Director-General Education & Justice
Àrd-stiùiriche Foghlam agus Ceartais
Neil Rennick

Scottish Government
Riaghaltas na h-Alba
gov.scot

E: dgej@gov.scot
T: 0131 244 3537

Sam Gluckstein
Head of the UK NPM
National Preventative Mechanism

By email

Your ref: Scottish Government position on recommendations from the Independent Review of the Response to Deaths in Prison Custody

22 August 2024

Dear Sam,

Thank you for your letter of 10 July 2024 regarding the Scottish Government's position on the recommendations from the Independent Review of the Response to Deaths in Prison Custody ('the Independent Review').

As you are aware, in 2021, the Scottish Government agreed in principle to the implementation of the recommendations from the Independent Review. I have provided some information below which might be helpful for you.

In April 2022, Gillian Imery, former HM Chief Inspector for Constabulary in Scotland, was appointed as external chair to provide oversight and leadership to the implementation of the recommendations of the Independent Review. In Gillian's final progress report, published in February 2024, she confirmed that eight out of nineteen recommendations had been completed, with another partially complete. In addition, two of the six advisory points had been addressed.

In March 2024, the Deaths in Prison Custody Action Group (DiPCAG) met to discuss the implementation of the outstanding recommendations. At that meeting Gillian confirmed that she considered a further two recommendations complete, bringing the total number of recommendations completed to ten (along with two advisory points). Those two recommendations were: recommendation 2.3 and recommendation 1.3.

The next meeting of the DiPCAG will be held in August 2024. Following the departure of Gillian Imery as External Chair, the DiPCAG will be chaired by the Deputy Director of Community Justice, Alex Doig. The Scottish Government remains committed to improving the experiences of those who have sadly suffered the loss of a loved one in prison custody. In assuming the role of Chair of the DiPCAG, Alex will provide continued oversight of the necessary work required for implementation of the recommendations.

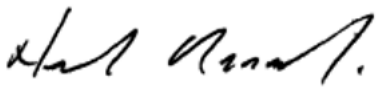
In advance of that meeting, organisations responsible for implementation of the recommendations will be asked to provide evidence of what further action has been taken to complete the outstanding recommendations. It is hoped that further recommendations will be able to be considered implemented. Discussions of the group are key to decision-making on whether the recommendations are considered implemented. As you may know, the latest DiPCAG updates are published on the Scottish Government website and a further update will be published following the meeting in August, which I hope you find helpful.

Regarding the key recommendation, I am grateful that you were able to participate in the recent roundtable discussion following the pilot exercises. I am grateful for the interest of the NPM in this work which, alongside other partners has helped us to understand a range of views on the outcome of a pilot exercise and potential next steps.

Thank you for your ongoing engagement on this matter.

I hope you find this update helpful.

Yours sincerely



Neil Rennick
DG Education and Justice

Scottish Government position on recommendations and advisory points from the Independent Review of the Response to Deaths in Prison Custody
July 2024

Type	No.	Text	Status (Feb 2024, from Second Progress Report)	Scottish Government position 2021	Scottish Government current position
Key recommendation	1	A separate independent investigation should be undertaken into each death in prison and should be carried out by a body wholly independent of Scottish Ministers, the Scottish Prison Service or the private prison operator and the NHS.	This is a long term piece of work and timescales are partially dependent on how many pilot exercises require to be undertaken.	Accepted in principle	Accepted in principle
Recommendation	1.1	Leaders of national oversight bodies (Healthcare Improvement Scotland, NHS boards, Care inspectorate, National Suicide Prevention Leadership Group and HMIPS) should work together with families to support the development of a new single framework on preventing deaths in custody.	In progress. This is a long-term piece of work.	Accepted in principle	Accepted in principle
Recommendation	1.2	The SPS and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.	In progress – product has been created that requires to be adopted and implemented in each NHS Health Board. No clear timescales for that to be completed.	Accepted in principle	Accepted in principle
Recommendation	1.3	The SPS should develop a more accessible system so that where family members have serious concerns about the health/wellbeing of someone in prison, these views are acknowledged, recorded and addressed with appropriate communication back to the family.	In progress. Due to be implemented by end of January 2024.	Accepted in principle	Implemented
Recommendation	1.4	When someone is admitted to prison, SPS and the NHS should seek permission that, where prison or healthcare staff have serious concerns about the health or wellbeing of someone in their care, they are able to contact the next of Kin. If someone is gravely ill and is taken to hospital, the Next of Kin should be informed immediately where consent has been given. This consent should be recorded at every admission to prison to allow for cases in which someone is unable to give consent.	Implemented	Accepted in principle	Implemented
Recommendation	2.1	SPS and NHS should jointly develop enhanced training for prison and healthcare staff in how to respond to a potential death in prison, including developing a process for confirmation of death.	In progress – product has been created that requires to be adopted and implemented in each NHS Health Board. No clear timescales for that to be completed.	Accepted in principle	Accepted in principle

