. As well as providing a further mechanism for raising awareness and promoting widespread implementation of the NHS Deaths in Custody recommendations, this network will provide strong links between boards and the SPS to support ongoing and systematic improvement of custody healthcare.

In addition to this, the Scottish Government has committed to invest £5.3m, over the next 5 years, to advance clinical IT across the prison healthcare estate which will reduce clinical risk and improve healthcare for those in prison as they enter, remain, and leave custody. We are also funding Public Health Scotland to work with SPS and NHS health boards to gather appropriate quantitative and qualitative information to help better understand the health and social care needs of the prison population.

Recognising the need to provide strategic impetus, leadership and direction to improving prison healthcare, a short-life Strategic Leadership Group (SLG) led by strategic leaders from across the health and justice system was established earlier this year to remove systemic barriers that impact the delivery of healthcare and positive outcomes for people in prison. This Group has been working to achieve improved consistency in the delivery of healthcare across the prison estate and to improve access to services

At ministerial level, a Cross-Portfolio Ministerial Group for Prisoner Health and Social Care has been established to provide collective ministerial leadership from across the relevant portfolios of Health and Social Care, and Justice, to ensure an integrated approach to prisoner health, mental health and social care.

In collaboration with SPS and NHS partners, we are fully committed to improving prison healthcare. This intent is underpinned by the Memorandum of Understanding (MOU) between Scottish Prison Service, NHS Territorial Boards and Integration Joint Boards, which has been refreshed and is in the final stages of approval. The overarching aim of the MOU is "to improve the health and wellbeing of people in prison, enhancing quality-of-life, enabling a reduction in harm to self and others whilst improving the safety of our communities". Within this work, we recognise that the prison population comprises individuals from across Scotland and have, through the Chair of the NHS Board Chief Executives Group, included each NHS territorial Board as a signatory to the MOU, regardless of whether or not they have a prison in their geographical area.

I understand that the Chief Inspector of HMIPS has also written to you separately to provide assurances on the scrutiny processes that are conducted in partnership with Health Improvement Scotland across the prison estate. Taken together with the information above, I trust that NHS Scotland's commitment to delivering the recommendations from the Deaths in Custody Review and making wider and meaningful improvements across health in custody, in partnership with justice colleagues and stakeholders, is evident.

I thank you for taking the time to write to me and please feel free to contact me again should you require any further detail on the work being carried out in response to the NHS recommendations and our wider prison & social care improvement work.

Caroline Lamb, Director-General for Health & Social Care and
Chief Executive of NHS Scotland

CJ/S6/23/31/1

Scottish Prisons Service

23 October 2023

Dear Ms Nicoll

Deaths in Custody

Thank you for your letter dated 25th September and for the opportunity to respond to the comments made at the recent Criminal Justice Committee by Gill Imery in her capacity as Chair of the Deaths in Custody Review Group. There is much to share in terms of the progress that has been made to date and the work that is being advanced to address the recommendations contained within the Independent Review into the Response to Death in Prison Custody Report.

Continuous improvement is critical to the Scottish Prison Service (SPS) and the above report is a key factor in shaping our commitment to improving practice with our partners as we look to make positive changes. I have outlined some key aspects of the work we have undertaken to date and have also included the more detailed Action Plan that is to be submitted to Ms Imery as Oversight Chair by 23 October.

As an organisation, SPS continue to be acutely aware of the importance of supporting the health and wellbeing of those in our care and the impact for families and loved ones. The loss of anyone in our care is devastating and we extend our condolences to everyone affected, particularly families and loved ones. Since the publication of the report on 30th November 2021, we have sadly seen 86 deaths which is not only reflective of the increasingly poor health of our population on admission, but also the increased complexity of their needs.

Where substances are involved, we mirror the national trends and are fully committed to supporting the national mission to reduce drug related deaths. Every death is a tragedy, and staff working across all our prisons daily show real compassion for people in our care. SPS staff work closely with NHS colleagues to provide the best possible care and support. Our staff are deeply affected by the loss of anyone in our care and demonstrate utmost professionalism in carrying out their roles. I am proud of their dedication and compassion, and it is vital that we support them to process the effects of a difficult and challenging job.

