Independent Review of the Response to Deaths in Prison Custody

November 2021

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

families outside
supporting families affected by imprisonment

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"It was a big shock for us, and I think we dealt with it by kind of fighting to get information. Instead of fighting, it would have been, I don't know I guess – humane – to get a bit of – not sympathy, but just a bit of information, I guess. Just information."

(family member)

"It's a hole that can't be filled. It can't be sealed, it can't be resolved – it's just a hole. People's lives have holes, but this one's mine."

(family member)

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Acknowledgements

This Review was co-chaired by Wendy Sinclair-Gieben, Chief Inspector of Her Majesty's Prisons in Scotland, Professor Nancy Loucks, Chief Executive of Families Outside, and Judith Robertson, Chair of the Scottish Human Rights Commission. Together we would like to thank a number of people for their contribution to the Review.

The team of researchers and staff supporting the Review changed through the course of the process, but the collective tenacity, insight, and effort of all involved led to a rich analysis and understanding. We would like to thank Ewan Patterson, Sally-Anne Mercer, Stephen Sandham, Kerry Love, and Dorothy Halliday of HMIPS; Eleanor Deeming, Frank Jarvis, Barbara Bolton, Jacqueline Kinghan, and Emma Hutton of the Scottish Human Rights Commission; and Todd Henshaw, Adam Wilson, Jenny Lowe, and Martin McKee of Families Outside for their sustained work over the last two years.

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We would also like to thank Jim Chisholm and the Scottish Prison Service for facilitating the information sharing and user engagement processes in this research.

A number of other individuals and organisations gave their time to assist us in the Review including the Scottish Government, Inquest, the Crown Office and Procurator Fiscal Service, and the National Suicide Prevention Leadership Group.

However, the most important contributors to the understanding and insight generated through this Review are the family members of those who have died in custody. A Family Advisory Group supported the Review and has provided advice and input throughout. A further group of family members added their experience through participating in research interviews. This contribution has been essential in building our understanding of what happens, and does not happen, when someone dies in custody. This has been essential to developing the recommendations for the Review. We truly respect and value their contribution.

Finally we would like to thank all the staff, people held in prison, and others who we interviewed and engaged with. In the context of COVID-19, this was often challenging. We acknowledge the difficulty of dealing with such a sensitive topic over remote communications and are grateful for everyone's commitment to taking part.

We would also like to acknowledge the delay in producing this Review. A range of personal and external factors contributed to this delay, including the significant and unavoidable impacts of COVID-19 on the process. However, people's willingness to overcome the considerable barriers we encountered on the way enabled us to complete this important work; we are grateful to them.

Wendy Sinclair-Gieben, Nancy Loucks, Judith Robertson

Language and Terminology

Abbreviations

CCTV	Closed Circuit Television
CIRS	Critical Incident Response and Support
COPFS	Crown Office and Procurator Fiscal Service
COVID-19	Coronavirus Disease 2019
CPR	Cardiopulmonary Resuscitation
DIPLAR	Death in Prison Learning, Audit and Review
EAP	Employee Assistance Programme
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
FAI	Fatal Accident Inquiry
FLO	Family Liaison Officer
GMA	Scottish Prison Service Governors' and Managers' Action Notice
HIS	Healthcare Improvement Scotland
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIPS	Her Majesty's Inspectorate of Prisons, Scotland
HMP	Her Majesty's Prison
HRBA	Human Rights-Based Approach
ICCPR	International Covenant on Civil and Political Rights
IPM	Independent Prison Monitor
KSOP	Kilmarnock Standard Operating Procedure
MSP	Member of the Scottish Parliament
MOU	Memorandum of Understanding
NHS	National Health Service
NSPLG	National Suicide Prevention Leadership Group
NSPMG	National Suicide Prevention Management Group
OBE	Order of the British Empire
PANEL	Participation, Accountability, Non-Discrimination, Empowerment and Legality
PF	Procurator Fiscal
PIT	Post-Incident Team
PICT	Post-Incident Care Team
PPO	Prisons and Probations Ombudsman (England)
RCA	Root Cause Analysis
SAER	Serious Adverse Event Review
SCCJR	Scottish Centre for Crime and Justice Research
SCTS	Scottish Courts and Tribunals Service

SFIU	Scottish Fatalities Investigation Unit
SIDCAAR	Self-Inflicted Death in Custody: Audit, Analysis and Review
SPAP	Suicide Prevention Action Plan
SPS	Scottish Prison Service
SPS HQ	Scottish Prison Service Headquarters
TRiM	Trauma Risk Management
TTM	Talk to Me (SPS Suicide Strategy)
VBRP	Values-Based Reflective Practice
VIA	Victim Information and Advice
YOI	Young Offenders Institution

Key Terms

Deaths in custody/deaths in prison custody

We use these terms interchangeably to refer to deaths of people held in custody in Scotland's prison estate. The Review's Terms of Reference did not include other custodial settings.

Health and care settings

Families who participated in the Review make reference and comparisons between prison healthcare and care received in psychiatric hospitals. It is important to note that health provision in prisons is intended to be equivalent to community primary care within the community, and not secondary hospital care.

People in prison/people held in custody/prisoners

We use these terms interchangeably to refer to people held in custody in Scotland's prison estate.

Prisons/prison estate

We use these terms to include all prisons in Scotland including Young Offender Institutions and private sector prisons.

Prison staff/SPS

We use these terms to include all staff working in prisons in Scotland including those working in private sector prisons (unless otherwise stated).

Review/the Review

We use this term to mean the describe this Review as a whole including the three Review Co-Chairs and the staff team that supported their work.

Referencing

We have mainly used Harvard referencing throughout the report. A full list of references is provided in the online Appendices. The only exceptions to this are when case law or organisations are referenced, where we have used citations and footnotes.

Executive Summary

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

This is the final report of the Independent Review into the Response to Deaths in Prison Custody (the Review).

We would like to begin by acknowledging the distress caused to many people when someone dies in prison custody. Families and loved ones are left bereaved, traumatised, and sometimes with unanswered questions. Those who support people held in prison and their families are also affected, as are members of staff involved in responding to the death, and people held in the same prison.

We have taken a human rights-based approach to this Review. In particular, this involved enabling those affected by deaths in custody to participate in the Review's work and, importantly, to inform and shape many of our recommendations. Human rights legal obligations, standards, and guidance also underpinned our analysis and guided our recommendations.

After nearly two years of research and analysis, the Review is recommending a wide-ranging set of systemic, practical, and compassionate changes that we believe would improve radically how deaths in prison custody are responded to in Scotland.

Key Recommendation

In particular, we are recommending that a separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.

- The independent investigation should be instigated as soon as possible after the death and completed within a matter of months.
- The investigation process must involve the families or Next of Kin of those who have died in prison custody.
- The purpose of the investigation should be to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice, or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Article 2 of the ECHR. All investigations must result in a written outcome.
- In determining the process of investigation and the intensity of review required, the independent investigatory body must have regard to applicable human rights standards, including those set out in the online Appendices.
- The independent investigatory body must have unfettered access to all relevant material, including all data from SPS, access to premises for the purpose of conducting interviews with employees, people held in detention and others, and the right to carry out such interviews for the purpose of the investigation. Corresponding duties should be placed on SPS and other relevant institutions requiring the completion, retention and production of relevant information in their possession.
- The independent investigatory body must be required to produce and publish reports analysing data on deaths in custody, identifying trends and systemic issues, making recommendations and promoting good practice.

- The independent investigatory body should also be tasked, in statute, with the duty to monitor and report on the implementation of its recommendations. The views of bereaved families or Next of Kin should be taken into account in this process.
- Families or next of kin of those who have died in custody should have access to full non-means-tested legal aid funding for specialist representation throughout the processes of investigation following a death in custody, including at the FAI

This change would bring Scotland into line with practice in other jurisdictions including England, Wales, and Northern Ireland.

Our recommendations reflect and respond to the clear evidence we heard from bereaved families that existing practice fails to provide them with choice and control – two pillars of trauma-informed practice. At every step of the journey currently, there is a noticeable lack of family engagement.

Implementation of this recommendation would also support compliance with the right to life under Article 2 of the European Convention on Human Rights, both the substantive and procedural elements, as well as other human rights obligations.

Background to the Review

Scotland has both a high rate of imprisonment and a rising rate of deaths in prison custody. Scotland is also a place where international human rights laws and standards are expected to underpin law, public policy, and the decisions and practices carried out by public authorities.

In November 2019, the Cabinet Secretary for Justice asked Wendy Sinclair-Gieben, Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS) to undertake this Review.

The Review was tasked with making recommendations on how to improve the response when someone dies in one of Scotland's prisons. The Review was also established with a remit and requirement to take a human rights-based approach to its work. This meant ensuring that relevant human rights legal standards framed our analysis and recommendations. It also meant ensuring that the voices of families, and others directly affected, were heard and listened to in making recommendations.

Professor Nancy Loucks OBE, Chief Executive of Families Outside, and Judith Robertson, Chair of the Scottish Human Rights Commission, joined HMCIPS as Co-Chairs of the Review in its early stages. Families Outside provided expertise to inform the Review and facilitated engagement with families. The Commission provided expertise on human rights legal standards and a human rights-based approach.

Method

The Review's work took place over nearly two years. Following the completion of a literature review and the development of a human rights analysis framework, we then carried out a wide range of research. We:

- interviewed 20 people whose family member had died in custody;
- established and were guided by a Family Advisory Group of 12 family members;
- interviewed 10 people held in prison;
- heard from 78 staff working in the Prison Service, by interview or online survey;
- interviewed 44 NHS staff;
- reviewed 6 key prison policies and documents;
- reviewed 71 NHS policies and documents;
- reviewed 93 Death in Prison Learning, Audit and Reviews (DIPLARs);
- reviewed 10 Serious Adverse Event Reviews (SAERs); and
- reviewed 20 concluded Fatal Accident Inquiry determinations.

Following this research phase, the Review Co-Chairs worked together to review the evidence gathered, identify key findings, make recommendations, and reach overarching conclusions. A small team of staff from each participating organisation supported and facilitated this work.

Findings

In summary, we have made the following findings:

- There is a wide variation in practices and experiences relating to deaths in custody across the whole of the prison estate despite the best endeavours of those drafting guidance to promote consistency.
- Improvements are required to address the key tests arising from human rights standards for right to life and inhuman treatment investigations, namely that they should be:
  - independent
  - adequate
  - prompt
  - open to public scrutiny and involve the next of kin.
- There is a lack of family engagement at every step of the journey; humanity and compassion are at times compromised.
- There is a need for more effective training and support for staff, grounded in an appreciation of the impact of a death.
- The current inquiry processes would benefit from greater independent scrutiny with enhanced family engagement at a much earlier stage.
- There is a lack of a national oversight mechanism to review data and report publicly on recommendations, learning, and good practice arising out of deaths in custody.
- There is need for a comprehensive review of the causes of deaths in custody, and the further steps that can be taken to prevent such deaths, which was outwith the scope of this Review.

Other Recommendations

To address our findings, we have made 26 other recommendations and a small number of advisory points. The recommendations are grouped around five themes, reflecting the findings of the Review.

Theme 1: Family contact with the prison and involvement in care

- **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.
- **Recommendation 1.2** The Scottish Prison Service and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.
- **Recommendation 1.3** The Scottish Prison Service should develop a more accessible system, so that where family members have serious concerns about the health or wellbeing of someone in prison, these views are acknowledged, recorded, and addressed, with appropriate communication back to the family.
- **Recommendation 1.4** When someone is admitted to prison, the SPS, and NHS should seek permission that where prison or healthcare staff have serious concerns about the health or wellbeing of someone in their care, they are able to contact the next of kin. If someone is gravely ill and is taken to hospital, the next of kin should be informed immediately where consent has been given. This consent should be recorded at every admission to prison to allow for cases in which someone may become unable to give consent.

Theme 2: Policies and processes after a death

- **Recommendation 2.1** The SPS and NHS should jointly develop enhanced training for prison and healthcare staff in how to respond to a potential death in prison, including developing a process for confirmation of death.
- **Recommendation 2.2** The SPS should provide improved access to equipment such as ligature cutters and screens to save vital time in saving lives or preserving the dignity of those who have died.
- **Recommendation 2.3** The 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 that they can pronounce death.
- **Recommendation 2.4** The SPS should review the DIPLAR proforma to ensure they evidence how the impact of a death on others held in prison is assessed and that support is offered.
- **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 the particular rights of children were fulfilled, with child-friendly policies and procedures followed in practice.

Theme 3: Family contact and support following a death

- **Recommendation 3.1** The Governor in Charge (GIC) should be the first point of contact with families (after the Police) as soon as possible after a death. An SPS single point of contact other than the Chaplain should maintain close contact thereafter, with pastoral support from a Chaplain still offered.
- **Recommendation 3.2** SPS and NHS should review internal guidance documents, processes, and training to ensure that anyone contacting the family is clear on what they can and should disclose. SPS should work with COPFS to obtain clarity as to what can be disclosed to the family without prejudicing any investigation, taking due account of the need of the family to have their questions about the death answered as soon as possible.
- **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 opportunity should be spelled out in the family support booklet.
- **Recommendation 3.4** To support compliance with the State's obligation to protect the right to life, a comprehensive review involving families should be conducted into the main causes of all deaths in custody and what further steps can be taken to prevent such deaths.

Theme 4: Support for staff and other people held in prison after a death

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

- **Recommendation 4.2** The SPS and NHS should also develop, with the meaningful participation of people held in prison, a framework of trauma-informed support for people held in prison to ensure their needs are met following a death in custody.

Theme 5: SPS and NHS documentation concerning deaths

- **Recommendation 5.1** The SPS and NHS should ensure that every family is informed of the DIPLAR and, if applicable, the SAER process, and their involvement maximised. This includes the family:
  - having the process (including timings) and their involvement clearly explained;
  - being given the name and number of a single point of contact;
  - knowing when their questions and concerns will be considered; and
  - receiving timely feedback.
- **Recommendation 5.2** 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.
- **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.
- **Recommendation 5.4** The full DIPLAR process should be followed for all deaths in custody, with a member of staff from Prison Service Headquarters in attendance.

In addition, the families and staff involved in the Review raised a number of points they would like to see addressed to the organisations in the report as advisory points.

- **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 (Nugent 2018). The NHS and SPS should commission the independent development and support of such a platform.
- **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.
- **Advisory Point 3** Consideration should always be given by the SPS and NHS to whether other people held in prison who knew the deceased may have relevant information to offer and how best to include their reflections in both DIPLAR and SAER processes where appropriate, in particular whether discrimination of any kind was perceived as a factor in the death.
- **Advisory point 4** The SPS and NHS should review the DIPLAR report form to include a separate section where observed systemic or recurring issues are recorded by the independent chair to ensure holistic improvements to broader systems and processes are more easily recognised and addressed.
- **Advisory point 5** The SPS and NHS should also consider developing a separate section in the DIPLAR document to ensure information on family involvement and the content of discussions is recorded, including any questions raised by the family and the response to them.
- **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.

Closing comments

The Review is deeply indebted to the families, people currently in prison, prison staff, and NHS staff who contributed their views to this Review. We know that this inevitably involved having to go back over extremely painful memories.

In the time that this Review has taken place, dozens of people have died in Scotland's prisons, and hundreds more have been left to deal with the associated grief, trauma, and distress. It is clear from our Review that systemic change is needed in how such deaths are responded to. We have made detailed recommendations that we believe could achieve this change, driving the development of a more humane, compassionate, rights-based response to the loss of life in Scotland's prisons. It is now incumbent on all of those with responsibilities to uphold human rights to take action to implement these recommendations.

We present this Review to the Cabinet Secretary for Justice and Veterans.

1. Introduction and Background to the Review

In November 2019, Humza Yousaf MSP, the then Cabinet Secretary for Justice, asked Wendy Sinclair-Gieben, Her Majesty's Chief Inspector of Prisons for Scotland (HMCIPS), in accordance with section 7(2)(d) of the Prisons (Scotland) Act 1989, to undertake an Independent Review into the Response to Deaths in Prison Custody (the Review).

The Review was to make recommendations on areas for improvement to ensure appropriate and transparent arrangements are in place in the immediate response to deaths in custody within Scottish prisons, including deaths of people in custody whilst in NHS hospitals. Investigation of deaths by the Crown Office Procurator Fiscal Service (COPFS), including arrangements for Fatal Accident Inquiries, was outwith the remit of the Review.[1]

The context for the Review includes the Scottish Government's stated commitment to respecting, protecting and realising international human rights, most recently reaffirmed in the Programme for Government, 'A fairer, greener Scotland' (Scottish Government, 2021).

Professor Nancy Loucks OBE, Chief Executive of Families Outside, and Judith Robertson, Chair of the Scottish Human Rights Commission, joined HMCIPS as Co-Chairs of the Review. Families Outside provided expertise to inform the Review and facilitated the family user engagement. The Commission provided expertise on human rights and conducted an analysis of relevant European and broader international human rights legal standards.

It is important for any review to set its findings in context in order that its purpose can be fully understood and appreciated. Every death in custody can be a traumatic experience for their families and their friends, and it can also be a distressing event for the people who care for them and for others in custody.

Prison population and prison mortality rates

Scotland has one of the highest imprisonment rates of Northern European countries with 143 people in prison per 100,000 population (SCCJR, 2019). It also has one of the highest mortality rates in prison.

A rolling three-year average rate of deaths (per 100,000 prisoners) from all causes, covering this period, was calculated using Scottish Prison Service and Scottish Government data. This showed that the rate (that, is deaths relative to the size of the prison population) is rising (Sarah Armstrong et al, 2021).

Between 2005 and 2019, an average of 24 people died annually in prison custody in Scotland. Between 2016 and 2019, the annual average rose to 32.5 deaths per annum.

The Council of Europe published figures in 2018 on the mortality rate of the prison population within each country (Aebi and Tiago, 2020). Scotland's prison mortality rate is high at 47.6 per 10,000, well above the average of 30.4 per 10,000.

The largest cause of death is by natural causes, and with an ageing prison population, the number of deaths by natural causes in Scotland is likely to continue to increase. The second highest cause of death is self-inflicted death. This has long been a cause for concern, with death by suicide the leading cause of death of young people (aged 21 or under) in prison in Scotland, as well as internationally.

1 CabSectoConveneronDeathsinPrisons20191107.pdf (parliament.scot)

Human rights obligations

Deaths in custody also need to be seen through the prism of Scotland's human rights obligations, in particular the right to life provided for in Article 2 of the European Convention of Human Rights (ECHR). The State has the duty to protect the right to life effectively, including by taking reasonable steps to prevent someone's life from being avoidably put at risk. This duty is heightened in the case of people held in State custody, due to their inherent vulnerability. When someone dies in custody, the State has a duty to provide an explanation of the cause of death, and if the death was apparently caused by a health problem, to explain the treatment administered to the person prior to their death.

In all cases where there is possible State responsibility for a death, there is a duty to carry out an effective investigation into the death, to establish if there was any State failure to safeguard the right to life, and ensure accountability where State responsibility arises. Similarly, under Article 3 of the ECHR, the State has a duty to prevent torture, inhuman, or degrading treatment, and the obligation to undertake an effective investigation in any case where State responsibility may be engaged.

In reviewing the immediate response to deaths in custody, the Review has had these human rights standards in mind and has made a number of recommendations which would improve compliance, in particular with the right to life.

In Scotland, the principal procedure through which the duty to carry out an effective investigation is addressed is the Fatal Accident Inquiry (FAI). The FAI procedure is outwith the scope of this Review. However, evidence provided to the Review by families and prison staff highlighted concerns about the adequacy of the FAI process, in particular the length of time between a death in custody and the FAI; the limited opportunity for family participation in the FAI; the narrow focus of the FAI; and the lack of broader learning from FAI findings and recommendations. A summary of this evidence has been included in this report, as following the human rights-based approach applied by the Review, it was important that the voices of families be heard on this point.

Deaths in custody need to be seen through the prism of Scotland's human rights obligations.

2. Terms of Reference

The Review's Terms of Reference were set by the Cabinet Secretary for Justice in November 2019.

The scope of the Review

The Review's specific Terms of Reference were as follows:

- Conduct a comprehensive analysis of the relevant human rights legal standards, at both the European and international levels.
- Examine the policies, training, and operational procedures in place within the SPS and NHS relevant to deaths in custody. This included arrangements in the immediate response to a death in custody, including the identification and preservation of relevant evidence and the roles and responsibilities of management and individual staff involved in such incidents.
- Examine the arrangements in the response to a death in custody, including current processes within the SPS and NHS for the immediate Critical Incident Response and Support (CIRS) process and the subsequent joint DIPLAR process as well as the previous Self-Inflicted Death in Custody Audit, Analysis and Review (SIDCAAR) Guidance. The DIPLAR process is intended to enable areas for improvement and potential learning to be identified following a death in prison custody (including where the death occurs in hospital). We were also to examine the consistency and differences between FAI determinations and recommendations and learning arising from the preceding DIPLAR process.
- Examine the openness and transparency of arrangements following a death in custody, including communication with family members.
- Examine the support arrangements in place fo. families, SPS and NHS staff and others affected by deaths in custody.
- Examine the views of families impacted by a death in prison custody including preventative approaches which can enable families to raise concerns regarding family members in prison, for the purpose of identifying and making recommendations for areas for improvement to ensure appropriate and transparent arrangements are in place in the immediate aftermath of deaths in custody within Scottish prisons and Young Offender Institutions (YOIs), including deaths of people held in custody whilst in NHS care, in relation to people in custody on remand (awaiting trial) or following conviction.

The Review was asked to draw on evidence from other previous reports and reviews within and external to the SPS and NHS, including the findings and recommendations arising from the published reviews by Dr Briege Nugent and the Expert Review of the Provision of Mental Health Services for Young People at HMP YOI Polmont (HMIPS, 2019a).

The full Terms of Reference can be viewed in the online Appendices.