Recommendation	2.2	SPS should improve access to equipment such as ligature cutters and screens to save vital time in saving lives or preserving dignity of those who have died.	Implemented	Accepted in principle	Implemented
Recommendation	2.3	NHS and SPS should address the scope to reduce unnecessary pressure on the Scottish Ambulance Service when clinical staff with appropriate expertise attending the scene are satisfied they can pronounce death.	In progress – product has been created that requires to be adopted and implemented in each NHS Health Board. Due to be implemented by end of January 2024.	Accepted in principle	Implemented
Recommendation	2.4	SPS should review the DIPLAR proforma to ensure they evidence how the impact of a death on others held in prison is assessed and support offered.	Implemented	Accepted in principle	Implemented
Recommendation	2.5	The SPS and NHS must ensure that child-friendly policies and practices are introduced and applied to all children, aged under 18 , in accordance with the UNCRC. Reviews of deaths in custody involving a child or young person must include an assessment of whether or not the particular rights of children were fulfilled, with child-friendly policies and procedures followed in practice.	Implemented	Accepted in principle	Implemented
Recommendation	3.1	The Governor in Charge should be the first point of contact with families (after the Police) as soon as possible after a death. An SPS single point of contact (other than the chaplain) should maintain close contact thereafter, with pastoral support from a Chaplain still offered.	Implemented	Accepted in principle	Implemented
Recommendation	3.2	SPS & NHS should review internal guidance documents, processes and training to ensure that anyone contacting family is clear on what they can and should disclose. SPS should work with COPFS to obtain clarity as to what can be disclosed to family without prejudicing any investigation, taking due account of the need of the family to have their questions about the death answered as soon as possible.	In progress. DSA due to be formally agreed between SPS and COPFS by the end of February 2024.	Accepted in principle	Accepted in principle
Recommendation	3.3	The family should be given the opportunity to raise questions about the death with the relevant SPS and NHS senior manager and receive responses. This should be spelled out in the family support booklet jointly created and reviewed by the SPS and the NHS.	Implemented	Accepted in principle	Implemented
Recommendation	3.4	To support compliance with the state's obligation to protect the right to life, a comprehensive review involving families should be conducted into the main causes of all	In progress. A further report is expected to be published in early spring.	Accepted in principle	Accepted in principle

		deaths in custody and what further steps can be taken to prevent such deaths.			
Recommendation	4.1	NHS and SPS should develop a comprehensive framework of trauma informed support with the meaningful participation of staff, including a review of Critical Incident Response and Support policy, to ensure accessibility, trained facilitators, and consistency of approach. This should ensure staff who have witnessed a death always have opportunity to attend and that a system of regular and proactive welfare checks are made.	In progress. New model for the CIRS is likely to be developed and approved by April 2024 and will then require implementation.	Accepted in principle	Accepted in principle
Recommendation	4.2	SPS and NHS should also develop, with the meaningful participation of people held in prison, a framework of trauma informed support for people held in prison to ensure their needs are met following a death in custody	In progress. It is likely to be a further 12-18 months for a strategy and plan to be in place that will then require to be rolled out.	Accepted in principle	Accepted in principle
Recommendation	5.1	SPS and NHS should ensure every family should be informed of the DIPLAR and if applicable, the SAER, process and their involvement maximised. This includes the family having the process (and timings) and their involvement clearly explained; being given the name and contact details for a point of contact; knowing when their questions and concerns will be considered by the Review and receiving timely feedback.	The aspects of this recommendation that relate to the DIPLAR have been implemented, whilst those relating to the SAER are still in progress. No clear timescales for completion.	Accepted in principle	Accepted in principle
Recommendation	5.2	SPS and NHS should ensure a single point of contact for families. They should be a trained member of staff and this staff member should be fully briefed about what can be initially shared with the family and subsequently fed back, both during the process and once the DIPLAR has been concluded. These communications between the staff member and family should be recorded in the DIPLAR report.	Implemented	Accepted in principle	Implemented
Recommendation	5.3	A truly independent chair, with knowledge of the prison, health and social care environments, should be recruited to chair all DIPLAR meetings providing the assurance that all deaths in custody are considered for learning points.	Not implemented – action taken does not fully meet recommendation.	Accepted in principle	Accepted in principle
Recommendation	5.4	The full DIPLAR process should be followed for all deaths in custody, with a member of staff from SPS Headquarters in attendance.	Implemented	Accepted in principle	Implemented

Advisory point	1	A platform should be available for families to share and process their experiences such as a Bereavement Care Forum as previously recommended. The NHS and SPS should commission the independent development and support of such a platform.	Under consideration	Accepted in principle	Accepted in principle
Advisory point	2	The SPS should review the scope to place emergency alarms within reach of the cell bed to ensure the ability to raise the alarm when incapacitated.	Not commenced – no plans to progress due to resources required	Accepted in principle	Accepted in principle
Advisory point	3	SPS and NHS to consider whether other people held in prison who knew the deceased may have relevant information to offer and how best to include their reflections in DIPLAR and SAER processes where appropriate, in particular whether discrimination of any kind was perceived as a factor in the death.	Not implemented – action taken does not fully meet recommendation	Accepted in principle	Accepted in principle
Advisory point	4	SPS and NHS to review DIPLAR report form to include a separate section where observed systemic or recurring issues are recorded by the independent chair to ensure holistic improvements to broader systems and processes are more easily recognised and addressed.	Implemented	Accepted in principle	Implemented
Advisory point	5	SPS and NHS to consider developing a separate section in the DIPLAR document to ensure info on family involvement and the content of discussions is recorded, including any questions raised by the family and the response to them.	Implemented	Accepted in principle	Implemented
Advisory point	6	The SPS should develop clear protocols for memorial services, letters of condolence and donations from people held in prison for families of the deceased.	In progress – due to be implemented by the end of March 2024	Accepted in principle	Accepted in principle