We have several processes in place that are embedded in practice, including our Suicide Prevention Strategy, Talk to Me, and Management of Risk due to Substance Use (MORS) policy for those affected by substance use. Our polices are currently under review with an emphasis on multi-disciplinary working and positive support planning centred around the individual. Our emerging Alcohol & Drugs and Mental Health Strategies will both have a clear focus on prevention and recovery.

The SPS Incident Report system evidences the responsiveness of our operational teams through their quick actions when summoning assistance and emergency care, especially where there is a need for specialist assessment and treatment. The actions of SPS and NHS multi-disciplinary working resulted in 1,306 transfers to hospital between 01/11/21 and 30/09/2023, highlighting the number of occasions that staff have positively intervened to access treatment and support for individuals in prisons.

In terms of the specific recommendations in the report and our absolute commitment to addressing them, I am keen to provide some clarity on the progress that has been made to date and the work that is ongoing currently. Throughout Ms Imery's tenure, SPS has supported meetings with senior staff including myself as Chief Executive, the Director of Strategy & Stakeholder Engagement, a SPS Advisory Board member/Non-Executive Director as well as access to Governors in Charge at several establishments.

Following publication of the Report, SPS prioritised the introduction of a Death in Prison Tasking Group, which meets on a monthly basis and is chaired by the Director of Strategy & Stakeholder Engagement. The group includes key personnel across SPS, the National Prison Care Network and the Policy Officer for the Death in Prison Custody Action Group. The group reports directly to the SPS Executive Management Group (EMG) and recently provided a deep dive paper to the SPS Advisory Board (AB) for additional scrutiny and to provide assurance that progress was being made.

SPS are also represented at all the national meetings and participate fully in them.

- Death in Prison Custody Action Group (DiPCAG)
- Working to Understand and Prevent Deaths in Prison Custody
- Key Recommendation Working Group (re Independent Investigation)

SPS was instrumental in providing an initial analysis of the deaths that had occurred from 2012-2021 to the national group 'Working to Understand and Prevent Deaths' and provided the basis for the report published in August this year. SPS were not included in the invite for this group initially and pro-actively requested involvement, joining the group in the last quarter of 2022. SPS have also commissioned an analysis of over 200 completed Death in Prison Learning Action Reviews (DIPLAR) which is nearing completion and will create an important baseline for learning and informing any further work.

The five recommendations already reported as having been implemented by Ms Gill Imery were driven by SPS and remain under review to ensure effectiveness. We have also fully consulted on and tested a revised DIPLAR process. This was formally adopted at the end of August and will be reviewed in February 2024. As a result, we consider that a further seven recommendations had been implemented at the point when evidence was provided to the Committee. We await confirmation from Ms Imery of that position. The current Action Plan is below in **ANNEX A**.

Improving our engagement with families and loved ones has been at the centre of all of the changes we have made. To date, we have attended the Family Reference Group on 3 occasions and have also shared updates with the Death in Prison Custody Action Group Policy Officer throughout. These meetings have been invaluable in shaping the final draft of the Family Support Booklet that has now been published as well as the final version of the DIPLAR. They have also been keen to hear how staff are supported and have heard about the review that is under way on SPS' Critical Incident Response & Support (CIRS) process as well as the trauma awareness training now available for staff.

By the end of this year, we will have also improved processes to allow families to raise concerns; directly implementing a further recommendation from the report. Although we do have an electronic concern form currently in place, we consider it important for SPS to be more accessible and to provide an opportunity for families to speak to someone quickly when they are worried. We are therefore currently installing direct phone lines into all establishments that will provide 24-hour access for friends or families to raise concerns about their loved ones. Processes have been developed to ensure there is a consistent and rapid response to check on the individual concerned, and to provide feedback to the caller.

There are a number of recommendations that require longer term deadlines and planning, these include the work for SPS to become a trauma informed and ultimately a trauma responsive organisation. This work is captured in the SPS Trauma Delivery Group workplans, and the Tasking Group will align progress with that structure.