Issues not within scope of the Review

Investigation of deaths by the Crown Office and Procurator Fiscal Service (COPFS) was excluded from the scope of the Review, including potential criminal investigations and arrangements for Fatal Accident Inquiries.

The Terms of Reference (TOR) note that the independent Inspectorate of Prosecution in Scotland carried out a thematic review of COPFS arrangements for Fatal Accident Inquiries in 2016, and completed a follow up review in 2019, which included arrangements for FAIs arising from deaths of young people in custody, both with relevant recommendations.

The remit given to the Review also made clear that we were not to consider or comment on the circumstances of individual deaths in custody, where there was an ongoing investigation by COPFS, where an FAI determination was yet to be made, the deaths of people in Police custody, or deaths following formal release from prison.

Children and young people

All people located in prison, including young people under 21 and children under 18 held in Young Offender Institutions, are currently subject to the Prison Rules.[2] The Review noted that responses by the SPS and NHS to clinical emergencies and deaths in prison were not differentiated by age during the Review.

Although the Terms of Reference cover people held in prison custody or Young Offender Institutions, none of the deaths in custody experienced by families who came forward to participate in the Review involved a child under the age of 18; none of the people interviewed were under 18 years of age; and the rules currently applied to children and young people in prisons and Young Offender Institutions are the same as those applied to adults.

However, the Review recognises the important additional protections that apply to children, including under the UN Convention on the Rights of the Child, which requires, among other things, the application of child-friendly policies and practices, with appropriately trained personnel, and the need for the systematic collection and analysis of disaggregated data and regular evaluations of the effectiveness of measures taken. These particular rights are covered in the chapter on human rights, and in more detail in the online appendices. The Review has drawn on these rights as well as on the literature review in order to include child-specific recommendations where possible.

While the remit of the Review was to consider the response to deaths in custody and not to review Scotland's approach to imprisonment or the causes of deaths in custody, it is important to note that the Review shares concerns expressed by others regarding the incarceration of children and young people. We support the work of the Children and Young People's Commissioner and others working to see an end to the imprisonment of children and young people in Scotland. We also support the recommendations of The Promise that 16- and 17-year olds should not be placed in Young Offender Institutions for sentence or remand.

2 The Prisons and Young Offenders Institutions (Scotland) Rules 2011 (legislation.gov.uk)

3. Methodology

The Review was grounded in a human rights-based approach that also recognised the gravity of the subject and the potential impact on the grieving relatives. Within that framework and understanding, the Review commissioned expert reviews, considered all relevant policies and documentation, and consulted users and stakeholders. The full methodology is available in the online Appendices.

Human Rights-Based Approach (HRBA)

The Review adopted a human rights-based approach, using PANEL principles (Participation, Accountability, Non-discrimination, Empowerment, Legality) to inform each stage of the design and delivery of the Review.

Human Rights Legal Framework

The Review had regard to the relevant human rights provisions in domestic and international law. These are summarised in the following Chapter and further detailed in the online Appendices. This legal framework provided a structure for analysis and evaluation of existing documents, policies, and procedures and provided the basis for identifying good practice, spotting gaps in the procedures, and developing recommendations.

Literature Review

A comprehensive review of local, national, and international literature was commissioned from Dr Briege Nugent and Dr Gemma Flynn. This was used to inform and later substantiate the information received from speaking with users. The full Literature Review is included in the online Appendices.

Prison Policy Review

Some policies have been frequently updated, and the analysis below relates to the most recent iteration unless otherwise stated.

We reviewed the following documents:

- Death in Prison Learning, Audit and Review (DIPLAR) Guidance – Revised December 2020. DIPLAR guidance has been updated a number of times in recent years.
- Critical Incident Response and Support (CIRS) policy guidance.
- Guidance on the role of the Chaplain following a death in custody.
- Family support booklet.

We also reviewed relevant documents from Scotland's two privately-run prisons, HMP Addiewell run by Sodexo, and HMP Kilmarnock run by Serco. Both privately-run prisons follow the DIPLAR process; however, supplementary policies in operation in each establishment were reviewed.

- Sodexo – HMP Addiewell policies: Operational Procedures following a Death in Custody.
- Serco – HMP Kilmarnock policies: Standard Operating Procedure – Operational Procedures following a Death in Custody (KSOP 35 Death in Custody).

NHS Policies and Serious Adverse Event Reviews (SAERs)

Seventy-one documents were initially received and reviewed across the nine Health Boards with a prison in their area regarding responses to deaths in custody.

We also requested good practice examples and copies of SAERs. A total of 10 SAERs were received.

DIPLAR

The SPS supplied the Review with all DIPLARs completed between January 2018 and December 2020. An initial batch of 20 DIPLARs (where the FAI had also been concluded) was provided, with a further 73 DIPLARs provided once SPS had received assurance from COPFS that this was appropriate and within the scope of the Review.

DIPLAR and FAI Comparison

We conducted a comparison of the learning and action points detailed in the initial 20 DIPLARs sent from SPS, against the (concluded) FAI determinations and recommendations. FAI determinations had not concluded for the other 73 cases.

Expert Review

Phil Wheatley, the retired Director General of the National Offender Management Service, and frequently an expert witness used by COPFS, undertook a review of current policy and approaches to deaths in prison custody in Scotland. Dr Alan Mitchell, President of the Committee of Prevention of Torture of the Council of Europe, former Scottish Human Rights Commissioner, and practising GP, advised the Review on the findings of the healthcare policies and documentation.

Engagement

A key aspect of a human rights-based approach is the requirement to ensure those most affected by a policy or procedure are included in making decisions and developing policy in the relevant area. The Review took active steps to involve and engage families of those who have died in custody; NHS and SPS staff affected by a death in custody; and people held in custody affected by a death.

We undertook the following activities:

Families

At our request, The Crown Office wrote to all 63 families who had been involved in an FAI regarding a death in prison custody over a two-year period (1 April 2018–31 March 2020). The Co-Chairs also put out a call on social media. In response, 23 people from 17 families (about a quarter of those who had been through a FAI in the relevant time period, plus one family that had not yet been through an FAI) came forward to take part in the Review. COVID-19 restrictions were in place throughout the Review period, and a few families subsequently withdrew. In the end, we conducted interviews by phone or virtual technology with 20 people from 14 families (a fifth of all families that had been through an FAI, plus one additional family).

The Review also invited families to volunteer to take part in a Family Advisory Group if they wished. A Family Advisory Group met monthly for the duration of the Review, with a total of 12 people from eight of these families taking part, and family members acting as Chair and Vice-Chair. The Advisory Group informed the work of the Review throughout, suggesting and commenting on the questions for families, staff, and people held in prison as well as the aims and methods of the Review.

In addition to direct interviews and discussions with families, the Helpline team from Families Outside collated inquiries from families from 1 January 2019–1 January 2020 regarding concern for someone in prison.

People in prison custody

Six prisons across the prison estate were approached (based on rate of death, cross-section of particular populations, and other factors) to provide a long list of people with experience of a death in custody within the timeframe of the Review.

- In total, 10 men in prison custody from across 5 prison establishments were interviewed. We were unable, despite significant efforts, to secure the participation of any women. The Review acknowledges that this is an area in need of further research.

People who had previous experience of prison custody

An invitation to participate in a focus group was circulated to members of the HMIPS Prisoner Advisory Group, volunteers with lived experience who can advise HMIPS. Unfortunately, however, we were unable to secure the participation of anyone with previous experience of prison custody.

Prison staff sessions (management, operational, Chaplain)

Despite our best efforts, the Review experienced challenges in securing the participation of prison staff and was unable to exercise control around ensuring randomised selection of participants and informed consent.

In total, 78 individuals in the Prison Service spoke with the Review either via one-to-one interview, focus groups, or via an online survey. This included 69 staff and 9 Chaplains, including 19 SPS and 11 private prison staff, 18 senior management staff, and 12 operational staff.

NHS staff sessions (senior and operational)

In partnership with Healthcare Improvement Scotland (HIS) colleagues, the Review contacted the Prison Healthcare Network and all Health Board Prison leads.

In total, 44 NHS staff members took part in the Review: 41 NHS staff members took part in 16 one-to-one or focus groups sessions, with only three people completing the online survey.

The Review recognises that the sample size of both NHS and prison staff was small given the overall number of staff working in prisons.

4. Human Rights Framework

In Scotland, the rights protected by the European Convention on Human Rights (ECHR) are given direct effect through the Human Rights Act 1998 and the Scotland Act 1998. In short, this means that public authorities, including the Scottish Prison Service and private prisons operating in Scotland, are obliged to comply with ECHR rights. Cases alleging breaches of the rights protected by the ECHR can be argued directly in Scottish courts. A fuller discussion of the ECHR framework specifically relating to deaths in custody can be found in the online Appendices.

In addition to the ECHR, the UK has ratified a number of international human rights treaties which are binding on the UK and Scottish Governments. These include, for example, the International Covenant on Civil and Political Rights, the Convention against Torture, and the Convention on the Rights of the Child. There is a significant body of international guidance which reflect and interpret these international obligations, providing a point of reference for good practice in the treatment of prisoners and prison management. A fuller discussion of relevant international human rights standards and guidance is available in the online Appendices.

The following chapter provides a summary of the human rights framework the Review used.

European Convention on Human Rights

Right to Life

Article 2 of the ECHR protects the right to life. Article 2 enshrines one of the basic values of the democratic societies making up the Council of Europe. It is a non-derogable right, which means that the State cannot depart from its obligations even in times of war or other national emergency.

The State has a number of obligations under the right to life in Article 2:

Negative duty

The State must refrain from the taking of life, unless this occurs in very narrow circumstances set out in Article 2, such as where it is absolutely necessary in self-defence; this is known as a negative duty.

The Article 2 right to life also strictly regulates the use of force by State agents. Use of force which may result in deprivation of life must go no further than absolutely necessary and be strictly proportionate to the achievement of the aims set out in Article 2: in defence of any person from unlawful violence; in order to effect a lawful arrest or prevent the escape of a person lawfully detained; or in action lawfully taken for the purpose of quelling a riot or insurrection. The European Court of Human Rights (ECtHR) has considered a number of cases where death was hastened by the use of restraint or arrest techniques. In these cases, the court examined whether there was a causal link between force used and the death of the person concerned, and whether authorities provided appropriate medical assistance.[3]

3 Mojsiewjew v Poland, no. 11818/02, 24 March 2009.

Positive duty

In addition to refraining from the taking of life, the State also has positive obligations under Article 2. These positive obligations can be summarised as:

- ensuring the effective protection of the right to life through effective domestic law and punishment; and
- the duty to protect life through the taking of specific actions.

The ECtHR has held that the Article 2 right to life imposes an obligation on the State to do "all that could have been required of it to prevent the applicant's life being avoidably put at risk".[4] The obligation applies when the State knew or ought to have known of a threat to life[5] and has been found to apply in a number of different contexts. A number of those contexts are particularly relevant to the work of the Review:

- protection of people from lethal use of force by non-state actors, for example protection from threats from other prisoners.[6]
- protection from self-harm.[7]
- protection of people deprived of their liberty and the provision of appropriate healthcare.[8]

Examples of circumstances the ECtHR has found to amount to a breach of the positive duty, through the failure to take adequate steps to protect people in the above listed contexts, are included in the online Appendices on the ECHR.

Deprivation of liberty creates particular vulnerabilities in terms of the right to life, and the State's obligations are therefore heightened in these circumstances. The State owes a duty of care to those held in prison custody. In the case of *Salman v Turkey,* the ECtHR described the obligations as follows:

Persons in custody are in a vulnerable position and the authorities are under a duty to protect them … The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent where that individual dies.

Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during such detention. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation.

When someone dies in prison custody apparently as a result of a health problem, the State must provide an explanation as to the cause of death and the treatment administered to the person prior to their death.[9] The ECtHR has found fault in various cases involving inadequate medical treatment to those in custody.

Procedural obligation

When a life has been lost in circumstances that may engage State responsibility, there is a duty to undertake effective investigations. This is often referred to as the procedural aspect of the Article 2 right to life. The obligation to investigate extends to all cases of alleged breaches of the obligations discussed above.[10] The purpose of an investigation under Article 2 is to secure the effective implementation of domestic laws safeguarding the right to life and to ensure accountability for deaths that have occurred under a state's responsibility.[11] State authorities must act of their own motion once a matter has come to their attention.

4 LCB v UK, no. 23413/94, 9 June 1998.
5 Osman v UK, no. 23452/94, 28 October 1998.
6 Paul and Audrey Edwards v UK, no. 46477/99, 14 June 2002.
7 Renolde v France, no. 5608/05, 16 January 2009.
8 Dzieciak v Poland, no. 77766/01, 9 March 2009; Tarariyeva v Russia, no. 4353/03, 14 December 2006.
9 Slimani v France at 27; Kats & Others v Ukraine at 104.
10 Armani da Silva v UK, no. 5878/08, 30 March 2016.
11 Nachova v Bulgaria, no. 43577/98, 6 July 2005, at para. 110.

It must not be left to family members to lodge complaints before investigations are triggered.[12]

The standards of investigation can be summarised as follows:

- **Independence** – Those carrying out the investigation must be independent from those implicated in the events. This requires "not only a lack of hierarchical or institutional connection but also a practical independence".[13]
- **Adequacy** – An adequate investigation is one that is capable of gathering evidence sufficient to determine if the behaviour or inactivity was unlawful.[14] Investigative authorities must take reasonable steps to secure evidence concerning an incident.[15] Where there has been a use of force by State agents, the investigation must be adequate and effective in that it should be capable of leading to a determination of whether the force used was justified.[16]
- **Promptness and reasonable expedition** The ECtHR has stressed that a prompt investigatory response is generally regarded as essential in maintaining public confidence in a state's adherence to the rule of law and in preventing the appearance or perception of a state's collusion in or tolerance of unlawful acts.[17] The Court has also found that the passage of time is liable to undermine an investigation and will compromise its chances of it being completed.[18]
- **Public scrutiny and participation of next of kin** – In all cases, there must be involvement of a deceased's next of kin to the extent necessary to safeguard their legitimate interests.[19] There will often be a lack of public scrutiny of Police investigations; however this can be compensated for by providing access for the public or the victim's relatives during other stages of the available procedures.[20]

Torture, inhuman, or degrading treatment

It is important to note that deaths in custody, while primarily triggering obligations under the Article 2 right to life, can also engage Article 3 ECHR, which protects against various forms of ill-treatment amounting to torture, inhuman, or degrading treatment or punishment.[21] For ill-treatment to amount to inhuman treatment under Article 3, it must attain a minimum level of severity. In particular, inhuman treatment must cause "either actual bodily injury or intense physical or mental suffering".[22] Torture is a particularly severe form of inhuman treatment and has been defined by the ECtHR as "deliberate inhuman treatment causing very serious and cruel suffering".[23]

The ECtHR has previously found certain deaths in custody to amount to a breach of Article 3 where there was no finding of a violation of the right to life in Article 2.[24] The failure to provide a timely diagnosis or medical care, including psychological care, may also amount to inhuman or degrading treatment.[25] Article 3 carries similar positive and negative obligations to Article 2, including a procedural obligation to conduct a thorough and effective investigation where a person raises an arguable claim of ill-treatment in breach of Article 3.[26]

12 Al-Skeini and Others v UK, no. 55721/07, 7 July 2011.
13 Armani da Silva v UK, no. 5878/08, 30 March 2016 at para. 232.
14 Armani da Silva v UK, no. 5878/08, 30 March 2016 at 243.
15 Armani Da Silva v UK, no. 5878/08, 30 March 2016.
16 Armani Da Silva v UK, no. 5878/08, 30 March 2016.
17 Al-Skeini and Others v UK, no. 55721/07, 7 July 2011.
18 Mocanu and Others v Romania, nos. 45886/07, 32431/08 and 10865/09, 13 November 2012.
19 Al-Skeini and Others v UK, no. 55721/07, 7 July 2011.
20 Hugh Jordon v UK, no. 24746/94, 4 August 2001.
21 Keenan v UK; McGlinchey and Others v UK, no. 50390/99, 29 July 2003 regarding lack of access to appropriate medical treatment in violation of Article 3.
22 Kudla v Poland, no 30210/96, 26 October 2000.
23 Ireland v UK, no. 5310/71, 18 January 1978.
24 Keenan v UK; McGlinchey and Others v UK, no. 50390/99, 29 July 2003.
25 For example, Kolesnikovich v Russia, 22 March 2016 at para. 72 - 81.
26 Gafgen v Germany, no. 22978/05, 1 June 2010 at para. 117.

Right to respect for private and family life

Article 8 ECHR protects the right to respect for private and family life, home, and correspondence. It is a qualified right, which means public authorities can impose such restrictions as are lawful, necessary, and proportionate in order to meet certain specified needs such as protecting public safety and preventing disorder or crime. The ECtHR has previously found violations of the Article 8 rights of persons held in prison custody in relation to their contact with the outside world, for instance in the arrangements made for visits and correspondence[27]. In other contexts, Article 8 has also been found to apply to family members regarding the way in which the body of a deceased relative is treated.[28]

Non-discrimination

Finally, Article 14 protects the right not to be discriminated against in "the enjoyment of the rights and freedoms set out in the Convention". This means that the right not to be discriminated against does not exist independently under the ECHR; it must be connected to the fulfilment of another Convention right. This does not mean that there must be a violation of another Convention right before Article 14 applies, simply that the right must be engaged.[29]

The ECtHR has defined discrimination as "treating differently, without an objective and reasonable justification, persons in relatively similar situations".[30] Article 2 right to life investigations require particular attention to be paid to questions of prejudice and discrimination and whether this may have been a factor in a person's death.

Protections against acts of discrimination also exist in domestic law. The Equality Act 2010 makes it unlawful to discriminate, harass, or victimise a person based on a protected characteristic.[31] This legislation also requires Scottish Ministers, executive agencies like the Scottish Prison Services, and public authorities to think about how they could minimise discrimination and promote equality when formulating policies or making decisions.[32]

A fuller discussion of the ECHR standards is available in the online Appendices.

International human rights law and guidance

There is a substantial body of international legal standards and guidance relevant to deaths in custody. The online Appendices includes a compilation of key sources the Review has had regard to in conducting the Review. In common with the rights protected under the ECHR, international human rights law protects the right to life and freedom from torture, inhuman, and degrading treatment,[33] and stresses the heightened duty of States to take necessary measures to protect the lives of people deprived of their liberty, which includes providing necessary medical care, shielding from inter-prisoner violence, preventing suicide, and providing reasonable accommodation to disabled prisoners.[34]

International human rights law also stresses the need for appropriate investigations into arguable breaches of the right to life. Investigations must be independent, impartial, prompt, thorough, effective, credible, and transparent. The involvement of a deceased person's next of kin in the investigation is also of paramount importance.[35]

A number of resources have been developed on the response to deaths in

27 See Guide on the Case-Law of the ECHR: Prisoners' Rights for further discussion of Article 8 caselaw

28 Girard v France, no. 22590/04, 30 June 2011 and Pannullo and Forte v France, No. 37794/97, 30 October 2001.

29 This is referred to as the Court's 'ambit test'. See Rasmussen v Denmark, no. 8777/79, 28 November 1984

30 Zarb Adami v Malta, no. 17209/02, 20 September 2006.

31 The protected characteristics are Age; Disability; Gender reassignment; Marriage and civil partnership; Race; Religion or belief; Sex; Sexual orientation. See for definitions of each.

32 S.149, Equality Act 2010.

33 Article 6 ICCPR.

34 Human Rights Committee, General Comment No. 36 on the Right to Life, para. 25.

35 For example, Human Rights Committee, General Comment No. 36 on the Right to Life, para. 28.

custody, providing state authorities with detailed guidance on the requirements. For example, Rule 72 of the United Nations Standard Minimum Rules for the Treatment of Prisoners,[36] the Mandela Rules, stipulates that:

> **... the prison administration shall treat the body of a deceased prisoner with respect and dignity. The body of a deceased prisoner should be returned to his or her next of kin as soon as reasonably possible, at the latest upon completion of the investigation. The prison administration shall facilitate a culturally appropriate funeral if there is no other responsible party willing or able to do so and shall keep a full record of the matter.**

Further resources include: the UN Manual on the Effective Prevention of Extra-Legal, Arbitrary and Summary Executions (known as the Minnesota Protocol); the Council of Europe CPT Effective Investigation of ill-treatment: Guidelines on European Standards, and the Bangkok, Beijing, and European Prison Rules. These various resources consolidate international expertise and best practice and provide useful provide benchmarks for assessing domestic arrangements for the prevention and investigation of deaths in custody.

The Convention on the Rights of the Child contains a number of important provisions relevant to those aged under 18, with particular emphasis on the need reduce detention to a minimum, particularly pre-trial detention; the application of child-friendly policies and practices, with appropriately trained personnel; and the need for the systematic collection and analysis of disaggregated data and regular evaluations of the effectiveness of measures taken.

A fuller discussion of the applicable international human rights standards and guidance is provided in the online Appendices.

Application of standards to deaths in custody

The Review has had regard to the above standards in considering areas for improvement to ensure appropriate and transparent arrangements are in place in the immediate aftermath of deaths in custody.

The FAI process is currently the principal way in which Scotland addresses the procedural requirement of the right to life in relation to deaths in custody. Assessment of compliance with the requirement for an effective investigation would involve consideration of the whole process. It was therefore not within the remit of the Review to consider if Scotland is complying with the procedural aspect of the right to life by conducting an effective investigation, as consideration of the FAI process is outwith that remit.

However, it is appropriate to apply the Article 2 effective investigation requirements to the whole process and therefore, in taking a human rights-based approach, the Review had those requirements in mind in reviewing the steps taken immediately following a death, prior to the FAI. In the course of obtaining evidence, concerns were also highlighted by families and SPS and NHS staff which echoed the findings of separate reviews of the FAI process. Given the importance of ensuring that the voices of families were heard in this Review, we have included summaries of that evidence and recommendations related to the FAI process which were of particular importance to families.