SPS Trauma Delivery Group will shortly commission an evaluation on Trauma Informed Practice in SPS. This will be a multi-year assignment, commissioned via the research framework contract. Phase one will be undertaken throughout 2023/24 and will be focused on mapping activity to date and baselining the organisational position (making use of Scottish Governments (SG) Trauma Informed Roadmap audit tool), this will create an evaluation framework for future use and make recommendations for the way forward. In line with this, our Trauma Informed Delivery group will also complete a baseline organisation audit using the draft SG Quality Indicators for Trauma Informed Practice.

SPS has delivered Trauma Informed Leadership training to all Senior leaders in the organisation and are now working with clinical psychologists located in prisons to roll out this training to all local senior management teams in establishments, including our multi-disciplinary partners. A session is planned with clinical psychology partners for November where a delivery plan to achieve this will be developed. This will then be share with all Governors in late December with roll out commencing in early 2024. This is being further supported through PHD Research which will gather evidence from Senior Leaders who have attended the Trauma Informed Leadership training that has been offered by SPS over the past year.

In partnership with NHS Education for Scotland, SPS has also recently added 4 modules to the staff online training platform MyLo. These are available for all staff on developing trauma skilled practice. The 4 modules are:

- Understanding the impact of trauma and responding in a trauma-informed way
- Trauma in children and young people
- Understanding the impact on mental health and evidence-based pathways to recovery
- Understanding the use of substances to cope with the impact of trauma

The review of the CIRS is already underway, and an interim process was implemented at the beginning of May 2022. A literature review has been undertaken and a scoping exercise of other options that are used by colleagues in other public and emergency services has informed the workplan to address this recommendation.

We have prioritised engagement with families whilst we have reviewed the DIPLAR process, testing our approach before formal implementation. As part of this process, the Governors in Charge were supported with a series of sessions led by the Chaplaincy team to share experience, get advice and guidance, and ensure compassionate practice. In our improved DIPLAR process, there is an emphasis on supporting families to understand the DIPLAR process, to ask questions and to receive timely updates and responses.

I hope this response demonstrates both the seriousness and commitment SPS has taken to address the recommendations in full, bringing forward change incrementally and quickly; and reassurance to our ongoing commitment to work with Ms Imery and others to implement the recommendations within the Report. There is no end point for continuous improvement, and we will continue to monitor and review the progress made.

Yours sincerely

TERESA MEDHURST
Chief Executive

ANNEX A

OVERSIGHT OF DEATHS IN PRISON CUSTODY RECOMMENDATIONS IMPLEMENTATION								
No	**Theme**	**Recommendation**	**Owner**	**Summary of work undertaken since last update provided on 11.07.23**	**Summary of forthcoming key activities in the next 2/3 months**	**Any proposed milestones for completion of tasks/work**	**Any anticipated risks**	**Mitigation plan for any anticipated risks**
1	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.	SG					
1.1	Family contact with prison & involvement in care	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.	Health care Improvement Scotland / NHS boards / Care inspectorate / National Suicide Prevention Leadership Group	Work is ongoing to finalise the draft report of the analysis of the DIPLAR reports. The emerging themes will be cross referenced with the changes that have occurred since the publication of the Independent Report.				

			/ HMIPS / SG					
1.2	Family contact with prison & involvement in care	The SPS and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.	SPS/NHS (NHS to lead)					
1.3	Family contact with prison & involvement in care	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.	SPS	Dedicated phone lines are being installed across all establishments. There were delays as a result of some requiring additional data points and cabling. There are 2 outstanding and procurement processes are in place to progress imminently. The accompanying standard operating procedures and processes to audit have been developed and the 'Raising a Concern Booklet' will be updated with the phone numbers before going live.	Final installation by November 2023 and system test before go-live by December 2023.	Lines installed and tested November 2023 Go-Live December 2023		

1.4	Family contact with prison & involvement in care	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.	SPS/NHS (SPS to lead)	**RECOMMENDATION IMPLEMENTED**				
2.1	Policies & processes after a death	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.	SPS/NHS (NHS to lead)					