In addition to the strict requirements for an effective investigation, it is important that the overall substantive obligation to protect life, including by taking reasonable steps to prevent someone's life being avoidably put at risk, be taken fully into account in considering the approach taken to deaths in custody and the steps in place to ensure appropriate learning and action to prevent recurrence. This is similarly the case for the duty to prevent torture and inhuman or degrading treatment.

36 (Mandela Rules)

5. Findings and Key Recommendations

We have summarised our findings and key recommendations into six sections, following a structure that broadly mirrors the typical order of key events and processes associated with a death in custody.

We begin with engagement with families prior to a death, then look at contact and support for families and everyone else affected by the death. We then examine the internal SPS and NHS inquiry mechanisms that seek to establish the cause of death and learn from it in the immediate aftermath. Finally, in those cases in which a completed Fatal Accident Inquiry (FAI) had taken place, we compare its findings to the learning recorded in the preceding SPS documentation.

We have therefore presented our analysis, findings, and key recommendations under the following headings:

5.1 Family contact with the prison and involvement in care before the death
5.2 Policies and processes following a death
5.3 Family contact and support following a death
5.4 Support for staff and other people held in prison after a death
5.5 Review of SPS and NHS internal documentation concerning the death
5.6 Comparison of learning from internal prison review and FAI findings

5.1 Family contact with the prison and involvement in care before a death

5.1.1 Summary of current process

- Reception process which screens new arrivals to the prison
- First night in custody processes which adds to the assessment of risk
- Talk to Me (the SPS Suicide Prevention Strategy)
- Induction for new arrivals
- Personal Officer responsible for a caseload of prisoners
- National Suicide Prevention Advisory Group.

Bereavement by death in prison is distressing and traumatic for families. It can also be traumatic for all the people involved in their care and those who lived beside them. Actions and policies leading up to the death in custody therefore have a bearing and must be considered (Wheatley, 2020). It is noticeable that none of the processes listed above specifically refer to family contact. There are opportunities to engage with families in all of these processes, but this does not often happen in practice.

The right to life in Article 2 of the ECHR requires that States take reasonable steps to prevent avoidable risk to life. Good prison policy must therefore be effective to prevent avoidable deaths in custody. Prison policy and practice must ensure that people held in prison who have psychological, medical, mental ill health, or other vulnerabilities are dealt with by both the Prison Service and the NHS, as far as practicable, in ways that reduce any reasonably foreseeable risks. Article 2 emphasises the State's obligation to take appropriate steps to minimise threats to life which the authorities know about or should have known about.

Families want involvement in decisions around the care of the person in prison and believe that the information they provide can help ensure an individual's vulnerabilities are identified, supported, and threats to life are minimised. Importantly, this would also reduce the distress for the families should a death occur.

5.1.2 Family involvement in care before a death

Most of the families who participated in the Review had not had any discussions with the prison about the health and wellbeing of their family member when they entered prison. This was sometimes because they did not feel they had a reason to worry or, more frequently, because they did not wish to interfere.

Some families, however, did have concerns about their family member in prison, some of whom had long-standing serious mental and physical health issues. In most cases, they did not contact the prison themselves but encouraged their family members in prison to seek help. A very small number of families spoke about alerting the prison to their concerns. One family alerted the Police at the point of arrest and followed this up with contacting prison staff early on in the sentence. The other family became concerned during the course of the sentence but said they could not get information or response from the prison other than that "their family member was fine". In two cases, the families heard from other people held in prison that their family member was not well, but they did not hear from the prison staff in this regard.

Interestingly, families who had had experience of someone in a secure health care setting said that the NHS notified them about their family member being taken into their care, providing contact details for the family if they had any concerns. Where someone was in hospital, families said they were able to communicate with the hospital staff or even (though not consistently) the contracted prison escort staff, which they found helpful. Having the ability and knowledge and where and to whom families can raise concerns is clearly important. However, patient confidentiality requires consent for prison and NHS staff to be able to share information.

5.1.3 Ability of families to raise concerns before a death

For most of the families, the death came as a real shock. Sometimes the person in prison was shortly due for release or had been in good health prior to the death, so they had felt no pressing reason to express concern. For others, concern about the person in prison was a normal state of affairs – "a lifetime of concern" or long-standing health issues that would not change due to their engagement with the prison.

There were, however, notable exceptions, where the family had noticed a change in behaviour in their family member, going from regular communication to none. The family contacted the prison to express their concern, as a similar change in behaviour had preceded a suicide attempt in the past. Another family said they had also made regular contact with the prison - at least eight times - to express concern, but they felt their efforts were not being taken seriously.

Some families also queried what would trigger contact from the prison. One family said a Governor had told them that protocol was only to contact the next of kin in a 'life or death' situation, but their family member had been taken to hospital by emergency ambulance without informing them.

This lack of proactive contact of family members is contrary to research which found that many people in prison actively maintain bonds with their parents throughout their sentence (Dixey and Woodall, 2012; Holligan, 2016). It also raises the challenges and limitations of the narrow status of 'next of kin', with recent academic work proffering that "expanded conceptions of family members of the incarcerated" (Christian, 2019: 84) is required in order to grasp the emotional impact a custodial sentence [and arguably a death in prison] can have on an extended group of invested parties.

The families participating in the Review raised a number of issues about the care their loved ones had received when in prison:

- nurses who were unable to operate equipment, or equipment that was not charged enough to function;
- not having the right equipment or medication to revive people;
- nurses who were reported to have been giggling (not an unusual response to a stressful situation, but inappropriate) and appeared to be young and inexperienced;
- medical staff not being given access to help people who were being restrained, or not being given information about what had happened;
- apparent lack of information from community-based GPs about medication, or a lack of communication with the family about medication;
- perceptions of "dispassionate" treatment, with people being given paracetamol and sent back to their cells rather than being taken more seriously;
- long waiting periods for appointments;
- difficulty accessing doctors, while nurses gave out medication and coped as well as they could.

Other concerns about care extended beyond prison-based health care staff to include questions about why people who were terminally ill and unable to move needed to be handcuffed to their hospital beds, on some occasions against the recommendations and requests of the hospital staff. Two families raised concerns about not being informed about the possibility of compassionate release or being denied it when they felt it would have been appropriate.

Despite such concerns, worryingly none of the families said they knew whom to contact to share these concerns. Two families said they had contacted Families Outside for help, one of whom knew about this service through her own work, and the other through doing their own research. The latter also learned about and contacted the prison's Family Contact Officers, mental health nurses, prison officers, and solicitors but said they received conflicting information and that, even for their family

member, they were basically "navigating a foreign system". A third family said they had simply phoned the prison but did not have a specific point of contact, while others said their only point of contact was their family member in prison.

Even knowing whom to contact did not always help: one mum said that she assumed she could contact the Governor but that she "wouldn't have dared to do that" because of her son's request not to interfere.

One family again highlighted the contrast between their experience with prison and their experience with secure mental health facilities such as the State Hospital. Whist they are not like-for-like institutions, the next of kin received a letter and contact details from the State Hospital, though even then, communication was not always consistent.

> **"**I was his next of kin [when he was] in Carstairs. They kept in touch for about a year. I do not know how many years he was in there. I know he got put back in there because he ran at a wall and bashed his head deliberately. [I] got a letter to say he was being moved back to [name of prison] in two months or something. I feel sympathy for him, because if things had happened earlier… everything is maybes and should'ves. He obviously couldn't live with it, and now he's at peace. He told me on the phone he was having bad thoughts.**"**
> (family member)

Families universally expressed a desire for information such as a specific point of contact or information sheet. Good practice experienced in other institutional settings could be replicated. Families expressed a need for information and communication once someone had been transferred to hospital, for example regarding how to transfer their money or belongings to the hospital or how to get their clothes cleaned. There were mixed views on the contracted prison escort staff, where some were very helpful with this in hospital, but one member of the escort team in particular was perceived as deliberately obstructive and, as an example, the family said it took 43 requests for belongings to be sent from the prison to the hospital.

5.1.4 Ongoing healthcare and support

Responsibility for the provision of health care services to people in prison custody transferred from the SPS and private sector to NHS Health Boards in Scotland in 2011. As part of that transfer, a Memorandum of Understanding (MOU) between Scottish Ministers and the relevant Health Boards was agreed. The MOU commits all parties to the agreement to preserve life and reduce harm recognising that prison and health care staff will be able to work more successfully if they share relevant information from their respective organisations.

Concerns have already been raised regarding the sharing of information, low morale, and lack of wider understanding in the wider NHS of the role of prison care (Royal College of Nursing, 2016; Scottish Government, 2017). This wider context of understanding is replicated in a number of recent reviews and reports that highlights the importance of joint working and information sharing in prisons, for example, the Expert Review of Mental Health in HMP YOI Polmont (2019a).

There are unique challenges faced in the prison setting (Perry et al, 2010) that can have a demoralising effect and make staff training, recruitment, and retention in this area a challenge. In previous studies, clinical staff reported feeling conflicted in their desire to view the people in prison custody as a patient, illustrating "the moral conflict that can be engendered by the current practice of imprisoning increasing numbers of older, frail people, and how important it is for staff to maintain their humanity (Turner and Peacock, 2017: 63). They also reported that the moral conflict of providing care for people held in prison and the public view of this practice can add to a reluctance to share experiences, confront challenges, or share models of good practice outside their workplace for fear of criticism by family, friends, and even sections of the media (ibid.)

Families wanted access and delivery of health care for their loved ones, including preventative care, to be as good in prison as that in the community and were concerned that this principle of equivalence with primary care being the same in the prison as the community was not being respected or achieved.

Part of the desire for equivalence for families included ensuring, through prison and health care staff training, that their family member was viewed as a person or a patient, rather than a prisoner or an addict.

Throughout the Review, our researchers saw a regular deference to prison processes above NHS processes. We also saw examples of the prison acting as the "carer" (rather than the family, as per mental health legislation). Prison staff took responsibility for transfers to hospital and for addressing any concerns prior to a death, with families (including next of kin) completely excluded from notification of these issues. Orchard Clinic, an NHS facility in Edinburgh, was flagged by one family as a model of good practice in terms of family engagement, signalling the need for parity between care under the NHS and care in prisons.

Families are often regarded as no one's responsibility (Loucks, 2019). From the Review, it was stark that families reported that they needed to have a voice, that they are taken seriously, and that their concerns are heard, both before and after a death. Throughout the Review, lack of information, lack of engagement, and even ineligibility for Legal Aid after a death contributed to this perception of lack of voice. This is in contrast to the research which shows the wealth of insight, knowledge, and suggestions for improvement that families can, and have, brought (Harris Review, 2015; INQUEST, 2020).

Families also universally expressed the need to be able to raise their concerns, ask questions, and be taken seriously. The majority of families had a poor experience when they contacted the prison with serious concerns, with responses varying from no one responding through to a perception of indifference. Reports of good responses were rare.

Communication with the prison, even when attempting to raise legitimate concerns, was a consistent source of frustration. The Harris Review termed this "institutional insensitivity" (2015: 164), a term which communicates not an intentional callousness on the part of individuals but a broader picture of neglect which can leave families with a feeling of having been forgotten or ignored.

SPS staff, however, commented that families can go directly to the prison, they can write, email, phone in, and use recently established electronic concern forms. They detailed that calls will usually be directed to the area where the person in prison is held, and an officer may speak to the family directly if appropriate. Newly, instituted concern forms were routinely cited as an area where concerns would be raised and actioned.

People in prison custody reported separately that access to appropriate and timely support, whether prison staff or NHS, was often lacking or inadequate.

Although there were issues over access, capacity, delays, and procedures, there were also positives and evidence of caring staff taking their duties seriously. While some people held in prison reported swift access to good care, and supportive staff who would action concerns, many did not. People in prison custody were very concerned that issues were not taken seriously or actioned timeously giving multiple examples of the referral and complaints system simply not working.

5.1.5 Training

Staff training also evidenced a mixed picture, with senior managers believing that training for response to a death in custody is strong and very process-driven, while front-line staff described it as very limited, with no specific or formal joint training.

One of the best ways of reducing the stress of dealing with a death in prison is to prepare prison and healthcare staff for the emotional impact it may have on them but also to be practised and comfortable through training in their respective roles.

The two main strands in response to a person who is non-responsive - emergency response training and contingency plans - were articulated well by senior management. In contrast, there was no description of explicit or dedicated training for deaths in custody described by prison staff, and for NHS staff, it concentrated on clinical procedures.

Overwhelmingly, the majority of clinical staff interviewed by the Review highlighted a lack of joint training with prison staff prior to an adverse incident as an issue. They were clear about their role in providing clinical emergency response and care to their patient, but the roles and responsibilities aside from the clinical procedures between health care staff and prison staff, particularly with regard to who should take charge in a life-threatening situation or when handover should occur, did not have the same clarity.

SPS and NHS staff felt strongly that they needed joint training in everything from the immediate response to a serious incident to handling the media. There was an overwhelming sense that this would be of value and help prepare staff for all emergencies including deaths in custody. Contingency testing and scenario training were not felt to be regular embedded practices.

There was a general acknowledgement too from prison staff that if training is not regularly provided or put into practice, learning can drift.

"Think we should train our first line and middle managers to deal with these incidents. Instead of it just becoming a case of dealing with it when it comes. Instead of training and developing awareness of it. There's 101 things that you need to do as a manager at the one time. There's a whole raft of things that need to be addressed. We don't have that specific training – how do you manage that death in custody? There's a big hall with [X] odd prisoners, and maybe only one manager. Unless you've got that incident command background, you've not been trained to keep logs, etc.**"**

(prison staff member)

NHS and prison staff responses around the awareness of Critical Incident Response and Support (CIRS), Death in Prison Learning and Review (DIPLARs) and Fatal Accident Inquiries (FAIs) prior to experiencing a death in custody were broadly similar, expressing ambiguity surrounding their scope and function.

In terms of the preparation or training aspects, there was a patchwork of awareness, knowledge, and attendance for each. For many staff, elements of uncertainty existed around all of the processes: CIRS, DIPLARs, and FAIs. This was further complicated by the involvement of prison chaplains in support of the family after a death in custody, (SPS, 2020a), whose primarily pastoral role and lack of specific prison training meant they were not as familiar with prison processes and procedures as senior or operational staff.

Prison staff and Chaplains regularly described having learned "on the job" from colleagues. Learning from colleagues is of course a vital element of learning in any role, but for serious events, it can lead to very variable practice, and this variability across establishments came through very strongly from the discussions with staff and the survey responses.

Learning from other staff necessarily makes a number of assumptions, namely that the colleague from whom a staff member is learning:

- is more experienced;
- has direct experience of deaths in custody; and
- employs good practice when a death is encountered.

This highlights that, currently, responses to deaths in custody are primarily experiential. Staff rely on deaths and their colleagues' responses to deaths to learn best practice in how to respond.

Some new staff in post remarked that they had no prior training and, given their employment before entering the Prison Service, discovery of a death or being involved in the response to a death was a 'totally alien' experience. Their professional lives before joining the Prison Service were often very different. These staff

did not feel at all prepared to deal with a death in custody in their first few months, whether they were first on the scene or not.

"Did not feel prepared at all. Wasn't first on the scene but in the area. Totally alien to me. You get used to it – cope with it."
(prison staff member)

"I went from working in a shop to two months later finding a body in a cell. We got first responder and CPR training, so knew to shout a code blue but the way they spoke about it was very casual, it's not as easy as that at the time."
(prison staff member)

Staff who had been in post for some considerable time acknowledged the procedural training improvements that had occurred over time. Staff collectively remarked that years ago there was nothing so, relative to that, they remarked that the current training felt progressive.

A relatively common theme that emerged from staff was that people often shy away from the possibility of a death in prison. Whilst a difficult topic to broach, staff (particularly new staff) wanted to be made fully aware of the possibility of discovering or responding to someone who was non-responsive.

"People do not like to talk about deaths in custody – they just want to get back to work. I've experienced all sides [in various roles], no formal training as such but training we get in other areas maybe touches on it. Awareness training would be good. "This is something that could happen in your job". Procedural awareness of things that need to be done."
(prison staff member)

Those staff who discussed the annual Talk to Me (TTM) training, part of the Prevention of Suicide in Prisons Strategy and Scotland's wider Mental Health Strategy, spoke about it positively and viewed it as good practice. However, they held a view that, while training in the prevention of self-harm and suicide was focused and well-managed, training and preparation for the response of a death in custody did not have the same rigour.

"We get TTM which is suicide prevention, which is vital. How to deal with people who are suicidal. Mainly focused on that, less on how do we deal if we find someone and how could we react and how others react. All different kinds of feeling and emotions."
(prison staff)

"Training required on yearly basis is TTM. It's just the core TTM training. For after a death in custody, there isn't any further training."
(prison staff member)

While the Review acknowledges that good practice exists, individually good or accidentally good practice does not equate to systematic good practice in preparing staff to deal with an individual's death in custody.

A positive systemic response to raising and responding to concerns, information sharing, consistent practices and procedures, and joint training for all staff involved in serious incidents including prison Chaplain, requires established good practice which is followed uniformly across the prison estate as a whole, led, maintained, updated, and cascaded by both the prison, private sector, NHS, and senior management.

Staff put forward the types of improvements they would like to see with regard to preparation and training for their roles in relation to responding to deaths in custody. Staff wanted regular, blended, scenario-based, and online comprehensive training delivered uniformly across the estate that covers awareness, procedural, and support elements.

One staff member suggested that all updated communications relating to TTM, deaths in custody, and so on, be delivered via "bite-size" training to inform people, rather than emails and Governors and Managers Action (GMAs) being forwarded on. Written communications with front-line staff were perceived to have little impact.

NHS and SPS staff were clear that they would like roles and responsibilities more clearly defined and real and relevant examples of successfully managed incidents – essentially, exemplars of best practice.

Families called for a review of the procedures preceding a death in custody, a review of the prevention of all deaths in prison custody, as well as an overhaul of the suicide prevention strategy.

5.1.6 Key recommendations

- 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.
- The Scottish Prison Service and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.
- The SPS should develop a more accessible system so that, where family members have serious concerns about the health or wellbeing of someone in prison, these views are acknowledged, recorded, and addressed with appropriate communication back to the family.
- Permission should be sought on admission to prison that where prison or healthcare staff have serious concerns about the health or wellbeing of someone in their care, they should 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.

While the Review acknowledges that good practice exists, individually good or accidentally good practice does not equate to systematic good practice in preparing staff to deal with an individual's death in custody.

5.2 Policies and processes after a death

5.2.1 Summary of current process

- Police take control of initial death scene and contact family.
- CIRS initiated as support for staff.
- DIPLAR takes place within 12 weeks to establish any learning.
- NHS may carry out their own review process.
- Private sector providers undertake an inquiry under legal privilege.
- SFIU contact families regarding future FAI.
- Support for staff, other prisoners, and family initiated.

Once death has been confirmed, the Police are immediately informed by the SPS and the scene secured. All deaths in custody are subject to an investigation directed by the Crown Office Procurator Fiscal Service (COPFS) followed by a fatal accident Inquiry (FAI). The FAI process is described in more detail section 5.6. Other investigation processes outside the FAI include the SPS and NHS Death in Prison Learning and Review (DIPLAR) organised within 12 weeks of the death. In the privately-run prisons, the company conducts its own inquiry under legal privilege for any deaths which occur.

5.2.2 Role of Police Scotland in processes after a death and contact with family

On being informed of a death in custody, Police Scotland take control of the scene, with the immediate area secured and evidence gathered and preserved, along with statements taken from all who have been involved and possession of the body.

Any request to view the body of someone who has died in custody is the responsibility of Police Scotland and the Procurator Fiscal (PF). Our engagement with families mirrored the findings from research in England and Wales by INQUEST (2018) that a particularly sensitive issue for families is access to the body and post-mortems. Their research found that if there is poor transmission of information at this part of the process, not only does this exacerbate the grief of the families a great deal but can stoke the "(unintentional but strongly held) belief that the process lacks independence or is being used to hide evidence of wrong doing" (ibid.) It is suggested that authorities "must be sensitive and empathetic regarding family wishes to see and touch the body of their loved ones" (ibid.) and that neglect of this issue can breed suspicion on the part of families.

Police Scotland, who may have no experience of the prison system, have first responsibility for notifying the family, after which the Chaplain makes contact with the families on behalf of prisons (SPS, 2020a). Chaplains commented on the variability in how and when this happens, and the sensitivity shown by Police in notifying a deceased's next of kin, and how this can be problematic.

In contrast, in Scotland's two privately-run prisons, the responsibility for contacting the family of the deceased rests with a senior member of the prison staff and not with the Chaplain. Families did not regard the Chaplain as part of the prison system and preferred the private sector approach of contact with a senior manager. They felt this highlighted the seriousness of what had happened and acknowledged (at an appropriately senior level) that a person has died and a family has been left bereaved.

COPFS, in their Family Liaison Charter (COPFS, 2016), explain that the Police may appoint a Family Liaison Officer (FLO) to keep the family informed about the progress of the Police investigation. A FLO is an experienced police officer who has been specially trained to provide information to bereaved family members. At an appropriate stage in the investigation, this role will be transferred to COPFS staff.

5.2.3 Critical Incident and Response Support, and Death in Prison Learning, Audit and Reviews (CIRS)

The focus in the written guidance on the immediate response when a death in custody takes place is that the CIRS policy is initiated for staff. The guidance sets out that this

involves a staff support meeting which takes place as soon as possible after the incident and is discussed in more detail in the section on support after a death[37] (SPS, undated). All staff involved in the incident are offered the opportunity to attend, including the NHS and external partners. The purpose of the meeting is to ascertain the wellbeing of staff and not to learn from the incident (SPS, 2020b). The evaluation of Talk to Me (TTM) (Nugent, 2018) noted that, in the privately-run prisons, the CIRS process is replaced by the Post-Incident Care Team (PICT). Following a death, staff are also brought together in the same way as with CIRS, and offered support.