2.2	Policies & processes after a death	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.	SPS	**RECOMMENDATION IMPLEMENTED**				
2.3	Policies & processes after a death	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.	SPS/NHS (NHS to lead)					
2.4	Policies & processes after a death	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.	SPS	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. A dedicated section has been included to record the impact and actions taken to support those affected by a death. Chaplains continue to play a key role in supporting those in our				

				care. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. **RECOMMENDATION IMPLEMENTED - Await confirmation from oversight Board**				
2.5	Policies & processes after a death	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	SPS/NHS/SG	The DIPLAR Review will be consistently applied for all deaths in prison custody. Where this involves a child or young person, further scrutiny and assessment will be followed up. This has been added into the new DIPLAR process, template, and guidance. Where the death of a child or young person occurs, their case manager must be included in the core attendees for the DIPLAR.	Further work is required to describe the policies that apply and the assessment tools that would demonstrate SPS are effectively working in accordance with UNCRC. Formal connection to be established with SG dept responsible and key experts in NHS.			

		followed in practice						
3.1	Family contact & support following a death	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 therafter, with pastoral suport from a Chaplain still offered.	SPS	**RECOMMENDATION IMPLEMENTED**				
3.2	Family contact & support following a death	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	SPS/NHS/COPFS (SPS to lead)	SPS - SPS sent to COPFS in April a draft version of the Information/Data Sharing Agreement for comment and some further information. Discussion is ongoing between SPS and COPFS, recently in June 2023. This work continues to be ongoing.				

		of the need of the family to have their questions about the death answered as soon as possible.						
3.3	Family contact & support following a death	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.	SPS/NHS (NHS to lead)	**RECOMMENDATION IMPLEMENTED**				
3.4	Family contact & support following a death	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.	SG/SPS /NHS					

4.1	Support for staff & other people held in prison after a death	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.	SPS/NHS (NHS to lead)	Attended Family Reference Group in July 23 to share an update on the work being progressed to support staff. This provided an overview of the interim CIRS process, the support package for individuals, line managers and peers. This was well received by those attending. Positive feedback being received from operational colleagues. Attending EuroPris meeting 10/10/23 to discuss approaches in place with European counterparts. From review of various models still favouring Scottish Fire and Rescue Service approach and linking this with peer support training like psychological first aid - which is an evidence-informed modular approach to help people in the immediate aftermath of a major incident. It is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. Key point with this type of training is it focuses on the practicalities rather than an in-depth discussion on the persons trauma. This can be delivered via Lifelines, so plan to approach them for an idea of costs. Attended Supporting Mentally Healthy	Attending Penrith facility (Fire Brigade rehabilitation unit) with ER&R and TUS in November 2023 to review the facility and support that can be provided. Meetings to be arranged with Cruse to discuss bereavement and suicide support Further progression on the FAI documents and finalising to make available	This is longer term programme of work	Lifelines has cost implications	Decision awaited from Executive Management Group

				Workplaces: National Learning Network for Employers – MSP promoting their new platform, which could be extremely useful in terms of staff support going forward - Supporting a mentally healthy workplace (healthyworkinglives.scot) Documents drafted on support for staff attending FAIs				

4.2	Support for staff & other people held in prison after a death	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/NHS (NHS to lead)	This work is captured in the SPS Trauma Delivery Group workplans, and the Tasking Group aligns with that structure. We have to date held 3 Scottish Trauma Informed Leadership Training (STILT) sessions for senior staff with a 4th one underway. In partnership with NES, we have also added 4 trauma awareness modules to our online training platform, MyLo for all staff. These went live at the end of September. -Developing your trauma skilled practice 1 : understanding the impact of trauma and responding in a trauma-informed way **(71)** -Developing your trauma skilled practice 2 : trauma in children and young people **(31)** -Developing your trauma skilled practice 3 : understanding the impact on mental health and evidence-based pathways to recovery **(24)** -Developing your trauma skilled practice 4 : understanding the use of substances to cope with the impact of trauma **(25)** Module completions so far in brackets above, this doesn't include the completions by SPS staff on TURAS prior to uploading in MyLo.	Further roll out of STILT training to operational managers Review uptake of the MyLo training, ongoing promotion	This is longer term programme of work	STILT training requires specialist facilitation, capacity of NES to continue to support	