Subsequent to the CIRS, a DIPLAR is held within 12 weeks of the death; the DIPLAR process is discussed in more detail in the section on DIPLARs and SAERs.

Following a death by suicide or an event of undetermined intent, or drug-related, NHS staff report the incident through NHS clinical governance adverse event management processes (e.g. Datix, an incident reporting system), and a (serious) adverse event review (SAER) may be completed either prior to or following the DIPLAR.

Nugent and Flynn (2021) explain that the SPS issued a Governors' and Managers' Actions notice (GMA) 071A-18 (SPS, 2018) detailing the information establishments are to send to SPS HQ Legal Services Branch. This is to assist with the preparation of a Death in Custody file used by the SPS Legal Representative to prepare for a FAI following a death in custody. The records to be sent are:

- statements from the staff who found the deceased;
- incident reports following the death;
- Talk to Me documents if they exist;
- any paperwork/evidence where concerns were raised prior to the death;
- CCTV;
- telephone recordings;
- relevant redacted intelligence in a format which can be disclosed to the court if required by the PF; and
- recording of the radio message requesting assistance.

The GMA also emphasises the need for the documentation to be relevant and to bear in mind that the papers could be provided to the deceased's family if they are represented at the FAI. Establishments are advised to make a copy of all records and when a request has been made by the PF that the original documentation is sent (Nugent and Flynn 2020).

5.2.4 NHS review processes

As highlighted by Nugent and Flynn (2021), where the deceased had died by suicide and had previous contact with mental health services, the NHS Board complete a suicide review, and an action and learning plan is completed and submitted to HIS. Health Boards report to HIS on how suicide review actions have improved the quality of care and reduced suicide risk, and there are processes in place for learning to be identified and shared across Health Boards. Some Health Boards may require the participation of the Prison Service and may include a joint learning and action plan countersigned by multiple organisations. However, it is not clear whether the learning from the NHS Boards is systematically shared with the SPS or private sector.

A review of the arrangements for investigating the deaths of patients being treated for mental disorder was carried out in 2018 (Scottish Government, 2018). This concluded that changes are needed to ensure investigations are more accessible to families and carers, with institutions needing to be accountable and responsible for fulfilling human rights. In the cases of suicide, there was a call for a clearer link between scrutiny and improvement.

37 Scottish Prison Service (SPS) (undated) Critical Incident Response and Support (CIRS) Policy. Edinburgh: SPS.

5.2.5 The Scottish Fatalities Investigation Unit (SFIU)

The SFIU was established to deal with sudden deaths reported to the Procurator Fiscal (PF) plus all deaths in custody. Rather than a single unit, they are organised in regional or thematic teams to manage the considerable workload. However, this makes it more difficult for SFIU staff to gain a full understanding of the national prison issues, and to read across from the case they are dealing with to other similar deaths in prison which have not been in their area. The process is as follows:

- SFIU deals with the death from the very outset, which is reported to them immediately by the prison establishment, the hospital, or the Police.
- They take initial details and compile a pro forma report with basic information about the deceased.
- They request a full sudden death report from the Police, with medical conditions, visits to medical centres, and any concerns that have been voiced.
- If the death were an apparent suicide, SFIU gets details from the Police, and if it involved anyone else within the establishment, the means for how it was carried out and any concerns.
- CCTV within the establishment is reviewed to check whether there were any contact between the deceased and staff or other people in prison custody.
- The SFIU then considers whether there is the need for a post-mortem and any sign of criminality. If so, it is organised through the mortuary and pathologist.

The cause of death is established by the pathologist, with an 'interim' cause given at this point, although the final determination can take weeks and, in some cases, even months, a delay for which the Lord Advocate recently apologised.[38]

The SFIU works according to their Family Liaison Charter[39] (COPFS 2016) which details how families should be supported through the FAI process.

The PF is also required to give permission for the deceased's property to be released to the next of kin, and prison staff raised this as an issue with the Review:

> **"**… can have a pile on their desk, and takes 6 months to release belongings. Doesn't help family with their grief and not helping them to move on.**"**
>
> (prison staff member)

All deaths in custody, even those that involve someone who has been identified with long-term palliative care needs, are investigated under the FAI process. The review by HMIPS (2019b) recommended that the SFIU reviews the DIPLAR process to ensure that the information collated and shared contributes to the FAI process. The follow-up review of FAIs (Inspectorate of Prosecutions in Scotland, 2019) advised that the SFIU prioritises the FAI of any young person in legal custody.

The FAI can be seen as the key procedure through which the Scottish Government upholds the procedural aspect of the Article 2 right to life. However, there are a number of issues with the FAI process, discussed in section 5.6, in particular: the significant delay between death and the FAI which can undermine the availability of evidence; the very narrow remit, looking at the specific factors that caused the death of that individual and not at any broader issues in terms of inadequate treatment or wider systemic failures; its adversarial nature; and the limited involvement of the family of the deceased.

The DIPLAR and SAER processes should be seen as part of the wider death in custody inquiry processes and the human rights standards set out in section 4 applied to the whole process. As such, family involvement and participation should be actively facilitated, having in mind the human rights law requirement that the deceased's next of kin be involved to the extent necessary to safeguard their legitimate interests. Whilst families are, in theory, able to contribute to inquiry processes including Police reviews, SAER, and

38 Lord Advocate to meet bereaved families over Crown delays - Scottish Legal News
39 www.copfs.gov.uk/publications

DIPLAR, in practice there appears to be limited engagement and feedback from these reviews. Families expressed strongly that they have a view and that their input could prevent further deaths and overcome institutional insensitivity (however well-meaning). Indeed, INQUEST's (2012; 2020) research highlights the positive changes which have occurred that arguably would have not come to light without family involvement in inquests.

Given that FAIs are currently the only opportunity for families to participate directly, and receive feedback, it is vital that the review highlights that access to non-means tested Legal Aid is not an automatic right for families. This is in direct contrast to all other organisations involved including the Prison Service, private sector, NHS, and the Police, who have access to legal advice and representation from the beginning of the death in custody process.

The lack of automatic access for families to Legal Aid is one of the starkest examples of inequality within the death in custody process.

5.2.6 Impact on people held in prison

Within the formal process after a death, advising other people held in prison of the death is an essential part of the communication process. The Review spoke to a number of people currently held in prison, many of whom had experienced multiple deaths. The participants described a range of experiences in relation to how and when they were informed of a death, ranging from discovering a non-responsive person, helping during an incident once someone had been found unresponsive, and incidents happening in front of them in a shared cell or communal area, as well as in adjacent or opposite cells. Others explained that remaining "locked up" at any time during the day is a sign that something serious has happened, whilst others reported hearing of a death through other people in prison. Some spoke of feeling scared because the person who had died had been of similar age or from a similar background to them, whilst others shared how a death in prison had brought back memories of other deaths in prison or within their family, speaking of their grief and associated trauma. All spoke of how death had a significant impact on themselves and others, as well as influencing the overall mood and atmosphere in the prison in general.

Whilst it was noted that the DIPLAR Guidance makes reference to the need to record how the incident has impacted upon other people held in prison, it is highlighted in our literature review (Nugent and Flynn, 2021) that the guidance does not give details about how staff should give or receive support. SPS representatives reported as part of this Review that Chaplains and staff talk with known friends of the deceased or those who are in the same residential location; however, a process for this is not documented. This is in keeping with our analysis of DIPLARs which regularly noted limited or no reaction to a death from others held in prison, with very little detail in the documentation about how this is assessed or the nature of support offered.

5.2.7 Improvements in the immediate response

Knowledge and experience of how to deal with a death are perceived as largely being gained on the job. Prison staff said they worried whether they had done the "right thing", and there was a consensus that an organised joint training package would provide assurance and confidence. Staff regularly talked about their concerns on following unknown policies and procedures when a death occurs, but also the equipment needed or used in the response to a death.

Staff were clear that a vital part of the role was for staff to have improved access to the equipment to perform their roles adequately and keep people safe, but also to ensure that care can be given and dignity upheld as quickly as possible.

There were instances given of staff having to go and collect ligature cutters from a communal area. In contrast, prisons in England and Wales introduced ligature cutters to all front-line staff. Their intention was to ensure that, as soon as a person was found to have ligatures the officers could immediately cut the ligature, with a "Fishtail Knife" – a type

of equipment which could not be used as a weapon against them. To be effective in saving life, it was believed that this had to be immediately available, as there may be only minutes of life remaining.

Another question posed to the Review by staff was whether, in light of the considerable pressure facing the Scottish Ambulance Service, it was necessary for NHS paramedics to be called out to every death in custody when it was absolutely clear to nurses and other first responders on the scene that the person had already died.

The issue about calling an ambulance needs to be treated with care. Normally when an officer finds a person who has apparently attempted suicide, they call the incident in over the radio to the communications room. Saving the life requires an immediate call initiated by prison staff in the control or communications room to the ambulance service. This ensures that paramedics with their equipment can be on site as quickly as possible. Within the prison, health care staff are alerted and go quickly to the incident, and they may feel competent to pronounce death. If the ambulance is not called until healthcare staff have arrived and considered whether they can confirm death, vital minutes may have been lost and a life lost that could have been saved. We recognise the need for appropriate clinical knowledge and expertise before confirming that death has occurred but recommend that there is scope to agree a process on confirmation of death in a prison setting and potentially reduce unnecessary demands on the ambulance service.

5.2.8 Impact on families

The Harris Review, in its seminal assessment of the circumstances surrounding self-inflicted deaths in prisons in England, described a system where formal processes of review were prioritised over compassion for families, resulting in institutional insensitivity (Harris, 2015: 164).

Institutional insensitivity occurs because of poorly designed organisational structures and despite the best efforts of well-meaning staff. The Harris Review for instance found that, "while the policies are intended to ensure families are more supported, the evidence we have considered suggests that families have found liaison with the prison following death to be unnecessarily distressing" (2015: 164). Regrettably, we heard those same frustrations in our own discussions with families in Scotland.

There should also be recognition of the human rights requirement that next of kin be able to participate to the extent necessary to safeguard their legitimate interests. There must be a focus therefore not only on obvious design elements of the process where families may be subject to active marginalisation and insensitivity, but also on potential gaps in communication that can lead to a feeling of neglect and a perception of a lack of compassion.

The views of families have been a central focus of this Review, and the practical manifestations of the communication issues summarised above are explored in more depth in the next section.

5.2.9 Key recommendations

- Better training must be available for prison and healthcare staff in how to respond to a potential death in prison, including developing a process for confirmation of death.
- Access to equipment such as ligature cutters and screens should be improved to protect lives or preserve the dignity of those who have died.
- Address the scope to reduce unnecessary pressure on the Scottish Ambulance Service when clinical staff attending the scene with appropriate expertise are satisfied that death has occurred.
- DIPLARs should evidence how the impact of a death on others held in prison is assessed and support offered.
- 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.

5.3 Family contact and support following a death

5.3.1 Summary of current process

- Police inform the next of kin of the death.
- In the SPS, the Prison Chaplain makes contact with family, offering pastoral support and information about the DIPLAR including the opportunity to pose questions for the DIPLAR.
- In the private sector, senior managers make contact with the family and offer pastoral support with the Chaplain.
- Family may be offered the opportunity to visit the prison and speak to senior management, and a memorial may be held, but these offers are inconsistent.
- Personal property is returned to the next of kin.

5.3.2 Current processes for contacting families

All deaths in Scottish prisons are immediately reported to the Police by the Prison Service and, in time, are subject to an investigation directed by the Crown Office and Procurator Fiscal Service (COPFS) followed by a Fatal Accident Inquiry (FAI). With the Police rather than the prison staff informing the family of the death, there is very limited opportunity for passing on detail and explanation to the family or next of kin at this first contact stage, which the families felt added to their distress.

Thereafter under SPS policies and processes, the Chaplain is expected to be in the lead on making contact with the family (SPS, 2020a). The detailed SPS guidance emphasises that information should be shared with the family on the principle of openness. However, the SPS guidance also states that the Governor will tell the Chaplain what can be disclosed, and the Chaplain is advised that he or she should be sensitive about giving too much detail. This somewhat contradictory advice seems to reflect a sense of uncertainty among staff as to what information is appropriate to share with families. This can put the staff and particularly the Chaplain in a difficult position.

Guidance should be sufficiently clear, specific and directive in order that whoever is asked to liaise with the family is clear on what they can and should disclose. Provision of clear guidance would promote consistency across the prison estate. While there will be a need not to prejudice any future formal investigation, this must be balanced against the legitimate interest of the family to have their questions about the death answered as soon as possible. SPS should work with the COPFS to obtain clarity as to what can be disclosed to family without prejudicing any investigation.

The Chaplain then acts as a continuing bridge between the establishment and the family, which includes asking the family if they have any questions about the circumstances surrounding the death that they would wish to be raised at the DIPLAR. In 2020, the SPS issued new guidance that a senior manager should provide any necessary feedback to the next of kin rather than the Chaplain.

The SFIU and the PF are expected to make direct contact with the family, offering to meet with them face to face and informing them throughout of the process. In Scotland, a review by Her Majesty's Inspectorate of Prosecution in Scotland identified this contact with families and the COPFS's Family Liaison Charter (2016) as good practice.

In England, communication with bereaved families appears to be handled more directly. The Family Liaison Officer (FLO), who has a similar role to the Family Contact Officer in Scotland, can break the news to the family face to face and give them an open, detailed account of the death. The Governor writes a letter of condolence, reporting the agreed action plan, arranging for property to be handed over and for a service to be carried out in remembrance, as well as offering to help with funeral costs. Clinical Reviews commissioned by the NHS in England can include families but in practice do not. In the English system, an independent investigation is carried out by the Prisons and Probations Ombudsman (PPO), who makes direct contact with families. However, even there 32% of families have reported wanting more communication (PPO, 2019).

5.3.3 Notification of the death

In most cases, the families we spoke to learned about the death when the Police came to their homes to tell them, consistent with current policy and practice in Scotland. Families' experiences of this process were very mixed, ranging from those who were home on their own to hear the news, who felt the Police approach was unsympathetic, or who were told by the same Police officer who made the original arrest; to those who found the Police to be kind and sympathetic, and one family for whom the Police officer was a family friend. More consistent was that notification of the death often took place several hours after the death – something many of the families queried – and that the Police often had few details of what had happened.

Some families learned about the death in other ways. The person notified of the death should be the next of kin, so other family members found out through other people. Not having a direct role as next of kin can make confirmation of a death problematic.

"Well, I got a phone call from someone else… to say that she had heard that [son] had been found dead … I phoned the prison, and the telephonist was obviously not trained in how to handle calls like this, because… I said "I'm just phoning to find out, I've heard that my son has been found dead in his cell, would you be able to confirm or deny that?" And she said "Well, can you hold on?" and she put on music to play. And I phoned back and said: "Can I speak to the Governor?" "Well, can I get him to phone you back?" and I said "No, this is urgent. I need to know whether my son is alive or dead". Out of frustration, I hung up … So that was the shambles that I felt that, and, you know, I still haven't heard from the prison.**"**

(family member)

Families also raised the issue of having the opportunity to tell other people in their own time. One family wanted to wait to tell their daughter about the death until they knew her partner was available to support her. The death had been reported in the press, however, and the daughter ended up finding out via a friend on Facebook.

Some families were able to be with the person when they died in hospital. Others had less positive experiences.

"Well this is the bit that I find quite cruel because … I got a call on my work phone … from somebody saying: "Are you so-and-so?" And then, a few minutes later, I got a call from the ward that he was on and basically they just said: "Are you [X], is your [ex-partner] date of birth blah blah blah your husband or whatever?" And I said "Yes" and then all she said was "He's died"… If I could be angry, I'd be angry at her … all I wanted to know was how he was … and if he'd been OK … as he died, because my understanding at that point was that he'd had nobody with him and just the two prison officers and all she said was, well, he was comfortable.**"**

(family member)

Only one family said they heard the news of the death directly from the prison (in this case, the prison governor).

5.3.4 Early information, next steps, and support

Families were unified in saying that they received very little information immediately after the death. Nearly all received contact from a prison Chaplain, but this was for support rather than information. Some recalled being told that a Fatal Accident Inquiry (FAI) would take place, and all had received a letter from the Crown Office PF to explain this. Those who had lawyers were able to access additional information, but most of this focused on engagement with the PF and the FAI process.

In some cases, the Police gave the family a telephone number for the prison, and where the death was in hospital, families received a hospital pack about what to do after a death. Information directly from the prison was largely absent, however, and families were unaware that could contribute to inquiry or learning processes such as the DIPLAR via the Chaplain. Consequently, none of the families took part in any investigation or follow-up, other than the small minority (two families) who pursued action on their own or with legal support.

None of the families had received information about where they could go for support following a bereavement for someone in prison, noting that the information the Review provided about this was the first they had seen. Most families received contact from the prison Chaplain, though some turned this down because they weren't "religious". Families' views of the support available varied widely and ranged from lawyers, chaplaincy, the Police, and sometimes the PF or undertakers/ funeral directors as the most helpful.

5.3.5 Information about what happened

Information to families to explain what had happened was sparse and mirrors existing research findings in this area (INQUEST, 2018). Sometimes this was because little information was available, or because the information was simply not shared. Families said they were told when their family member was found rather than when they had died – a distinction they clearly found upsetting and unhelpful - or other questions were left unanswered, such as why their family member had to be handcuffed to their hospital bed when they were clearly not needing to be restrained.

Only one family member said that medical staff in the hospital explained what had happened; others, meanwhile, were told that it was their family member's right not to have involved them. The apparent cause of death might be shared, but families wanted to know the detail, the reasons, and the context – or indeed any information that might provide an explanation and closure. Instead, families almost universally shared the feeling that they were being dismissed.

5.3.6 Moving the deceased

Families raised other issues in relation to the barriers they faced immediately following a death. One had not been told that their family member's body needed to be moved to a different hospital following the death, for example. Another had a similar experience, learning that the Police had already moved the body for autopsy without telling the family that this was happening. This family had been speaking with a funeral director about getting the body released before learning from the Police that this was not possible "because he was a prisoner". The family was not even able to get a death certificate until the funeral director arranged for this.

The location of the death could also pose difficulties: the death may have taken place in one prison or hospital, but the body was then moved to another area, the Police handling the case were in yet another area, while the family in turn lived in an entirely different part of the country.

> **"**All we wanted was to have [family member] home. What would have helped at the time is that we could have had [them] home, even to the west of Scotland. Wasn't until we got [the] body back to the undertakers that I felt a bit better.**"**
>
> (family member)

5.3.7 Information families wanted

Families wanted to know more about how their family member had died – what had led up to the death, what care and support they had been receiving, and the details of the death (time, place, circumstances). One family spoke about how they had been worried about the person in prison but had struggled to get any information from the prison about their family member's health and wellbeing, only learning after the death that the person had not been washing or eating and was breaking up his cell.

Families wanted the first contact to come from a senior manager in the prison. Universally, families did not equate the prison Chaplain with contact from the prison. They then wanted someone to reach out to them who could take their questions and help them understand the sequence of events. Crucially, they wanted to feel heard and to be taken seriously – an experience that only one family reported positively.

Overall, families wanted information about their family member and the death to be provided as a matter of course, without them having not only to ask for the information but also having to pursue it again and again.

"The worst problem was us having to chase it up constantly. It would have been really nice if they could have kept us up to date with everything that was going on."
(family member)

"They should really provide families with the information cos they're already going through grieving and just trying to think like "everyday" as well."
(family member)

5.3.8 Support for families following a death

Opportunity to see the family member's body

Few families had an early or immediate opportunity to see their family member after the death. More immediate opportunities were available when the death was in hospital, with some families able to be with their family member when they died. One was only able to see their family member through glass, which they described as "horrendous", while another was able to see their son slightly earlier through personal connections (the undertaker was a family friend). Another said their lawyer offered to show them photographs.

Most families, however, spoke of having to wait at least two weeks after a death until after the post-mortem. This too could vary, however. In one extreme case, the family did not get the body back for six months.

"[We] wanted to bring him home but couldn't as [the body was] too badly decomposed… we asked for our own [post-mortem after] and he couldn't as [body was] too badly decomposed. Had to go off previous one … Couldn't even put clothes on him; lassie was in tears saying we can't even put clothes on him as too badly decomposed. His body was leaking in the coffin …"
(family member)

For some families, seeing the body gave them comfort and closure, and the importance of this should not be underestimated.

"He looked healthy. Just when I got near, he had a goatee beard, his hair was all brushed nice, and he just looked amazing. And I am so glad I went to see him, because he looked like a grown man."
(family member)

The opportunity to identify the body came out as important to the families, both in this Review and in previous studies (INQUEST, 2018), not least because this opportunity was not made available to them. Rather, the prison took responsibility for this, which took some families by surprise. Communication between agencies created some additional tensions here. For example, following a death in hospital, one family received a card from the Police and said they were told that someone would be in touch for them to identify the body. They rang the number on the card to be told that the body had already been identified and that:

"they'd "taken that burden away from you now" … It was the shock. They just did it."
(family member)

Opportunity to see where their loved one lived and speak to people who knew them

Most (but not all) families said they were offered the opportunity to see where their family member had died or had been with their family member in hospital when it happened. Only one said this had not been offered to them. Not everyone wished to or accepted the offer, with one explaining that they wanted to see where their family member had lived rather than where they died. Only two families said the prison staff had invited them proactively, with one invitation including an audience with the Governor. One of the two families declined the offer at first but tried to take up the offer several months later, at which point they were refused. Three others said specifically that they had to push for a visit and for an audience with the Governor, again with mixed success.

Families generally valued the opportunity to speak with people who knew their family member and valued the support they received from them. They spoke of receiving cards and other contact from other people held in prison alongside their family member; contact

from prison Chaplain who had a relationship with their family member; memorial services or commemorative football matches held in the prison; and in one case, the Open Estate providing buses for people held in prison to attend a service in the community, with staff attending. Families were understandably touched when staff and other people in prison custody had good things to say, and some still kept in touch and received letters from people in other prisons who had known their family member.

Contact with the prison and access to the family member's personal property

Only two families said the prison Governor had reached out to them and invited them to the prison. One family said the Governor contacted them to express condolences, and in this case, the prison Chaplain got in touch the same day. Importantly, as previously stated, very few families equated contact from the prison Chaplain as contact from the prison. Families universally believed that the prison should have reached out to them but did not recognise this as happening through the chaplaincy. One described contact from the Chaplain as a comfort but that they were:

"not the person to ask things of.**"**
(family member)

Further, families did not find all contact from the prison to be positive.

"We kind of thought the [Family Contact Officers] were supporting us, but they weren't. They were trying to pacify us. It became very clear that we were asking questions …**"**
"… they were giving us a quick answer to shut us up.**"**
(family members)

A further problem was communication between agencies. One family noted the lack of communication between the hospital, the prison, and the family, for example, with no explanation or understanding as to why the body had been moved from one hospital to another after a death.

Particularly distressing was families who were contacted after the death regarding their family member's whereabouts: one family said the prison rang them to say their family member was missing and to ask whether they knew where he was, and several weeks later, the Police also rang to ask why their family member had not turned up for his court date. More than one family reported this experience which, understandably, they found exceptionally upsetting. It is clearly important to ensure that systems for registering a death and sharing information in a timely manner between agencies are rigorously implemented.

Another sensitive issue was collecting their family member's belongings after the death. For some, the prison Chaplain or social worker brought these to the family within a few days. For others, the return was delayed until after the post-mortem, with some retained for considerable periods as evidence, and one noting that they had to wait several months, eventually receiving the items in a clear polythene bag. For families, the collection of belongings amplified the pain they were already feeling, especially if they "got the run-around from the prison" in trying to collect these – for example, when a family member went up to the prison to collect the belongings and was told they were not there so had to turn around and leave.

Of note was the high proportion of families who said that items were missing, such as watches, rings, or rosary beads. Families said that items removed from those who died in hospital were taken back to the prison or to a "production store" at the Police station rather than given directly to the family, and at least five families claimed that items were still missing.

Needless to say, the experiences of families had stayed with them. Some were still receiving medical support to cope, with at least one formally diagnosed with post-traumatic stress. A few expressed empathy for the prison staff who find someone who has died, recognising the impact a death must have on staff as well.

5.3.9 What families found helpful

Families' experiences of support and what they found helpful varied considerably. Many simply said they received no support. Three mentioned support from Chaplains, one of whom came from outside the prison.

> "100% [the prison Chaplain] … he's the one that sticks in my mind with being so kind … He was just this big, bold character and he made me feel like a person because he spoke so fondly of [family member], and then he done the service for him … [when I asked] he said 'I'd be honoured'… all that's sticking in my mind was him [family member], as a person."
>
> (family member)

Those who were able to go to the prison and speak to people who knew their family member, on occasion attending a memorial service there, expressed having a much more positive experience overall. Individual families spoke about support from the PF; from their lawyer; or from Families Outside – in the latter case saying that more families should be aware that such support is available.

The support families wanted was equally varied but generally included a desire for more information and contact from the prison – something existing research also highlights (INQUEST, 2018, 2019; Tomczak, 2019). They spoke of wanting someone to tell them what was happening ("just the truth"), someone to tell them about next steps, and to have the opportunity to ask questions. They mentioned a need for compassion, even by phone or letter, and to feel they were not being ignored and that someone was taking them seriously.

> "I just wanted somebody like to sit with us or sit with me and go, like [prison Chaplain] did… support like, this is what happens next. "Can we come and see him? Do you want to see where he died? Do you want to see his wee cell?" … I just didn't know things were like that were possible … I just feel I would have liked somebody just to give us that support to say "this is what would happen next."
>
> (family member)

Some spoke more specifically about a desire to have been told beforehand that their family member was struggling, or to be told about standard procedures such as the body being moved to a different hospital after the death. Even one who was a registered carer for her family member prior to the imprisonment due to his mental health spoke of receiving no information from the prison. The struggle for information was a recurring theme for nearly all of the families.

> "It was a big shock for us, and I think we dealt with it by kind of fighting to get information. Instead of fighting, it would have been, I don't know I guess – humane – to get a bit of – not sympathy, but just a bit of information, I guess. Just information."
>
> (family member)

Earlier sight of their family member's body was also a contentious issue, with almost all families unable to have sight of the body until weeks (and sometimes months) after the death.

> "It would have been helpful to have actually seen [family member's] body within a couple of days. I know it wouldn't have been possible before then. But, you know, until we saw him three weeks later, the reality of the fact that he was dead was moot…. I would have liked to have seen him when he was still [my son] and not a corpse. By the time we saw him, he was a cadaver."
>
> (family member)

In summary, families want and need information, explanation, and communication to bring closure, which should not be impossible to achieve.

5.3.10 Prison staff perceptions about family contact after a death and the challenges in getting it right

As with other aspects surrounding deaths in custody, practices surrounding family contact appeared inconsistent across the prison estate. There was a mix of views from staff interviewed by the Review. Some staff and establishments were very proactive in terms

of family contact, but others less so. There was an acknowledgement from some of the SPS staff that they were still not getting contact with families right yet despite continued endeavours to do so:

"… been doing a lot of work on that – trying to formalise those processes. Have been trying to get this right for a long time. Get frustrated that we're not getting it right yet."
(prison staff)

In relation to the challenges in getting family contact right, staff remarked that the information held about families varies hugely, with virtually no information for those on remand.

"… varies hugely. On remand virtually nothing … don't always have accurate or up-to-date next of kin. One case no one really wanted to take responsibility, and had to approach local council."
(staff member)

The accuracy of current next of kin details was raised by staff a few times. It was said to have hampered contact numerous times in the past. next of kin details not always being up-to-date had caused issues, and this had come out at DIPLARs. Staff said that establishments should be re-taking prisoner photographs annually, and some establishments would update next of kin records at the same time.

"Need to put something out nationally, so that every establishment is reminded about what they should be doing about next of kin. Need to also remind prisoners what to do if they want to change next of kin."
(staff member)

Timescales

Early and sensitive communication with families was considered essential by staff. A timely, open, and honest conversation from the establishment was recognised as important for families and prevented the feeling by families of a lack of care.

"The first thing is early communication with a family. Be honest about what you do and do not know. Offering further support where you can: do you want to come in to see where your son or daughter was, human touch helps and settles families. Sometimes families are angry, understand that, and say we'll still be here. A follow-up letter or phone call can be effective. If you do not try, they build up an impression that people do not care about their loved one. Has a really negative impact on how families are feeling, if they say we never want to speak to you again then you have to keep the door open, but respect their decision."
(staff member)

Chaplains mentioned that there were sometimes issues of time delay and a lack of sensitivity around Police informing the family, and staff also briefly touched on this.

Information sharing

Staff were often unsure how much they could provide to families in terms of detail and processes during this period. This was due in part to confusion about what can or should be shared with families while any investigations were ongoing, and in part to the involvement of other agencies.

When talking with families in the immediate response of a death, there are certain things that would not yet be known. There were also uncertainties considering subsequent FAIs. Much more clarity is needed for both staff and families in this regard.

"Also have to think about FAI upcoming – not just our information that we might be sharing. NHS, etc, will also be involved. There is a mentality within senior people that we do not share anything because of FAI, which is not right. Often families ask questions that are really for the Fiscal to answer."
(staff member)

"There are things you will not know; what's been found in the cell, telephone calls that might come out, you will not have access to them."
(staff member)

"Might have a meeting with the family. But the meetings are difficult, because you cannot really answer their questions because there is still an investigation to go. They have got all these questions, and your answer has to be "an FAI will take place" but you know that will not be for three years."

(staff member)

This was particularly difficult for Chaplains whose primarily pastoral role and lack of specific prison training meant they were not often as familiar with prison processes and procedures as senior or operational staff.

As we noted previously, this unease and caution in staff correlates with the families' perceptions that no one was telling them anything. Much more clarity is needed for both staff and families in terms of what information can be shared and at what stage.

5.3.11 Main point of contact

Establishments generally gave the main point of contact for families as the Chaplain, although there were notable exceptions to this. One of the private establishments had a member of the senior management team being the primary contact for families.

Despite establishments having set procedures around family engagement, the main contact or contacts varied considerably between establishments. Prison staff generally viewed Chaplain as the right staff member to make contact, often precisely because they are not viewed by families as SPS staff, despite technically being so.

There are obviously merits and demerits to this approach depending on perspective. There may be anger from families who feel the establishment has not been in touch, when in effect they have, and some families with no religious leanings themselves may not welcome Chaplain as the principal point of contact.

"I have always taken the view that the Chaplain should make contact, and the reason for that is because they are seen as more independent. I usually send a card to the family, through the Chaplain. I would not phone or meet with the family because I think it is better the Chaplain meets them. Some families would then interpret that as Governor does not care, "my relative's death has no value to them", and that is not the case, but you see how that dynamic impacts."

(staff member)

"I like Chaplain's experience of supporting with the grief and bereavement and working with the individual and then feeding into the organisational response."

(staff members)

Chaplains felt that in general families were very positive towards them, and this was often juxtaposed with anger towards the prison. Chaplains seemed to consider themselves at arm's length from the Prison Service and recognised that families do not view Chaplains as "the prison".

"… sometimes the family complains that no one from the prison has been in touch while we are sitting in their house, they expect the Governor to be there."

(staff member)

It was difficult to determine if Governors and Deputy Governors are worried about a potential lack of skill in this challenging area or simply believe that Chaplains are the most appropriate staff member to be the face of SPS. Chaplains are technically prison staff, and this could be viewed by families as deceptive if this is not clear at the outset of any communication.

It is important to record, however, that the Review heard from Chaplains of excellent practice relating to senior prison staff and their conversations with families, extending invitations to come to the establishment to meet and discuss. Chaplains perceived that as hugely beneficial, although it was not reported as frequent practice.

"The family came to speak to me in the multi-faith centre … and there was a very powerful meeting with the actual Governor talking compassionately with them about how upset they were and offering support. That was very helpful to the family at that time."

(staff member)

The consensus from chaplains was that a senior member of the establishment must be involved, but there were no consistent guidelines or practice across Scotland.

Prison staff reported that engaging families could be difficult for a range of reasons but most importantly because blame is often attached to deaths in custody that might not be applied if the death had occurred in any other setting.

"Understandable because we are the ones responsible for holding their relative in custody and no one wants to be in custody, but that colours every other reaction. I have memories of turning up at FAI where family members are shouting, hissing at you in the court and not addressed by who is leading the court. Staff feel under attack. That impacts the contact with family in the immediate response [of the death itself].**"**

(staff member)

Prison settings appear to add an additional level of complexity to grief, and establishment and staff attempts to reach out at the time of a family's loss might not be well received. Families may also have had prior concerns over their family member's care or treatment while they were alive, so any staff member reaching out to engage upon a death may be met with mistrust. Families will often be angry. This anger may be justified or simply a natural reaction to their bereavement.

"It can be tough for the family. I have dealt with family who have blamed me, I have said sorry for your loss and been told by a mum that if I was that bothered he would still be [expletive] alive. I have the upmost sympathy for them, I would be the same.**"**

(staff member)

A number of staff raised concerns about the difficulty in ensuring first contact with the next of kin due to other people held in prison being able to phone ahead of them.

"Last death, the next of kin knew because a prisoner called them. Prisoners having a phone is advantageous, but also means information is being given out quicker than we can do it.**"**

(staff member)

Regardless of any family anger or frustration, they agreed that a uniformly sensitive and transparent approach is needed across the prison estate. One staff member aptly captured this sentiment:

"Think we need a national standard operating procedure for the responsibilities of the Governor or Deputy Governor to make contact with the family in a thoughtful and respectful manner. Understand that families might have a lot of anger directed at SPS, and I think that is why initial contact from the Chaplain softens that, but SPS should also be in touch.**"**

(staff member)

Family reactions to the establishment will vary greatly; the establishment's attempt at engagement should not. Some families may want to be significantly involved, while others may not. It is about choice and flexibility, but a consistent approach across the prison estate to how establishments engage with families is clearly essential.

5.3.12 Examples of good practice in supporting families

For all the variation and inconsistency, the Review also heard excellent examples of sensitive and supportive staff and establishment practice when it came to discussions or meetings with families: invitations to the establishment to see where their family member lived for context or closure, sensitive discussions with senior staff, collection of personal items, meeting friends and cell mates, inclusion in memorial services, and so on. Many powerful examples of care and compassion in action were provided by prison staff. Unfortunately, however, it appears these good practices are not applied as consistently as would be desirable, and there was a recognition from staff of needing more training and specialist support.

"If family want to come and see, for their closure for grief – I think that is probably the right thing to do. It can be quite difficult. It needs guidance and perhaps a specially trained person from HQ. You sometimes ask a Chaplain to mediate, and they might not be the right person. This [use of Chaplain] was established years ago when more people went to church."

(staff member)

Staff recognised too that meaningful engagement with families will often add valuable context to a person's life and death, which can help at the DIPLAR.

"Sometimes family say things that you have never known, and you can feed that into the DIPLAR, the deceased's history. You gather information but are trying to be supportive. "

(staff member)

Chaplains in particular recognised the importance of offering families the opportunity to visit their relative's cell to see where they lived as part of the support process. For those families who wished to do this, it was seen as an important part of the grieving process. Understandably, some families did not wish this, so it is about offering personal choice. The importance of memorial services in the prison and sympathy cards in supporting grieving families was also raised by Chaplain:

"I would meet with them at the prison and I would take them down to the cell when other prisoners locked down, like meal times. A bit of a softer side, acknowledging this is a grieving family. Then the belongings of the person will be gathered and I would deliver these to the family, along with any money. There have been times the family have asked me to conduct the funeral, and I have worked with them to do that. If I do conduct a funeral, I would go and visit the family a few days after to see how they are … if they cannot afford the funeral, signposting them on. Some feel as they died in prison then prison should pay, but have to explain that is the next of kin's responsibility."

(staff member)

"Many have said coming to the memorial service and being with their loved one's "family" was useful and in some ways more useful than the funeral … sometimes prisoners themselves will ask for sympathy cards, and they will ask me for two or three cards and all prisoners will write something and I will deliver that down to family with the belongings."

(staff member)

5.3.13 Improvements in support for families following a death

Looking at the comments of prison staff collectively, it was clear that they believed significant improvements could be made to engagement with families, both in terms of processes and offers of support. There were some very specific suggestions for improvements and some quite stark messages on the need for change:

"… bereavement counselling for both prisoners and family."

(staff member)

"Post-death processes need to be updated to be far more sensitive to bereaved families. Property and money processes are awful: insensitively worded letters and unnecessarily difficult process for families to get money, valuable property and personal effects, lack of communication from the prison to families due to legality of FAI still to happen. Asking families for their questions for DIPLAR then not being able to tell them the answers due to legal issues! It must be awful for them. "

(staff member)

Taking the reflections of families, prison staff, and Chaplains together, several conclusions emerge:

- Families want to feel they have a voice, that they are taken seriously, and that their concerns are heard after a death, with recognition that as next of kin they knew about the individual. Without prejudicing future inquiries, as much information as possible about the death should be offered without the family having to push for it.

- They want the option to identify the body and to know the actual time of death rather than when the body was found. They want the opportunity to see where their family member lived and not to have to chase the return of personal property and private cash.
- Where a person in prison custody had died, the families sought improved communication from agencies and in particular that they should not have to learn of the death from other sources, which caused significant and unnecessary additional stress.
- Families would like communication with the Governor or senior management and someone assigned to them who can talk them through things, and answer questions, such as the dedicated Family Liaison Officer in Police Scotland. While the sensitive role played by chaplains in acting as the main point of contact with families was widely praised, there were differing views (even between SPS staff and chaplains themselves) on whether they were the right choice for that role in a more secular world where families may not have religious leanings themselves.
- Families specifically wanted a clear, consistent means of asking questions and sharing concerns with clear answers to their questions. This could enhance the DIPLAR and FAI processes and aid in preventing future deaths.
- Families wanted a platform to discuss their experiences with others. A Bereavement Care Forum was recommended in the evaluation of the Talk to Me strategy (Nugent, 2018), but none of the families were aware of the existence of any such fora or how to access the trauma services for bereaved families outlined in the SPS's Bereavement Care Strategy.
- Families wanted closure, which should include help from the prison with the funeral costs when necessary.
- Finally, families had an understandable desire to ensure that no other family should suffer as they had done, and this included seeking reassurance for other families that training for prison and healthcare staff was adequate and equipment functional and accessible. Families therefore called for a full review into prevention of deaths in prison and an overhaul of the suicide prevention strategy.

The motivations of families for taking part in the Review were clear and consistent, and the Review commends all their suggestions to you on that basis.

"If even one family is saved by this, then it will be worth it.**"**
(family member)

5.3.14 Key recommendations

- The Governor in Charge (GIC) should be the first point of contact with families (after the Police) as soon as possible after a death. An SPS family liaison officer rather than a Chaplain should maintain close contact thereafter, with pastoral support from a Chaplain still offered.
- SPS 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.
- The family should be given the opportunity to raise questions about the death with the relevant SPS and NHS senior manager, and receive responses.
- 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.

5.3.15 Other main recommendations

- SPS must verify and update the next of kin details for all people held in prison at least annually and whenever a readmission occurs to ensure no issues in contacting the correct person after a death including for those on remand.
- The SPS should work with COPFS to confirm what can be disclosed to families and make this consistent across the estate.
- Families should be told as soon as possible after a death about the services and support available to them, either when first contacted by Police Scotland or immediately thereafter by the SPS.
- A Family Support Framework should be developed by SPS and NHS with the involvement of families that includes:
  - Expansion of the Family Support Booklet to include details on ability to raise concerns and access to Legal Aid;
  - The development of a Bereavement Care Forum; and
  - Other initiatives as recommended by families.

It is about choice and flexibility, but a consistent approach across the prison estate to how establishments engage with families is clearly essential.

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

5.4.1 Summary of current process

- Chaplaincy are called and may come to provide support to staff and people in prison custody.
- CIRS (or private sector equivalent) meeting is arranged for staff support – one initial meeting and one follow-up meeting. NHS staff are invited to attend.
- Private prisons have their own debriefing and support processes in place.
- NHS staff have their own support processes alongside CIRS.

5.4.2 Impact of a death in custody on a prison

The significant impact of a death in custody on both staff and people held in prison, particularly where the death was unexpected, came through strongly in nearly all the interviews but was often most vividly expressed by a Chaplain,

"You always sense that it will add to another prisoner's despair so they need a lot more support at this time. [It] casts a dark cloud over other prisoners. The trauma for the staff too, the colleagues that are hands-on in the incident that have found them, tried to resuscitate or were close to the prisoner.**"**
(staff member)

5.4.3 Current support arrangements after a death

Normally Chaplains are quickly alerted by staff to the death and make themselves available in the hours after a death or in the next few days, maintaining more of a presence in that area in order to provide support if anyone held in prison or staff need it. While Chaplains are available for both people in prison custody and staff, it was reported by Chaplains that staff sought support less frequently than people held in prison. This may be because staff have access to mechanisms of support that people held in prison do not. However, both staff and people in prison custody also spoke of the challenge of seeking support without this being viewed as a sign of weakness.

Immediately following any death in prison, and before a DIPLAR meeting is convened, the CIRS process can be initiated. The private prisons will initiate their own critical incident support processes. The CIRS model is designed to help SPS and NHS employees following a death or other serious incident and ensure access to a specialist short-term therapeutic intervention for those who need it. When CIRS is initiated, an initial staff support meeting will take place as soon as possible after the incident and before staff go off duty. All staff involved in the incident will be offered the opportunity to attend, including NHS and external partners. If additional support is required for an NHS staff member, they will be referred through normal NHS processes. The purpose of this meeting is to ascertain the wellbeing of staff, not to learn from the incident.

A CIRS Meeting then takes place 3-10 days following the incident and can be facilitated for either groups or individuals. This is not an operational debrief. This meeting allows staff the opportunity to make sense of the reactions they may be experiencing and feel more in control of what is happening to them. It also ensures that staff who are not coping have access to appropriate support.

Attendance is not compulsory; however, the SPS strongly encourages staff to consider attending. The information from this process is used to assist SPS Occupational Health and/or Employee Assistance providers to give further support to staff showing signs of marked reactions to trauma. The CIRS is confidential, and information is not shared without the consent of the individual staff member. Staff can still access employee assistance even if they do not participate in the CIRS process, though there is little research evidence about the efficacy of these processes (Nugent, 2018).

5.4.4 Support for staff after a death

Impact of death on staff

Whist recognising from earlier points that preparation for discovering and dealing with a death diminishes the potential for a traumatic and damaging experience, a small number of staff did report not being negatively affected by deaths and accepted that it was part of the job. The majority of staff talked candidly about the shock and emotional impact of a death in custody, particularly if the death was a suicide (echoing findings by Ludlow et al, 2015), which can bring feelings of guilt or introspection on whether they missed signs that could have prevented the death occurring.

"You hope deaths in custody are rare but they are really traumatic for staff and people in our care.**"**
(staff member)

"Prison staff develop long and often caring relationship with the people they look after, so it is devastating for them to find someone, (they) replay interactions they've had, whether there was something they could've done.**"**
(staff member)

Some staff described 'going into themselves' a bit more, being a bit distant at home with their own family, or drinking more than usual. Others described struggling and being off work sick after a death. Some admitted they did not want to step back into a prison. Even when it was confirmed they acted appropriately, followed policy, and did everything they could, they still suffered feelings of guilt and nagging questions, sometimes years later. As noted earlier, some staff describe not reaching out for help or speaking up because they did not want to appear weak, and this has been flagged as an issue in previous studies (Sweeney et al, 2018). The perception of the "hardened prison officer" is a legacy with a cost attached to it that continues to this day.