5.1	SPS & NHS documentation concerning deaths	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	SPS/NHS (SPS to lead)	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. Families are advised re DIPLAR at the point of initial contact, they are provided by a copy of the Family Support Booklet that will include local contacts, including NHS, the Chaplaincy service continue to support. The revised process records questions raised, responses where possible and identifies who and when this will be shared back with families. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. **RECOMMENDATION IMPLEMENTED - await**				

				confirmation from Oversight Board				

5.2	SPS & NHS documentation concerning deaths	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 one the DIPLAR has been concluded. These communications between the staff member and family should be recorded in the DIPLAR report.	SPS/NHS (SPS to lead)	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. Recording of communication with family is included in the DIPLAR. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. Chaplaincy Team led sessions with GiC's and others. The outcome to date: 15 out of 19 face-2-face workshops with GICs and Deps (in SPS College), and SMTs and Duty Managers (in their establishments) are completed - with the remaining 4 scheduled for completion by mid-November. Meeting with SPSC scheduled on 3	Consider this recommendation implemented with the additional commitment to ensure long-term sustainability is supporting senior staff as changes occur with an eLearning package. The aim is to complete this by March 2024.			

				November to continue development of an eLearning module based on the content of the GIC/SMT Workshops - The eLearning module should be complete by March 2024. It is important to note that most of the Govs, Deps, SMTs, and Duty Managers in SPS and private prisons have received the face-to face training now, and the feedback has been excellent. **RECOMMENDATION IMPLEMENTED - Await confirmation from Oversight Board**				
5.3	SPS & NHS documentation concerning deaths	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.	SPS	A deep dive paper on the progress being made was presented to the SPS Advisory Board in July. Discussion ensued re the role of the Independent Chair and who that should be. It was agreed that it continue to be someone identified within the AB membership given their independence and role in advising the organisation. Seeking an external chair was not considered a requirement. Given the				

				volume of work involved, there is an outstanding query on capacity of this individual to do all deaths, including natural cause. A central tracker is already in place to record learning points.				
5.4	SPS & NHS documentation concerning deaths	The full DIPLAR process should be followed for all deaths in custody, with a member of staff from SPS Headquarters in attendance	SPS	**RECOMMENDATION IMPLEMENTED**				
1	Advisory point	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	SPS/NHS (SPS to lead)	An initial exploration meeting Families Outside took place in August. This included SPS, a member of the Family Reference Group and the National Prison Care Network. This hasn't been progressed further at this stage.				
2	Advisory point	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.	SPS	No immediate plans to progress this recommendation. Would require a large estates project and significant budget implication which the SPS is not currently resourced to deliver.				

3	Advisory point	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.	SPS/NHS (SPS to lead)	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. The revised template allows for recording of any intelligence that could be relevant. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. **RECOMMENDATION IMPLEMENTED - Await confirmation from Oversight Board**				

4	Advisory point	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.	SPS/NHS (SPS to lead)	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. The template includes learning points and an action plan, these are recorded on a national tracker however, local DIPLAR co-ordinators are required to identify recurring themes to highlight at the meeting. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. **RECOMMENDATION IMPLEMENTED - Await confirmation from Oversight Board**				

5	Advisory point	SPS and NHS to consider developing a separate section in the DIPLAR document to ensure info on family involvement and the content of discussions is recorded, including any questions raised by the family and the response to them.	SPS/NHS (SPS to lead)	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. A section has been added to reflect this recommendation. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. **RECOMMENDATION IMPLEMENTED - Await confirmation from Oversight Board**				

6	Advisory point	The SPS should develop clear protocols for memorial services, letters of condolence and donations from people held in prison for families of the deceased.	SPS	Following extensive consultation with partners including the Family Reference Group and testing over the summer period. The revised DIPLAR proforma and guidance went live August 2023 - GMA028A/23. This added to previous GMAs already implemented re HQ attendance at all DIPLAR meetings and the role of GICs and Duty Managers in family contact. The guidance includes details on considering memorials etc relevant to the individual and their family and is recorded on the form. It is acknowledged that a range of options may be considered and should be individualised. The revised form will be formally reviewed in February 2024. Presentation given to COPFS colleagues 5th October to promote understanding raise awareness. A presentation and engagement session with Governors in Charge will feed into the review and is scheduled for 25th January 2024. **RECOMMENDATION IMPLEMENTED - Await confirmation from Oversight Board**				

Oth er		Please use this line to provide information about any other work ongoing which is relevant to improving the response to deaths in prison custody but doesn't fit neatly into one of the recommendations						

HMIPS

22 September 2023

Dear Convenor,

Evidence from Gill Imery, Chair, Deaths in Custody Review Group

I watched with interest the evidence that Gill Imery gave in the recent committee. Without commenting on the rest of her evidence, I thought I would write and clarify the scrutiny of prison healthcare raised as a concern by Ms Imery in the session.

HMIPS developed, with specialist expertise, a suite of rights-based Standards for Inspecting and Monitoring which are published on our website. The nine standards set out the quality indicators we use when inspecting and monitoring prisons. Standard 9 covers the specialism of healthcare and has 17 Quality Indicators.

I have discussed our observations and concerns on prison health in numerous forums including addressing the Cross-Party Group on Health Inequalities in Prison.

HMIPS do on average, four full prison inspections every year. Since 2014, Healthcare Improvement Scotland (HIS) have inspected the provision of healthcare in prisons as a specialist part of HMIPS's inspection process. This involves analysing information from a wide range of sources, including data collection, talking to all levels of staff and prisoners, and observing day-to-day service delivery. HIS consider what good care looks like for the individual and for the service, so that they can identify areas of strength, good practice, and areas for improvement.

In addition to carrying out the full inspections with HMIPS, HIS undertake a number of follow-up inspections and meetings during the year to assess progress in response to concerns escalated during inspection or when information is received expressing concern.

HIS also share learning, such as areas for improvement and areas of good practice, at a national level; influence local and national solutions for the delivery of healthcare; and take part in national reviews to share knowledge and expertise to support continuous improvement.

It is worth the Committee knowing that HMIPS and HIS visited every prison during COVID-19.

Finally, since 2022, HIS have also been inspecting healthcare provision within police custody centres across Scotland as part of inspections led by His Majesty's Inspectorate of Constabulary in Scotland (HMICS).

Yours sincerely,

Wendy Sinclair-Gieben
HM Chief Inspector of Prisons for Scotland

CJ/S6/23/31/1

Scottish Human Rights Commission

11th October 2023

Dear Convener

Independent Review of the Response to Deaths in Prison Custody: Implementation of recommendations

As you are aware, the Independent Review of the Response to Deaths in Prison Custody (the "Review"), published in November 2021, was co-chaired by Wendy Sinclair-Gieben (Chief Inspector of His Majesty's Prisons in Scotland), Professor Nancy Loucks (Chief Executive of Families Outside) and Judith Robertson (former Chair of the Scottish Human Rights Commission).

The Commission listened with interest to the oral evidence of Gillian Imery, External Chair of the Deaths in Prison Custody Action Group, delivered to the Committee on Wednesday 20th September 2023. As co-chair of the Review, the Commission shares the concerns expressed by Ms Imery as to the slow progress in implementing the Review's recommendations. It is particularly concerning to hear Ms Imery's reflections on what she perceived as the lack of interest or willingness to implement the Review's evidence-based recommendations from duty- bearers such as the Scottish Prison Service (SPS) and National Health Service (NHS).

During her evidence, Ms Imery confirmed that only five of the Review's recommendations and advisory points have been completed. The slow pace of progress is, in our view, unacceptable, particularly when viewed in the wider context of the increasing numbers of people dying in Scotland's prisons.

Review's main recommendation

There was discussion during Ms Imery's evidence around the implementation of the Review's key recommendation, which is that a separate independent investigation should be undertaken into each death in prison custody. The investigation should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.

Although work is underway in developing the process for the key recommendation, the Commission is concerned that some important aspects may be overlooked.

The development of the key recommendation is based on the relevant human rights framework, most notably it would support compliance with Article 2 ECHR, which protects the right to life and sets out the need for an investigation to be independent, adequate, prompt, and undertaken with public scrutiny and with the participation of the deceased's next of kin. The full explanation of the reasoning behind the key recommendation, and a detailed account of the attributes the investigation body should have, together with an account of comparable systems in other UK and Irish jurisdictions, are detailed at pgs. 75-79 of the Review.

The Commission wishes to highlight the following points to the Committee.