"Still a bit of bravado in terms of being a prison officer – don't want to seem weak in the eyes of your colleagues.**"**
(staff member)

"I never accessed any support; it was there, told to take time off it I needed it etc. but me being the big man I didn't need it … When I look back, going home, buying a six pack was not the right way to cope.**"**
(staff member)

"I put on a brave face but every death ate away at me … I spoke to my mum and she said, "who's supporting you" and I said "no one" and she said "that can't go on.**"**
(staff member)

Support for staff immediately after a death

The Review asked staff if they were given the option of changing duties or going home. Half said they had not received or requested this option; the remaining half remarked they had been supported to do so or felt they would be offered this option or comfortable asking for it. Those staff that remained on shift mentioned that changing duties or going home would be seen as weakness. Others, including NHS staff, mentioned staff capacity as an issue (also raised by INQUEST, 2020) and that they felt they were rushed back to their post despite being in shock. Those staff that had been supported to change duties or leave spoke of effective support for themselves, or supporting colleagues to do this. One staff member described how directly involved staff would be taken away from the scene, to write down as much as they are able right away. The staff member would then be asked what they want to happen – go home or stay at work. One staff member felt strongly that staff should be removed from their duties as standard practice. The Review recognises, however, that some staff may wish to continue on their shift as part of their own coping mechanism, but the option to go home or change duties should always be offered, regardless of whether someone appears to be coping.

There was great variability in support practices, with some staff remarking they felt well or fully-supported, and others reporting a lack of support mechanisms. As a result, the Review learned of a mix of good and poor practice across the prison estate, with some staff reporting that support processes have improved considerably over time.

"We have support through CIRS and EAP and people talk to each other in as healthy a way as possible, it's not 30 years ago."
(staff member)

Unfortunately, poor support was described by approximately half the staff who spoke with the Review or provided their experiences via the online survey. Those who commented negatively believed there was a dearth of support, or that support was too informal or of poor quality, with a tick-box approach.

"Asking "are you okay?" is fine, but there is no genuine support. SPS are really good at identifying when people need help – but not at providing help…. They're excellent at ticking boxes. "
(staff members)

Another staff member raised the potential for repeated traumatisation by being back at work the next day and in the same situation:

"A train driver who has two suicides is then medically retired; SPS officers can have it happen again and again, if you find someone hanging here you could potentially be back in that hall tomorrow, opening up the same door. You can't retire everyone obviously, but what impact does that have?"
(staff member)

The SPS Employee Assistance Programme (EAP) also came in for criticism. There was a feeling from some staff that you needed to reach some kind of invisible threshold to feel able to call, or to be taken seriously if you did call. EAP appears to be an underused resource: despite being available at all times.

"For me, you have to be really brave to get through to EAP. You only get help if you're articulate – and say certain words – like "I need help" or "I'm not coping", rather than "I had a bad day today."
(staff member)

One individual raised the challenge of knowing how or when to approach a colleague after the event to check in with them:

"I texted the staff member and said are you OK? He said it wasn't nice, felt he'd have bad dreams but was OK, and was back at work the next day. I've not spoken to him since to see if he's felt supported, and don't want to keep bringing up the event. "
(staff member)

More positively, however, good support was also described at length. The Review heard of experienced, compassionate staff taking it upon themselves to look after and support colleagues. Staff talked of coming together with colleagues to support each other inside the establishment, as well as socially outside; playing golf or having a drink with a friend. While it is heartening to hear about these positive informal support networks, these should always be in addition to formal support rather than in place of it.

The Review heard from staff who praised support from their establishment:

"… the support from [establishment] was excellent, and I was reassured I had done everything right. Everyone comes together; it's [the establishment] at its finest."
(staff member)

One of the private prisons had a similar programme to EAP with a line to call anytime, face-to-face counselling if needed, and a Post-Incident Team (PIT) to come in and help support staff with statements and other procedures, though it is important to note that the PIT support is not detailed in policy. Staff from private prisons often spoke in positive terms of their debriefs, as well as their appreciation of private health support for staff and families.

"… have support available also through BUPA, and that is also available to staff's family members if it's impacting on them."
(staff member)

Some SPS staff positively described the availability of their Occupational Health service, and separate psychological counselling services through them, and called EAP "very hands-on". This was counter to the more negative EAP experiences offered by many others.

"Not sure that everyone is really fully aware that these things are in place. Think the Employee Assistance line is good because you don't know the person on the other end. Sometimes you don't want to talk to colleagues that you know."

(staff member)

Chaplains also came in for regular high praise for their role with staff as well as prisoners. Almost universally, their contribution in the immediate response of a death was valued by staff and people in prison custody alike.

5.4.5 Critical Incident Response & Support (CIRS)

CIRS also had a mixed reaction, well thought of by some and disliked by others. Good practice needs to be informed by the positive reports of CIRS support and the process reviewed where feedback is not positive. Staff recognised the need for such support but did not always feel the format suited them or like how it was led. NHS staff involvement in the CIRS process was also varied, with some NHS staff stating they had never been asked to attend, and some stating they could not attend (if asked) due to staff rotas prohibiting attendance.

Positive feedback included NHS staff who did attend CIRS, reporting that it was a positive experience and was found to be supportive and a good opportunity to debrief formally. Some prison staff welcomed that CIRS meetings did not criticise or look for faults but offered direct support for all individuals concerned. Some complimented it as a positive reflective process with a lot to offer.

"I found it really helpful and got a bit emotional, it was quite raw … it helped me to understand my thoughts and it wasn't just you going crazy."

(staff member)

It was further reported as a useful, supportive, confidential forum to collect and share all pertinent information, well facilitated by those delivering. Staff felt able to talk and share without blame, noting that it was helpful to hear other staff describing similar feelings or reactions, and an opportunity to talk through events with others who have also been involved.

"CIRS makes you understand that you are not alone and that you are feeling the same as others who have experienced similar trauma. I've always come out and said that that was really worthwhile. The way they're managed is really good practice, the guys know their stuff."

"Unfortunately, because a lot of people commit suicide at night, you have a very small group of staff who everyday they go into duty, every time they open a door, they are anticipating finding someone. We have a group of staff who are finding people two, three, four, five times and being re-traumatised."

(staff members)

The support from psychology was also well-received and the process was highlighted as an opportunity for closure.

However not everyone was positive about CIRS. Some staff were not invited despite being directly involved, or having a close or daily relationship with the person held in prison and knowing them well. Some staff members were on annual leave, or a rest day, and commented that they did not reschedule the meeting, suggesting an inflexibility in administration. Other staff did not want to attend due to the perceived lack of skills and experience of those facilitating CIRS in their establishment, believing it should be professionally run rather than peer-led. Additionally, some were suspicious of SPS motives and any action that would follow.

"I do not feel that prison staff trained in CIRS are the best people to speak to following such an event. Feel more comfortable speaking to a professional counsellor."

"No faith in the staff delivering it, no confidence in their skills."

"Having colleagues deliver CIRS was a worthless exercise as I wouldn't take to those colleagues in normal day-to-day business.**"**
(staff members)

Some saw it as a "talking shop" with a lack of follow-up, while others found the meetings too brief. Capacity was also seen as an issue if there was only one CIRS responder for a whole establishment and follow-up appointments were sometimes missed by HR. It was considered that the CIRS format and attendees may put some staff off and that an alternative opportunity is needed to voice concerns and issues.

"I didn't feel comfortable going into a group setting… sometimes it can be a cast of thousands. You might not even like one or two of your colleagues in the CIRS room. I'd rather a one-to-one person who's external.**"**

"Think the whole CIRS policy has to be replaced. That was something from 20 years ago. Need to look at more trauma-informed approaches.**"**
(staff members)

Critical Incident Response & Support summary

CIRS appears to be offered to many, but sometimes not all affected staff (including NHS staff) are invited or are able to attend. It has a lower take-up than one might expect given the gravity of the event. CIRS has been in place since 2004 and has not been reviewed or evaluated since its introduction 17 years ago. The feedback from SPS and NHS staff show that it may be too inflexible and not fit for purpose as a universal support mechanism. While designed as support for staff who have been through a traumatic event, the format did not suit everyone; due to a lack of respect for the skills of the facilitator, dislike of colleagues, and concern that they would be criticised or suffer repercussions. CIRS should be reviewed while considering expansion to include alternative one-to-one mechanisms with professional input.

5.4.6 Improvements suggested by staff

Staff provided the following suggestions for improvements:

- **Better medium- to long-term support.** Staff believed that more attention needs to be given to the impact of deaths on staff, sometimes months after the death itself.
- **Change of duties.** While some staff reported being fine to carry on with their duties in the immediate response of a death, many would appreciate the option to change duties or to go home to be more consistently applied.
- **Additional support for some staff.** Prison staff who regularly open cells in the morning are more likely to discover a person who is non-responsive and ultimately experience a death. While all staff should be appropriately trained and supported, it seems appropriate that this group might benefit from additional or more focused support.
- **More trauma-informed support.** More proactive and trauma-focused support, such as Trauma Risk Management (TRiM) training and support, was mentioned as likely to be beneficial.
- **Greater awareness of CIRS and reinforcement of confidentiality.** CIRS was not considered to be well promoted. Trust was a key issue, with reticence to open up and concern about repercussions.
- **Prioritised access to CIRS.** Reinforced efforts were needed to ensure that the safe running of the establishment does not hinder access to CIRS.
- **Recruitment and training for CIRS facilitators to be reviewed.** Given the great disparity in the perceptions of the competence of CIRS facilitators, recruitment, and training processes should be reviewed and best practice highlighted where feedback is positive.
- **Independent, professional, one-to-one counselling.** Such counselling should be available if required.
- **More robust follow-up processes** More robust follow-up processes after the offer of CIRS were needed for both SPS and NHS staff.

5.4.7 Support for NHS staff

Healthcare staff were able to describe what help and support was available to them following a death to manage the emotional impact. This ranged from referrals to Occupational Health to local peer support and advice. When there was a death in custody, we heard that staff felt supported by their immediate healthcare managers and colleagues, and all said they were offered the opportunity to have a break and an immediate debrief.

Due to the pressure of work in some instances, and to ensure the safe running of healthcare, staff would then carry on with their duties. It is important to note that most staff wanted to carry on to provide care. Consistently, there were processes in place for staff to contact immediate managers when an incident occurred, and we were told of many instances of managers coming into the prison whilst off duty to offer support to staff.

Healthcare staff described being guided by their senior managers in being prepared for what to do regarding statements to the Police and processes immediately following a death in custody. Guidance for managers was also available at a local level, but managers acknowledged the balance between supporting staff and maintaining service continuity required careful management and was at times difficult. A number commented on the positive willingness of teams to work to deliver care and support their colleagues. Interestingly, staff were asked to complete their own records of events and store this locally; there did not appear to be a clear universal approach to governance around data management and protocols for keeping records.

However, healthcare staff who were new to working within a prison environment told us they had not had any discussion or preparation for the impact of a sudden death within the prison environment. They described almost a sense of shock at their first experience, and several staff told us they knew of colleagues who had left prison healthcare due to the stress following a death in custody.

> **"**Had a nurse leave because she was having panic attacks, couldn't deal with the stress.**"**
> (staff member)

As noted previously, Healthcare Staff advised that training drills and scenarios were not part of the staff induction, and there was an overwhelming sense that this would be of value and help prepare staff for emergencies and a death in custody.

> **"**If you had training around the whole process, wouldn't be in such a state of fear. Would feel more confident about how you were going to deal with it.**"**
> (staff member)

NHS staff support, participation and accountability

When it comes to staff support following an incident and throughout the (S)AER process, staff are meant to be supported via a combination of debriefs, line management support and supervision, clinical supervision (usually offered every 4-6 weeks), and Occupational Health services.

The SPS-led CIRS process is also highlighted by most of the Health Boards as a means of support for NHS staff, though some Health Boards highlighted application of this process has been variable in practice, with healthcare staff not always involved appropriately and Healthcare Managers not informed of outcomes/recommendations in relation to their own staff.

Chaplaincy/Spiritual Care services were also noted as potential sources of support for staff in four Health Boards (Lanarkshire, Lothian, Greater Glasgow and Clyde, Forth Valley).

Lanarkshire Health Board cautions managers not to underestimate the impact on staff, whilst Greater Glasgow and Clyde has a leaflet entitled 'Manager's Guide for Supporting Staff involved in a Significant Clinical Incident' (note this term has now been superseded by (S)AER, to bring them in line with the rest of the Health Boards), which acknowledges that being involved in an incident can be traumatic for staff and the importance of looking at

psychological as well as physical needs. Support can include assigning a (peer) buddy to a member of staff to offer support in the immediate period following an incident.

The Senior Leadership Team at Tayside describes arranging a same-day Staff Support Meeting to provide the opportunity for staff to explore the event and share their thoughts in a safe space, with staff also having access to support via the Wellbeing Centre which includes telephone and group support, alongside Values-Based Reflective Practice (VBRP ®). NHS staff generally appear to be able to access dual support, both from the NHS and via SPS or the private organisations who run HMP Kilmarnock (Serco) and HMP Addiewell (Sodexo).

A good example of this is NHS staff at HMP Kilmarnock being able to access Serco's Staff Support Team (who can offer support following an incident, at court appearances, etc.) in addition to NHS Occupational Health and employee support services.

5.4.8 Support for people held in prison following a death

A key concern for the Review was the support people held in prison received following a death, both in the immediate response and in the longer term.

Support for people held in prison in immediate response

People in prison custody spoke about the immediate response of a death. These ranged widely from receiving no support, or very little support, to caring staff and Chaplains. The Review heard positive accounts of caring staff and Chaplains regularly checking in with people held in prison to see if they were upset and needed a chat or help. Such interventions were often greatly appreciated.

"I'd like to say thank you to the staff for the help they gave me … the way they came around me, it was good to see the care and support they gave me.**"**

(person held in prison)

Alternatively some offered less positive experiences:

"… comments in passing from staff saying, "are you ok?" but nothing else.**"**

""Go make yourself a cup of tea" they'll say.**"**

(people held in prison)

It was suggested that some long-serving members of staff got to know people in their care quite well and were tuned in to people's typical moods and behaviours able to pick up very easily on changes. The perception was that this has changed in recent years with a higher turnover of staff. This view was by no means universally held, but it did come through strongly.

"Officers used to take the time to get to know you. But these new officers – it's like they're in here to close and open doors. No communication. That's the biggest problem.**"**

(person held in prison)

There was a strong suggestion from people held in prison that to access any support, they needed to be very proactive.

Support from Chaplains was referred to positively. Some people in prison custody spoke of "quick access" to the Chaplain after a prison-related or family bereavement, but when this included a personal touch beyond the first few days, it was particularly valued.

"Have found it helpful talking to the Chaplain. Arranged for me to go down and light a candle and say a prayer. That gave me closure as well. The Chaplain and I went into some depth … came by a little bit more in the response of [friend's] death. Any time [Chaplain] was in the hall after his death, he would make a point of popping in.**"**

"… the Chaplaincy was amazing and the only option to me at the time.**"**

(people held in prison)

Again, sometimes this was mentioned as being conditional on a person proactively seeking this. Some staff remarked that there was "nothing formal for prisoners" and support was "minimal at best", whilst another

member of staff commented that there was no assessment of the impact of a death on the majority of people held in prison, only those in close contact with the deceased and with very little support offered by NHS or counsellors. Again, some comments from prison staff leant weight to the suggestion that people in prison custody needed to ask for help rather than this being routinely offered.

"I don't believe there is much consideration of that unless a prisoner approaches staff, then I would be confident help would be offered."
(staff member)

"Well, obviously if it hits you badly you can request to see the mental health nurse, saying "I'm not coping" and they'll come up and see you. [After last death] they said if I needed anything they were there … and they said don't be afraid to contact us."
(person held in prison)

Unfortunately access to, and experience of, mental health support, though, was not always felt to be this positive, particularly if support was needed out of hours.

Support offered by staff

Individual staff also came in for praise regarding the support they provide. Particular mention was given to the immediate staff that people held in prison engaged with on a daily basis. People in prison custody considered many staff very approachable, and staff approached prisoners in return. Universally, the quality of the relationships with staff affected the support they felt: good communication skills, being approachable, and a sense of care resulted in people in prison custody feeling better supported.

"I spend more time talking to the hall staff than I do the Chaplain or the mental health team. They're here every day with me, they see how I am, how I'm behaving. If they see I'm quiet, they come up and ask me if I'm ok. Reassuring to know they're looking out for you. It's good to have people that care for me. "
(person held in prison)

However, some people in prison custody suggested there was an inherent difficulty in an "us-and-them situation" with prison staff, which affected the ability to give and receive support.

Counselling for those in prison custody

Along with support from particular staff, dedicated forms of bereavement and trauma counselling were extremely well-received, and people held in prison were unsure why this wasn't offered more, wasn't operating more regularly, or whether it had ceased. A number of people in prison custody had received bereavement and other counselling and had found this incredibly helpful in processing deaths in custody but also issues relating to their own lives. It was very highly regarded by those who had experienced it.

A Mental Health Nurse had referred one person for counselling:

"...[counselling] was 100% genuine and people could speak about trauma, and it helped me to realise how to close that door. It's just a shame it's been away for about [X] years."
(person held in prison)

It was also recommended by a person in prison who had received counselling outwith prison and believed it would be incredibly valuable for people inside prison.

The ability to call the Samaritans easily for support was also viewed positively.

Peer support from others held in prison

Perhaps surprisingly, Listeners[40] were not generally mentioned as a useful support route, with concerns that Listeners might pass information on from that discussion onto other people, so people held in prison on the whole did not want to speak to them. Masterton (2014) also commented on the potential for fear of exploitation to inhibit communication for those in prison.

40 Listeners: a scheme operated by the Samaritans that trains prisoners in peer support

However, most people held in prison spoke about the importance of peer support from people they trusted or were friends. It came across strongly as an important network of support and encouragement which has also been commented on by Turner and Peacock (2017). Indeed for some people held in prison, this was their only form of support.

"It helps me to be inside a community; if someone is struggling. We pal up and we'll help him through his struggle.**"**

"If I didn't have my pal [name], I don't think I'd be sitting here. If we didn't have other prisoners, we would have nobody.**"**
(people held in prison)

The emotional challenges for people held in prison is deeply impacted by the prison environment (Aday and Wahidin, 2016; Vaswani, 2019). Indeed, the challenges of so quickly returning to the normal regime after a death in custody and the discovery of a body were mentioned.

"I can see why they [staff] need the routine back to normal as quickly as possible … but just expecting people to get back to normal, physically is quite easy – emotionally not so. Just wake up and expected to crack on.**"**
(person held in prison)

Staff were themselves conscious of this dilemma, and the sensitivities when another person goes into the cell where someone has died.

"I think the trickiest thing is the timing of moving on from it. For example, if someone has committed a suicide in a cell, a new admission will at some point go into that cell and if this is done too soon it might look like that person in custody was not important.**"**
(staff member)

Memorial services

Memorial services were not automatically held in all establishments, so the act of collectively or communally remembering someone who has died appears to vary across the prison estate. However, people in prison custody mentioned several memorial services taking place for deceased friends and cellmates. They uniformly described these services as being helpful in coming together with others to cope with deaths and pay their respects, whether that be for someone held in prison or even a prison officer. The contribution by the Chaplaincy in conducting memorial services was also praised.

"They had a wee service on the landing for him. The Chaplaincy were really good. They brought food with them for the prisoners. … we had a wee collection for him – for flowers for the funeral. Officer went to the funeral and gave the flowers from us.**"**

"We have memorials when there's a death. For Officers, too. Gives us all time to explain how we felt about the person, and feel a lot more able to deal with things after that.**"**
(people held in prison)

This was an area where staff also felt that a more standardised approach to the holding of memorials would be beneficial.

"I think it would be nice to have a memorial service as standard for the person so peers can attend (and staff) within the prison. In my experience, prisoners want to make a contribution so perhaps a standard collection (doesn't have to be money, could be a picture or a poem) that they want to create and send out to family. Something that marks the life of the person.**"**
(staff member)

An important feature of memorial services was the attendance of families. While there was a recognition and understanding of why some families do not want to attend the prison, or the red tape associated with bringing in members of the community, speaking with families formed an important part of these services for some people held in prison. It was a valuable opportunity for prisoners to meet the family of friends and share their stories and condolences.

"His mum came to that service … mum and his brothers and sisters came to the service in the prison, held within the multi-faith centre.

Got a cuddle off his mum. I spoke about how I knew him, and how we got on. Some of the things that we got up to."

(person held in prison)

Even if families did not attend for any reason, people in prison highlighted that it was nice if a collection was taken for flowers or other items, and they could send sympathy cards or pass on a copy of the order of service.

"Would be a good thing for us and maybe the families, we could close the door because we'd be able to say sorry for your loss."

(person held in prison)

5.4.9 Improvements suggested by people held in prison

People in prison custody suggested a range of improvements. These touched on access to physical and mental health care and support in general, but particularly in the response of a death. Prison staff corroborated the views and talked about the inadequacies or delays in mental health support and agreed that timely access to bereavement counselling and additional mental health or emotional support for people held in prison was important.

People in prison made clear that support in the immediate response needed to be prompt and genuine, with a key role for front-line residential area staff.

"Someone coming to the section – needs to be an officer. Chaplaincy is good, but for a lot of guys as soon as you mention religion they close up. Just come into the section and talk to us."

(person held in prison)

Many people held in prison and some staff highlighted that a group forum would be particularly useful for people in prison custody after a death, as well as at other times, as part of a normal routine and support network. Talking was described by all people in prison custody as cathartic and valuable.

"You think about what you could've done, did I let him down? In an ideal world, would've been good to have some sort of forum where we could all talk about what happened. Nothing at all like that."

(person held in prison)

However, somewhat like the alternative views of staff about the value of CIRS, some people in prison suggested an aversion to speaking openly or sharing vulnerabilities in certain groups or with certain people, and it was regularly reported that neither people held in prison nor staff wanted to appear weak in front of others. Some staff recognised that and therefore the need to allow more time for individual peer support.

"Those that need it, should be given time to grieve (up to three days), i.e. no obligation to attend work etc. More time to associate with peers if they wish, as it aids the grieving process."

(staff member)

5.4.10 Conclusions on support for staff and those held in prison

- The interviews with SPS (including Chaplains), NHS staff, and people in prison custody suggested that variations in practice around support for both staff and those held in prison continues across the estate, despite the best intentions of the current guidance to promote consistency.
- The findings also imply scope to improve the support available to both staff and people in prison custody. The variability in perceptions suggests that support for people held in prison following a death needs to be urgently reviewed and included in a training package offered to all staff around deaths in custody.
- The CIRS policy has been in operation without review for 17 years and is not considered by all staff as meeting their needs.
- Good practice on staff support identified by staff in individual Health Boards is not cascaded to other NHS Health Boards and the SPS.

5.4.11 Key recommendations

- A comprehensive framework of trauma-informed support should be developed and implemented with the meaningful participation of staff, including a review of the Critical Incident Response and Support policy, which is rolled out across the prison and NHS estate to ensure consistency of approach and trained staff. This should ensure staff who have witnessed a death always have opportunity to attend CIRS and regular proactive welfare checks are made on them.
- A comprehensive framework of trauma informed support should also be developed and implemented with the meaningful participation for people held in prison to ensure their needs are met following a death in custody.

5.4.12 Other recommendations

- A standardised approach to immediate support after a death should be developed and clarified including offering the option to go home or change duties.
- A standardised approach to memorials should be developed and implemented that recognises their value to the deceased's family as well as other people held in prison.
- A more proactive approach to supporting people in prison custody should be developed and implemented , including better access to mental health support and bereavement counselling, and more opportunities to associate with their peers to aid the grieving process.
- Good practice identified by staff in individual Health Boards should be disseminated and adopted by other NHS Health Boards and the SPS.
- The SPS and NHS review the CIRS process that should include representatives from the NHS and CIRS support team as well as seeking views from the wider staff population. In particular, we believe there are a number of points in the current CIRS policy that require greater clarity, development, or further consideration:
  - details on how CIRS responders, managers and co-ordinators are selected, including grading requirements, and how many are in needed in each prison;
  - consideration of the training CIRS responders and managers receive and how regularly refresher training is provided;
  - details of the "regular supervision" CIRS responders can expect to receive;
  - clarifying when CIRS meetings must be held – for example after events such as a suicide, sudden death or attempted suicide (not an exhaustive list) whether one follow-up CIRS meeting is sufficient;
  - policy development to improve support for staff in the lead up to and following their attendance at an FAI; and
  - clarity that the CIRS policy applies to NHS staff as well as SPS staff.

Both staff and people in prison custody spoke of the challenge of seeking support without this being viewed as a sign of weakness.

5.5 Review of SPS and NHS internal documentation concerning the death

5.5.1 Summary of current process

- The DIPLAR meeting is arranged up to twelve weeks after a death. This is a joint SPS and NHS process.
- No DIPLAR meeting is required for expected deaths through natural causes, although it usually occurs.
- DIPLAR findings are finalised within eight weeks of the first DIPLAR meeting.
- Recommendations are recorded in a national learning spreadsheet. It is the responsibility of local suicide prevention co-ordinators to monitor and report on actions taken.
- Quarterly and annual reports are presented to executive management group and national suicide prevention management group.
- Alongside DIPLAR, the NHS may hold a Serious Adverse Event Review (SAER).

5.5.2 Evolution of death in custody reviews

Since 2008, the SPS has had an internal means to investigate deaths by suicide (Self Inflicted Death in Custody: Audit Analysis and Review – SIDCAAR). However this remit of enquiry was widened in 2015 with the introduction of the DIPLAR process, whereby all deaths in custody are subject to internal review.

The DIPLAR process was piloted across prisons and NHS Boards for two years prior to being formally introduced in November 2018 and was intended as a joint process between the SPS and the NHS. The DIPLAR process was amended in February 2020 to introduce a level of external oversight into the process, whereby if a death appeared to be unexpected or self-inflicted, then the DIPLAR meeting must be chaired by a Non-Executive Member of the SPS Advisory Board. Expert consultant Phil Wheatley attributes the prompt for these changes to two recent reports which highlight the need for greater transparency in the process after a death.

Whilst this chair is referred to as "independent" in the DIPLAR policy, the Review does not feel that this is an appropriate term to be used, as the chair is a non-executive member of the SPS Board. The human rights requirement of independence in an Article 2 loss of life investigation requires that those carrying out the investigation are independent of the events, in terms of institutional connection and practically. As the Chair is a non-executive member of the SPS Board, there is an institutional connection which undermines the independence of the process.

As such, the Review recommends that a truly independent chair, with appropriate health and/or social care and prison experience, is appointed to ensure consistency of approach and oversight.

5.5.3 DIPLAR process

The DIPLAR process is intended to enable areas for improvement and potential learning to be identified following a death in prison custody (including where the death occurs in hospital) in advance of an FAI.

From 2018, the SPS and NHS have jointly implemented the DIPLAR process. According to the Guidance (Scottish Prison Service, 2020b: 2), the aims of a DIPLAR meeting are to:

> … learn from the incident, consider the circumstances and the immediate actions taken. It examines management processes and practice and how the person was being managed in prison, whether shared practice and service integration was apparent. The process also focuses on how the incident impacted on staff involved, other prisoners, the person's family and the establishment as a whole … The process should not focus negatively on the incident but adopt an objective, critical stance when appraising the information, seeking to identify not just areas in need of development or improvement but also highlighting the reason certain practices and processes were successful in supporting the person during previous difficulties.

An established timeline of expectations includes the DIPLAR being convened within twelve weeks of the death, and the final DIPLAR meeting paperwork submitted to SPS Headquarters within the following eight weeks.

However, where there is an ongoing Police investigation, the DIPLAR cannot take place until this has concluded.

Staff attendance is voluntary, but as part of this Review, the SPS reported that as yet they have had no one opt out of participating.

There are three 'levels' of review, namely:

1. Self-Inflicted Death in Prison Review (suicide or intentional self-inflicted death including cases where it is clear that the person's intention was suicide).
2. Event of Undetermined Intent Review (cases where it is not clear whether the death was the result of intentional self-harm or accidental).
3. Natural Causes Death Review (deaths where there was a known health condition that may have contributed to the death or where it was an expected death due to terminal illness).

The DIPLAR consists of three sections:

1. Death in Prison Learning, Audit and Review Report;
2. a timeline of significant events; and
3. a joint private sector, SPS, and NHS Learning and Action Plan

The DIPLAR guidance outlines that a member of the SPS Headquarters Health team has several roles within the DIPLAR process:

- attend all DIPLAR meetings for apparent deaths by suicide or apparent drug-related deaths;
- liaise with the local Suicide Prevention Coordinator and the Independent Chair;
- review the draft DIPLAR within two weeks of being uploaded onto the SPS "SharePoint" portal (digital intranet); and
- ensure the learning from DIPLARs is shared across all prisons where appropriate.

The SPS then prepares an individual Death in Custody file to prepare for an FAI. Further detail of the file contents can be found in the Literature Review which can be read in the online Appendices. The Governor, or Director in the private prisons, and NHS Prison Health Board leads have responsibility to ensure an action plan is put in place following the DIPLAR.

SPS HQ Healthcare maintains a DIPLAR tracker, which is a log of all the actions and recommendations to monitor progress and conduct an analysis of deaths in custody annually for the SPS Executive Management Team, which provides oversight. The tracker, DIPLARs, and annual report are not in the public domain.

DIPLARS are discussed in the Suicide Prevention Coordinator's Forum which meets quarterly and reviews all DIPLARs in full to discuss the learning and implement actions. They also provide a report to the SPS National Suicide Prevention Management Group (NSPMG), which has representation from relevant organisations outside the SPS who are experts in this field, such as the Samaritans, Breathing Space, and Families Outside. The NSPMG can raise concerns with Scottish Government Ministers (Nugent and Flynn, 2021).

5.5.4 Analysis of DIPLARs

The HMIPS report (2019) observed the lack of training for those involved in DIPLARs to maximise learning outcomes from the process and the inconsistency in approaches.

5.5.5 DIPLAR and families

Involvement by families is specifically stated by both policies and guidance for DIPLAR and SAERs.

Although the importance of the contribution a person's family can make to preventing suicide has been emphasised in policy for many years, there is little or no evidence in any of the death in custody policies and DIPLARs relating to suicides that this emphasis has consistently been translated into practice.

Of the 93 DIPLARs analysed by the Review, none state that the DIPLAR process was explained to families or that families were explicitly asked if they had questions or concerns that they wanted the DIPLAR to

consider. Only one family interviewed had been informed about the DIPLAR process. The DIPLAR documentation does have a section for those involved to comment on the impact on family, staff, and other people held in prison; this section rarely gives information about the content of conversations had and the type or level of support given.

This highlights a worrying lack of involvement and potential for support being offered to bereaved families both in the more immediate response of the death, represented by the DIPLAR, or in the longer term via the FAI process. It also loses the opportunity for what may be a vital understanding of the context of the death.

There is value in adopting a consistently open and supportive approach to the family. Such an approach helps the family by answering their questions quickly, diminishing fears, and ensuring that areas of contention do not fester.

For bereaved families, the absence of explanation and involvement in the early "lessons learned" process and the delays experienced before the conclusion with the subsequent FAI was a major cause of concern, and are echoed in the limited literature regarding a family's need for timely justice (INQUEST, 2018; Tomczak, 2019).

The apparent cause of death might be shared in the period after death, but families wanted to know the detail, the reasons, and the context – what had led up to the death, what support they had been receiving, and the details of the death (time, place, circumstances) – or indeed any information that might provide an explanation and closure.

The DIPLAR documents do include a section which considers the impact of the deceased's death on their family and staff members, as well as detailing (and to an extent evaluating) the support offered to all. However, the SPS learning review process and reports are not publicly available documents, are shared only within the SPS (including the private prisons run by Serco and Sodexo) and do not include an expectation of a note of condolence or feedback for families.

The DIPLAR policy states that Chaplains are the point of contact between the prison and the family (DIPLAR Guidance, para. 5.16) and, as such, are the ones tasked with both explaining the process and raising any questions or queries the family may have at the DIPLAR meeting.

Across the nine different NHS Health Boards with a prison in their area, the SAER policies and procedures stipulates contact should be made with families at various stages throughout the Review process. However, this contact is removed for those cases where the person died whilst in prison custody. This is a clear breach of the right to health equality for people held in prison.

For NHS attendance at the DIPLAR, we were informed that senior NHS staff would usually attend the DIPLAR, not necessarily the staff who were involved directly in the incident. Whilst this decision seemed to have been taken by senior managers wishing to protect their operational staff from what some had experienced as an adversarial process, this reduces the opportunity for the experience of front-line staff's involvement in a death in custody to be heard first-hand, explored thoroughly, and learned from.

5.5.6 SAER and families

In terms of the ten SAERs, three of them made no mention of the family, two of them stated the families were contacted, two of them did not mention the family, one documented that the family was contacted but declined to take part in the SAER, and a further two stated that letters had been sent to the next of kin or family member but that no reply was received.

The inconsistent approach to communicating with families of the deceased is despite the fact SAER Policy and Procedures across the nine Health Boards are consistent in emphasising that face-to-face or telephone contact with families is preferable.

Throughout our analysis, there was no evidence of any feedback being offered to families after any DIPLAR or SAER meeting, even where questions had been asked.

5.5.7 Involvement of people held in prison

The lack of engagement and involvement with families is mirrored in the lack of involvement with other people held in prison, despite the fact that many told the Review that they had experienced a number of deaths in their time in prison and often had known the person who had died for many years and could have contributed information.

The Review recognises that the purpose of SAERs is to consider clinical issues which may have impacted, contributed to, or caused the death of the person in prison. Given the proximity of those who shared a friendship and potentially a cell with the deceased, it seems remarkable that their views of the events leading, and potentially contributing, to the death are not considered or seen as potentially informative.

5.5.8 The role of the Chaplain in the DIPLAR process

The DIPLAR Policy makes clear that the Chaplain is the main point of contact between the prison and the family. In practice, however, the Chaplain's own role in, and knowledge of, DIPLARs appears variable, and the Chaplain in the privately run prisons do not assume the lead role as outlined in the DIPLAR policy.

Chaplains confirmed there had only been a few DIPLARs since they were made aware of their role to facilitate questions from the families to the DIPLARs and shared their frustration at not being routinely invited to attend the DIPLAR meeting.

"Last one the family had questions, and I found out the DIPLAR had passed and I asked why wasn't I invited, and they said think it was your day off …why isn't my contact automatically on the contact list? ... At the last one, they said the Governor filled in the involvement you had with the family, and I said how could they do that as they don't know the questions the family asked me.**"**

(staff member)

The discussions with Chaplains kept returning to one main issue: feedback to families after a DIPLAR, with the main sentiment being one of confusion. This confusion was twofold: uncertainty over the validity of putting questions to a DIPLAR that Chaplains believed only an FAI would be able to answer, and a lack of clarity over their ability to feed back to the family more generally from the DIPLAR. The general consensus amongst Chaplains was that, although they had been tasked with raising questions from the family at a DIPLAR, they had:

"… been pretty much told to feed nothing back regarding the DIPLAR outcomes. **"**

(staff member)

This is turn had led them, collectively, to highlight the grey area of what in fact they are able to feed back and the ethics of inciting questions from families, raising expectations of a reply but then being unable to offer any response. One Chaplain summarised the general feeling most succinctly when they explained:

"Think there is an issue of it being one-way traffic; allowed to have questions but DIPLAR has its hands tied in what can be fed back … You're really saying we can feed into the DIPLAR but we might not be able to feed back to you [the family]. It will all come out in an FAI but that may be two or three years away, but you don't say that …**"**

(staff member)

Chaplains felt that guidance and clarity around what could be shared with families was needed, and that whilst it was felt families should be able to have questions answered in the DIPLAR process, there was also an understanding that it is an internal learning process in which staff needed to feel safe in order to be able to share their experience.

All Chaplains commented on how worthwhile and important they felt the DIPLAR process was, however they were also keen to emphasise that there should be a focus on what actions are then taken once the DIPLAR has been concluded.

"It's a valued process, but it's what happens after that.**"**

(staff member)

5.5.9 Joint process

The Review's analysis of NHS SAER policy and procedures found that a conflicted picture emerged in terms of joint working and the quality of the working relationship and information sharing between SPS and the NHS.

Some NHS Health Boards clearly commented and evidenced the excellent relationship they felt had been developed with prison(s) in their area. Others, though, shared their sense that NHS staff are often informed or involved in the DIPLAR process at too late a date, and with too little time to prepare for informed, meaningful, and useful participation.

NHS and SPS also need to clarify (to remove discretion and ambiguity) when they participate in the NHS SAERs and countersign joint learning and action plans.

On a positive note, several Health Boards made reference to recent changes in SPS policy, signalling a welcome move towards what they viewed as greater transparency.

Whilst it was intended that the DIPLAR was a joint SPS NHS process, analysis undertaken by the Review highlighted wide variations in involvement and chairing of DIPLARs. This was mirrored in the parallel NHS-focused review via the Serious Adverse Event Review (SAER) process. Whilst some Health Boards were clear that the default review for a death in custody was solely the DIPLAR process, unless there were significant clinical issues, others were less clear. There was no evidence of DIPLARS being chaired by the NHS.

Clarity is needed about when an SAER is to be completed for a death in custody and how and whether this should inform the DIPLAR process. Health Boards should also jointly consider including a section on deaths in custody in their SAER policies and procedures to ensure that all prison-based NHS staff have a single point of reference.

It is worth noting the difference in emphasis expressed by SPS and NHS, notably around the need for transparency expressed by all NHS Boards in their SAER policies. The NHS also uses Root Cause Analysis (RCA) as a way of offering a framework for reviewing patient safety incidents. Using the RCA model, the NHS can identify what, how, and why patient safety incidents have happened, and bring a more systematic lens to decisions.

5.5.10 Approach to DIPLAR

Both the DIPLARs and SAERs analysed by the Review evidenced a focus on deaths by completed suicide. Deaths by other means appear to attract a less intense standard of review. One example of this is the longer list of seven people stated in the DIPLAR guidance who must be in attendance at a DIPLAR meeting when the death is the result of a completed suicide, including a representative from SPS Headquarters.

Yet, where a death is apparently expected or foreseeable due to natural causes, DIPLAR paperwork can be completed jointly between SPS and NHS without the requirement to hold a full DIPLAR meeting. Where a reduced DIPLAR is required, only three people are listed as being required to attend including the Governor, Deputy Governor (Director or Deputy Director in Private Prisons), NHS Health Care Manager, or Clinical Manager in Charge, and Front-Line Manager for the area the deceased was located.

The Review was concerned at the lack of a rigorous process in the categorisation of deaths as being expected or foreseeable from natural causes. Given the lower level of scrutiny applied to these deaths, it is essential that there are clear policies and procedures in place to ensure that only those deaths that properly fall within this category are documented as such.

In addition, a natural cause death should not automatically be considered a foregone conclusion. Every death has the potential for both local and operational learning as well as providing pause for thought on institutional assumptions which may influence a person's life and illness trajectory, as well as allowing for consideration of systemic practices which may either consciously or otherwise influence decision making and actions.

The assumption that there is less likelihood of a) a need for discussion or b) learning points arising from an unexpected death of natural causes needs to be challenged, the perception exists from families and from people held in prison of a lack of health equivalence between people in prison custody and those living in the community.

As discussed in the Chapter on the Human Rights standards that apply to deaths in custody, the vulnerability of those in prison detention means that the State's obligation to account for their treatment is particularly stringent. For all deaths in custody, the State must provide an explanation of the cause of death and, where the death was apparently the result of health issues, the treatment provided to the person prior to their death. If there is any possibility of inadequate care in terms of the Article 2 right to life requirements, or the Article 3 prohibition of torture, inhuman, or degrading treatment, there must be an investigation that complies with the specific requirements for an effective investigation.

The Review noted the families' concern that the lack of rigour in the investigation process where a death was deemed to be expected due to natural causes did not allow for potential failures in service to be identified, particularly given their concerns about the provision of healthcare.

5.5.11 Learning from DIPLAR and SAER

The processes outlined in the DIPLAR guidance (SPS, 2020 b) refer to Local Suicide Prevention Co-ordinators' responsibility to update the National DIPLAR Learning and Action Plan by the 7th of each month, with progress against action points identified from DIPLARs and FAIs. Little detail, however, is given on the National DIPLAR Learning and Action Plan, and it is not a publicly available document.

The national NHS Knowledge Network Adverse Events page has learning summaries (anonymised summaries of (Serious) Adverse Events) posted (The Knowledge Network, 2021) and are categorised according to the main issue considered in the (S)AER.

Whilst there is a chance generally to share learning from SAERs, prison healthcare staff told the Review that there was no mechanism in place to share national prison issues and learning from Adverse Event Reviews across the prison healthcare network.

The DIPLAR policy does not explicitly refer to any analysis tools for the purpose of looking at more systemic issues which may be influencing and impacting on deaths in custody. There also appears to be no vehicle for learning from DIPLARs to be consistently shared with staff across the prison estate, other than via Governors and Managers Action notices (GMAs). SPS staff shared with the Review that GMAs can be limited in terms of staff having time or motivation to access their emails regularly. Indeed, staff commented that learning in bite-sized face-to-face training was more effective.

There was insufficient evidence for the Review team to consider whether a DIPLAR involving a child or young person included an assessment of whether the particular rights of children were fulfilled, with child-friendly policies and procedures followed in practice.

There was also no evidence in the DIPLARs analysed by the Review that the monitoring or evaluation of actions recommended by a DIPLAR would be shared with families and the wider public. Families felt that publishing would help them feel that lessons have been learned and that the death of their family member contributed to positive change for others.

The Review notes that the State has a duty to protect people from avoidable deaths, which requires the taking of reasonable steps to prevent avoidable risk of life. Breach of that duty applies where the State knew or ought to have known of a threat to life and failed to take reasonable steps. Effective processes and practices in relation to learning lessons and preventing recurrence are therefore highly relevant to compliance with the right to life.

5.5.12 SPS and NHS staff views

Staff generally shared that DIPLARs had improved over the years and pointed to more detailed timelines, jointly-chaired meetings with healthcare, and introduction of designated chairs as markers of that evolution. That Unions no longer routinely sit in on the DIPLAR meetings was also seen as a sign that:

"They [the unions] are more content that the purpose of DIPLAR isn't to apportion blame.**"**
(staff member)

The usefulness of DIPLARs was raised by a number of staff, who spoke positively about them in terms of the involvement of a mix of SPS and NHS staff, the style of the meeting (where everyone was given a chance to speak and express their experience), and the focus being on review and learning.

"I think they are useful in helping to share information and create learning points so that we can move forward as a prison to make things better for staff and for prisoners.**"**
(staff member)

However, whilst some staff felt that the DIPLARs have changed for the better, others also temper this optimism with the fact that the cultural assumptions (about lack of care, etc.) persist:

"… the DIPLAR process is much more robust than it was years ago, much more consistency about documents needed, independent chair, but it is what it is. Not about the process … it comes back to the cultural context in which it's been taking place and that view that staff wouldn't have cared and would definitely have been doing something wrong.**"**
(staff member)

When discussing healthcare staff's experiences of attending DIPLARs (and its predecessor, SIDCAAR), the Review again received mixed responses on their perceived effectiveness. Some NHS staff explained the decision to have separate adverse event reviews by a number of the NHS boards was taken because DIPLARs did not support adverse event management in a timely and effective manner and were not clinically-focused. Responses from NHS staff regarding the process of attending DIPLARs were very mixed, with staff telling us their openness to contribute was dependent on the Chair, and some staff stated that they could be very adversarial (a point which was echoed by some SPS staff, who felt DIPLARs still operated in a protectionist way for the Prison Service).