Statutory footing

The investigations were to be carried out by an independent body. The body's functions and remit – which includes timescales for investigations and the parties that must be involved in an investigation – should be set out in statute and explicitly linked to human rights standards. The body tasked with carrying out the investigations should be accountable to the Scottish Parliament, with appropriate reporting requirements also set out in statute. It appears to us that the importance of a statutory footing, with appropriate accountability and oversight mechanisms, may have, to date, been overlooked by Ministers.

Participation of next of kin and legal aid

Article 2 ECHR requires that the family or next of kin of a deceased person are provided the opportunity to participate in the investigation of a death where the responsibility of the state may have been engaged.

We know that existing processes allow, in theory, for family participation. However, as the Review highlighted, in practice, that involvement is minimal. An independent investigation sitting alongside existing processes would allow families to raise concerns and questions at an early stage, perhaps with a wider focus on systemic issues leading up to their family member's death.

Another vital aspect of the Review's key recommendation was that families or next of kin of those who have died in custody should have access to free and immediate non-means-tested Legal Aid funding for specialist representation to allow for their participation in the different processes that take place following a death in custody. Again, the Commission is concerned that focus on this crucial aspect of the recommendation has been lost.

The Fatal Accident Inquiry (FAI) process

The Commission recognises that the primary means to achieve compliance with Article 2 ECHR in Scotland is through the FAI process.

The FAI process was specifically outwith the scope of the Review; however, due to our work on the Review and in our engagement with families and other stakeholders since, it is very clear to us that the current FAI process is neither providing what it should for families, nor is the FAI process in its current format delivering the systemic change, learning and improvement that is badly needed.

We know that the purpose of an FAI is to establish the circumstances of a death and to consider the steps (if any) that might be taken to prevent other deaths in similar circumstances. Despite this, we also know that in over 90% of all FAIs relating to deaths in custody, no finding of a reasonable precaution is made, no finding of defect is made, and no recommendations are made that might improve practice or prevent deaths.2 FAIs currently consider relevant Death in Prison Learning, Audit & Review documentation (the SPS's own review into a death in custody); although this is no doubt useful, it represents the SPS's own account of events and their assessments of improvements they or the NHS need to make. An independent investigation could improve the FAI process by ensuring all relevant facts are brought before a court.

There is too often an extremely long time period between a death and an FAI. This is traumatic for all involved, most notably for families of people who have died. An independent investigation would be completed within a matter of months, ensuring a better chance of families receiving swift answers and supporting the SPS and NHS learning processes at a much earlier point, all with the aim of preventing future deaths in similar circumstances.

Other jurisdictions have in place comparable investigations alongside their equivalents of the FAI process.3 Although we appreciate every legal system is different, the Commission questions why such a process envisaged by the Review's main recommendation should be so uniquely difficult to achieve in Scotland.

Separately, the Committee should be aware that the Review recommended that a review of the FAI process should be undertaken to consider alternative approaches to our current system. The time between the death occurring and the FAI must also be reduced. The Commission believes action on a more widescale review of the whole FAI process is urgently needed. The Commission would be pleased to explore this further with members of the Committee.

Lack of systemic focus and ongoing scrutiny and monitoring

Having reviewed a number of completed FAIs alongside internal SPS and NHS documentation as part of our work on the Review, and with regard to available research into the effectiveness of the FAI process in relation to deaths in custody, our view is that the current system lacks any real focus on identification of trends and systemic issues. Similarly, there is no transparent process in place to monitor implementation of recommendations arising from deaths in custody and to track progress.

It was the Review's recommendation that there should be a regular independent review of data trends on deaths in prison, with the same independent body being tasked to collate, analyse, monitor and report on trends, systemic issues, recommendations and learning.

Suggested role of the Criminal Justice Committee

The Commission notes the discussion around the time remaining on Ms Imery's appointment as external chair. As a co-chair of the Review, the Commission is concerned that without an external focus on implementation, progress will further slow or halt. In our view, there would be great value in ongoing Parliamentary scrutiny of implementation of the Review's recommendations, to complement and assist the work of the external chair and to ensure implementation once Ms Imery's term has come to an end. Should the Criminal Justice Committee agree to adopt this as part of its ongoing work, the Commission offers any assistance required in fulfilling a scrutiny role.

We hope the above information is helpful to the Committee. We would be happy to discuss further anything outlined above, should that be useful.

Jan Savage
Executive Director, Scottish Human Rights Commission