"DIPLAR are very SPS-led and not a learning culture, there is not a clear process in terms of what should happen and actions taken from that, and very variable about when DIPLARs take place.**"**
(staff member)

In contrast, staff from those NHS boards who used the DIPLAR as their main adverse event mechanism explained that it was very much a joint process, with joint ownership and a joint lead. Yet, overwhelmingly, the majority of NHS staff interviewed highlighted a lack of training around the whole process following a death in custody and stages around how to manage this including understanding the process, purpose and outcomes of the DIPLAR.

This lack of training was echoed by prison staff, who expressed an element of uncertainty when walking into a DIPLAR meeting. There were examples of good practice where staff were informed about the purpose and scope of the process, though this did not appear to be particularly comprehensive or in-depth and primarily appeared to be aimed towards senior managers. Staff commented on the wide variation amongst staff of the need to attend DIPLARs, with one staff member succinctly making the point about the importance of training:

"…some staff will only ever attend one DIPLAR, so it is important to provide the information before it.**"**
(staff member)

Even those staff who had been more involved in DIPLARs argued that the SPS needed to ensure sustainable, regularly updated training. The impact of not having training is that staff attending a DIPLAR may not know, as one staff member explained, whether they were going to get a "cuddle or a kicking", a sentiment echoed

by several members of staff who explained that staff can continue to feel judged in a DIPLAR process that continues to be "a blame game".

There also continues to be no obligation for actions arising from a DIPLAR to be implemented: whilst quarterly and annual reports are prepared to ensure learning from across all DIPLARs is collected and considered (a key example of good practice), these are internal documents only, with the SPS only giving permission for Her Majesty's Chief Inspector for Prisons to review these documents but not for these to be analysed by the rest of the Review. This places limits on organisational transparency as well as denying SPS the opportunity to share good practice with other partners, stakeholders, and more importantly, families of those who have died in prison.

Support following a DIPLAR or SAER was also something that some SPS and NHS staff flagged needs to be improved, whilst the impact of being involved in a death in custody was clearly expressed by an SPS employee.

"Always that idea in staff's mind: did I miss something? Could I have done something? am I going to lose my job? … it's not easy. And some people are stronger than others, and take that on, but others can really set them back.**"**

(staff member)

This mirrors the findings of the literature review (Nugent and Flynn, 2021), which comments on the high levels of trauma being reported by staff that had been in contact with self-inflicted deaths in prison and the extensive emotional difficulties felt by staff in this context. The literature review goes on to echo the feelings expressed to the Review by SPS and NHS staff in relation to "institutional anxiety" (Chiswick et al, 1985) where the perceived blame-attribution element of inquests (and arguably internal reviews) meant that reflections on good practice can be sparse. SPS staff in particular shared that, whilst the DIPLAR brings back all the details of a death:

"….at no point do people ask if you're okay with this.**"**

(staff member)

Managers in the NHS acknowledged the balance between supporting staff and maintaining service continuity required consideration. A number commented on the willingness of teams to work to continue to deliver continuity of service and support their colleagues. We also heard of variable experiences from NHS staff of support and interaction from SPS staff following a death in custody. Relationships between the two staff groups were noticeably variable, with some prisons being felt to be very inclusive of NHS staff and recognising the impact on both staff groups, whilst others felt a disconnect and lack of involvement with the SPS.

5.5.13 Timescales

Currently DIPLARs and SAERs must convene no later than 12 weeks after a person's death, with some staff considering this timescale appropriate due to the complexity of trying to get everyone together. Yet there was also a preference expressed by some staff for conducting DIPLARs sooner, usually due to supporting people's recollection of events, providing some answers for families and continued re-traumatising of staff who may be, 12 weeks after a death, beginning to move on.

"Think 12 weeks is too long. People are going into different mind sets by then, they might have gotten over it and then you're asking them to re-live it.**"**

(staff member)

There is a need to balance the complexity of managing diaries and ensuring the right people are able to attend the DIPLAR/SAER meeting, with the view of staff who feel shorter timescales are better both in terms of supporting recall and reflection, and avoiding re-traumatisation.

In summary, DIPLARs can be a difficult exercise to ensure weaknesses are exposed and lessons learned. The documents will be seen by SFIU and will be referred to in the FAI process. Admitting failures may therefore lead to public censure. Admitting weaknesses in policy and procedures is also likely to lead to public criticism. It is not surprising, therefore, that staff and managers will not wish to admit

blameworthy failures in a DIPLAR. To counter this tendency, DIPLAR reviews need a well-informed Independent Chair, backed by a genuine commitment from senior leaders to identifying any failures or weaknesses in order to learn from incidents to make prisons safer. While all of this is in place, keeping the lessons learned confidential contributes to the perception of concealment.

5.5.14 Key recommendations

- 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 (including 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 main point of contact for families should be a trained member of staff, who is 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 senior staff member and the family should be recorded in the DIPLAR report.
- The full DIPLAR process should be followed for all deaths in custody, with a member of staff from Prison Service Headquarters in attendance.
- Next of kin should automatically qualify for non-means-tested Legal Aid to ensure they are able to have legal representation including in relation to the DIPLAR process.
- 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.

Next of kin should automatically qualify for non-means-tested legal aid to ensure they are able to have legal representation.

5.5.15 Other recommendations

- Each Health Board with a prison in their area should include a section on deaths in custody in their (S)AER policy. This would allow for families and NHS staff in prison to be clear about how the policy relates to a death in prison.
- Health Boards and the Prison Service should work together to review the current policy and practice around deaths in custody, to review what currently works, what can be improved and to consider a single, joint process.
- Health Boards should follow their own policy and procedure regarding involvement, and participation, of a family in an SAER where the death has occurred in custody. To remove the families' right to NHS contact, support, and involvement in the SAER process is against the ethics (and legal basis) of health equivalency for people held in prison and their families.
- All prisons and Health Boards should widen the remit of their review processes after a death to allow for the greater (and, in terms of SAERs, any) engagement of people held in prison, recognising their potential knowledge and understanding of both the events leading up to a death, and the prison environment itself.
- The Scottish Prison Service and Health Boards should convene a joint national Deaths in Custody Steering Group (relating to all deaths, not just suicides) to share best practice, to discuss challenges experienced around joint working, and to support joined-up thinking between different prison establishments and health board areas.
- The NHS best practice approach regarding the offer of an expression of condolence to families at the beginning of any review process should be taken up by all organisations involved in a death in custody.

5.6 Comparison of learning from internal SPS review and FAI findings

5.6.1 Fatal Accident Inquiry process

The Crown Office and Procurator Fiscal Service (COPFS) is Scotland's prosecution service. The Procurator Fiscal (PF) investigates all sudden, suspicious, accidental, and unexplained deaths to establish the cause of death and the circumstances. In all cases, deaths in custody (whether the death occurs in prison or hospital) are immediately reported to the Police and are subject to an investigation directed by the Procurator Fiscal Service followed by an FAI, unless the Lord Advocate decides an FAI is not required as they are satisfied that the circumstances of the death have been sufficiently established during the course of proceedings listed in s3(2), which would include criminal proceedings.

The investigation is managed by the Scottish Fatalities Investigation Unit (SFIU) under COPFS. The work of taking statements is done by Police officers working with the Procurator Fiscal Service, most of whom have no expertise in prison custody.

An FAI involves a public examination of the circumstances of a death in the public interest. Like most civil and criminal cases in Scotland, an FAI takes place in the local Sheriff Court.

FAIs in prison cases are heard by different Sheriffs depending on which area the death has occurred and the availability of Sheriffs. Only in a very small number of cases is an expert opinion sought on prison management issues, and that opinion is sought after the initial inquiries have been completed, so the expert has little influence on the inquiry process (Wheatley, 2020). Nowhere in this process is there an opportunity to identify emerging problems, including changes to the vulnerability of people held in prison, or to uncover systemic weaknesses in operational performance in prisons (ibid.). Equally, the lengthy time between the death and the FAI undermines the public scrutiny of any issues that may been experienced at the time of the event.

FAIs are usually held in a Sheriff Court, though they can be held in alternative accommodation (Scottish Government, 2014). Previous recommendations to hold FAIs in less formal and intimidating settings by, for example, Lord Cullen in 2009[41] on the Consultation on Proposals to Reform Fatal Accident Inquiries Legislation, have never been implemented (Scottish Government, 2014).

Families and staff both reported that they found the FAI intimidating and adversarial and universally would prefer a less formal setting.

The FAI is defined as a:

> **"**...fact-finding procedure rather than fault finding … not to establish civil or criminal liability. Witnesses cannot be compelled to answer any questions which may incriminate them and the sheriff's determination may not be founded upon in any other judicial proceedings … to encourage a full and open exploration of the circumstances of the death.**"**
>
> (Scottish Government, 2019: 3).

The Scottish Government states that the purpose of the FAI is to expose systematic failing and is deemed critical for the maintenance of public confidence in the authorities (Scottish Government 2014). Armstrong et al (2021) found that this does not appear to be the case in practice. The Sheriff in conclusion makes a determination as to the time, place, and cause of death and can make recommendations as to how deaths in similar circumstances may be avoided in the future. It is noticeable that very few FAI determinations include recommendations to improve practices or prevent future deaths.

Armstrong and colleagues (2021) found that, in over 90% of all FAIs, no finding of a reasonable precaution is made, no finding of defect is made, and no recommendations are made to improve practice or prevent death. However, significant findings and concerns following one FAI led in 2019 to the SPS undertaking

41 (see https://archive2021.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_15-23_Inquiries_into_Fatal_Accidents_and_Sudden_Deaths_etc_Scotland_Bill.pdf)

a comprehensive review of one of their key operating protocols, some considerable period after the incident.

Following the consultation in 2014, the Scottish Courts and Tribunals Service (SCTS) now has responsibility to disseminate the determination and recommendations to all relevant parties. The relevant parties are then to respond in writing within eight weeks, and this is published. If no response is given, this is also published by the SCTS.

5.6.3 Comparison of FAI and DIPLAR findings

The Review examined the FAIs and DIPLARs that took place between 2018 and 2020. What became abundantly clear was that, even within that short range, the FAI and DIPLAR process concentrated on different aspects and had very different outcomes. FAIs look at the death in question and the circumstances related to that death, while the DIPLARs focus on the immediate operational issues. It is not surprising, therefore, that in contrast to the FAIs analysed by the Review, the DIPLARs recorded a significant number of learning points, recommendations, and action points.

However, neither the FAI nor the DIPLAR processes ensure that lessons learned from prison deaths are collated, analysed, and available to policy makers and prison staff or to those who investigate prison deaths so they can do their work in a more informed way.

In England, Wales, and Northern Ireland, all deaths in custody are independently investigated before the inquest, by the Independent Prison and Probation Ombudsman (PPO). The PPO and staff therefore build up an expertise in prison deaths in addition to their existing work investigating complaints, which already gives them a detailed understanding of the prison context. The family is contacted by the PPO office to contribute to the process, and the reports of the Prison Ombudsman are thorough and well-informed. Full reports, which have been anonymised, are published on the PPO website and are readily available after the conclusion of the Inquest. Following the publication of the report, Her Majesty's Inspectorate of Prisons reviews the progress on the recommendation for individual prisons in their inspection.

The Ombudsman's report on a death in custody is provided to the Coroner, who carries out a similar role to a Scottish FAI – the Inquest. The report provides assistance to the Coroner as to the key issues in the death and helps to identify the what evidence to call. Coroners regard these reports as a useful additional source of information rather than as a replacement for the normal enquires carried out by the Police Officers acting on behalf of the Coroner (Wheatley, 2020).

This system enables the Prison Ombudsman to keep a close watch on emerging trends and allows for publication by an independent body of bulletins identifying areas that need additional attention. These can include emerging information on new or changed vulnerabilities or deteriorating areas of operational performance.

In Scotland, there is no comparable publication that identifies areas that need additional information.

In England and Wales, data on suicide, deaths from all causes, self-harm, and assaults are published in a quarterly bulletin (quarterly death registration) and later in greater detail in an annual report. Both quarterly and annual publications are prepared by the Government Office of National Statistics.[42] Deaths are recorded as "apparently self-inflicted" rather than suicide, obviating the requirement to wait for a Coroner's verdict before the deaths are classified. This category includes self-administered drug overdoses. The only delay is caused when there is a need to wait for the results of toxicology reports when it is not clear if the death is caused by natural causes or an overdose of drugs.

42 https://www.ons.gov.uk/ .

Consistency and differences between FAI and DIPLAR recommendations

Ninety-three DIPLARS were examined by the Review, and the findings of the 20 DIPLARs where the FAI had also been completed, compared.

Only one of the 20 FAIs made any recommendations. The vast majority of the remaining 19 FAIs were agreed by joint minute, with only a handful calling witnesses before formal findings were declared. Given the high number of FAIs where joint minutes were agreed, it is pertinent to note the comments of Sheriff Gillian Wade QC (2020: 35) who cautions that:

It is essential in approaching the Inquiry into any death in prison that it is not treated as a formality.

That is not to say that due diligence is not undertaken in FAIs where joint minutes are agreed, but it is a timely reminder of the essential nature of the FAI process, perceived by families and staff as adversarial, the unequal access to counsel faced by families of the deceased, and the public pressure to complete FAIs timeously.

In contrast to the FAIs, the vast majority of the DIPLARs did note learning points, recommendations, and action points, with only two of the DIPLARs stating that no learning or action points were identified. Issues with next of kin details were noted in five of the DIPLARs but were not raised in the any of the FAIs, and whilst this does not have a direct bearing on what may have impacted, influenced, or caused the death of an individual, it was a significant issue for families of the deceased.

Given that only one of the 20 FAIs analysed made any recommendations, it is not possible for the Review to comment (as per the Terms of Reference) on the consistency and differences between previous FAI determinations and recommendations and learning arising from the DIPLAR process.

There is also very little explicit cross-referencing to the DIPLAR in the FAI, with the latter rarely making mention of the former. Indeed, if the DIPLAR is mentioned in the FAI, it appears only to note that this process has taken place.

Family involvement in, and views of, FAIs

There was no mention of family involvement in 12 out of the 20 FAIs. Of the eight families that were involved in the FAI in some way, only two families were formally represented by a Solicitor, with a further one involved but not formally represented at the Inquiry. A further three families were kept informed of the Inquiry (often via contact with the Procurator Fiscal Depute); one family was initially involved but then withdrew from the proceedings, and one FAI noted that the family of the deceased had stated they did not wish to be represented at the Inquiry.

Most of the families who spoke with the Review had attended the FAI for their relative. For them, "being in court was my voice". For others, other circumstances prevented them from attending (e.g. deaths of other family members or serious ill health), with one person avoiding the court due to fear of media exposure. One family member said, in hindsight, that she wished someone had encouraged her to attend, despite the fact that deaths by natural causes tended to be more straightforward. Regardless, attendance at an FAI could engender mixed feelings for families:

> **"**… part of me wished I was there to say my bit for him because that was my bit [to] sort of [fight] his wee corner, let everybody ken he was a decent man… and then part of me was like I'm glad I never. Because I'd have probably been in bits listening to all this cos I thought he was all right in prison. I thought he was well-liked and looked after and things like that and it just sounded to [family member] that he wasnae.**"**
>
> (family member)

None of the families gave evidence themselves, with any views they had expressed on their behalf via lawyers or the Procurator Fiscal. Only one family member said she had been offered the opportunity to speak (an opportunity she missed due to the death of her mother on the court date).

Support during the FAI

A number of families mentioned that legal representation was suggested to them, though only one said they were encouraged to apply for Legal Aid, and only two said they had received it. Some families decided against legal representation on the grounds that they didn't think they needed it or that they couldn't afford it. One mum spoke about her efforts to get a lawyer but said that no one would take the case, telling her that this would be a waste of time as an "open and shut" case (a drug-related death). In this case, the Sheriff proved to be a useful advocate.

"The judge just wanted kinda like a timeline on everything, and a lot of stuff in … and so on for like maybe a year because the judge wasn't happy with certain things that [the prison] was presenting … [so he] sent [the Procurator Fiscal] back a lot, you know, a lot, [with] a lot of questions. Saying there was just too many discrepancies as far as he was concerned – he wasnae amused actually. He was … a good judge, to be fair.**"**

(family member)

Another family that was unrepresented at the FAI said the Sheriff made sure they understood what was happening throughout and actually demanded that the reports were read out to the family when he learned they had not seen any of them.

Unfortunately, positive experiences were not universal, with families describing their experiences as humiliating and traumatising:

"I actually sent a complaint in about [the Sheriff] because of the way he addressed [my solicitor, and a statement] that I wrote. My being in court is my voice, and being mocked like that I was furious … [Family member] should have been allowed to die with dignity and he couldn't even have any dignity after he died. I just felt like the Fatal Accident Inquiry was just going through the motions.**"**

"… And I knew he was just another number to them, I get that, I understand they're just fodder, but it shouldn't be like that.**"**

"… it just seems to be they have to do it because it's mandatory, the FAIs. It's a complete waste of the public purse; … I think the main way I'd like to describe it is as an exacerbation of trauma, the FAI process. That's what it is.**"**

(family members)

Management and perceived fairness of the FAI process

Very few families spoke positively about the experience of an FAI. While the issue of long delays before the FAI took place were raised again, the main issues related to feeling heard and feeling they were being taken seriously.

"I just felt they don't actually listen, they don't actually hear you, you know, they look as if they're listening but I just felt no one had really listened to my opinions and my views on it and that sort of left me in a state of bewilderment and I'm not easily confused. I'm quite an intelligent woman but I'm like, well what was the point of this.**"**

"But some of the stuff that they were saying was kinda a shock as if they didn't care about my brother. He was just another prisoner with mental health issues. They were saying he's a drug addict. I don't care if he's a drug addict or no, it disnae matter, he still has mental health issues … It was as if he was just another drug addict in prison and they just didnae care about him really.**"**

(family members)

Families also raised concerns about the proceeding feeling one-sided and adversarial, with answers from officials appearing inconsistent or, conversely, prepared in advance. One family said they learned half-way through the FAI that prison staff had been offered immunity from the Crown if they told the truth.

"... but they didn't tell the truth, we knew they weren't because of the way they acted and changed their stories and judge kept calling them out on it, and [they] would tell another version.**"**

… we felt ganged up upon by the NHS, the Prison Services, and the Procurator Fiscal. Just so everything that we were saying or our lawyer was trying to bring on board they had answer ready beforehand."
(family members)

The few positive comments underlined the need for families to feel heard and able to contribute, even if this were only through their lawyers or through the Sheriffs themselves."

"We were able to contribute a lot to be fair and we done quite a lot. We were able to get recommendations heard by the Sheriff who was able either to put the recommendations in place at the prison or not."

"The Sheriff was listening. He was there for the reason he was there."
(family members)

Other concerns from families were more varied. One mother worried that the findings of FAIs were not compared with each other, suspicious that her son's death was one of a number of similar deaths relating to people having drugs "tested" on them by others held in prison. Another did not believe that the media should be allowed into FAIs, while a third queried why an FAI was needed when a death was expected, saying that no one explained any of this.

Unsurprisingly, and following discussion of a number of these concerns, a specific request from the Family Advisory Group was for the FAI system to be reviewed as a matter of urgency. This was a view almost universally expressed by both prison and NHS staff as well.

The Family Advisory Group recognised that the individual's criminal record might in a few instances provide relevant background information when an FAI probes the cause of death but questioned the need for the published report of the FAI to refer to the criminal record.

Three key conclusions in relation to families and FAI process were as follows:

- Families wanted simplification of the FAI report ("just tell me why he died") and choice about how and when to share information about the death with others rather than the media being allowed to report a death once the next of kin has been informed. They saw no need for the published FAI report to refer to the individual's criminal record.
- Limited access to Legal Aid inhibits the active participation of families in the FAI process.
- Families wanted the FAI process to happen much sooner after the death.

Staff views of FAIs

Staff who had worked within prison healthcare prior to their transfer to the NHS recalled preparation for attendance at FAIs being part of their initial training. Responsibility in preparing staff for FAI (from a prison setting to an NHS setting) now appeared to be reliant on sharing experience within teams.

One NHS Board had introduced a more robust arrangement with their Central Legal Office, and this was viewed positively:

"if someone is called to an FAI, the Central Legal Office lawyers will go through it with NHS staff and we have someone attend to sit in the court while the FAI is ongoing."
(staff member)

The time lapse between a death occurring and an FAI taking place can be lengthy. Armstrong and colleagues' study of FAIs following deaths in custody found that the average time taken to complete an FAI was nearly two years (720 days) and that more than three-quarters (76%, or 150 deaths) take two years or more (Armstrong et al, 2021). There were local arrangements for storing statements; however, staff felt the lack of preparation contributed to their anxiety.

"Got statement from Police, and was totally unprepared for four lawyers and a judge"
(staff member)

Most NHS staff described the experience of attending an FAI as "distressing" and "stressful", a point echoed by prison staff who had variously been involved in FAIs and who universally described them as unpleasant, combative, adversarial, anxiety-inducing experiences. The adversarial nature of FAIs was evident in most staff comments.

"In my opinion you can't be prepared for it. Single worst experience as [prison staff role]."

The level of support from the Prison Service and NHS Boards was variable (something also noted by Ludlow et al, 2015) and staff found the challenges of waiting times for an FAI to be unhelpful.

Prison staff reported feeling like they were on trial and being expected to convince people that their role in an incident did not contribute to it. FAIs were widely viewed by prison staff as an exercise in blame, a culture of attempting to 'finger-point' rather than an opportunity to learn, and staff very much felt it was the lawyer for the prison versus the lawyer representing the family, with little representation for staff members – and a sense of being caught in the middle.

"SPS has representation but [staff role] has no representative."

"Biggest issue, after a death in custody, staff feel it's a 'point the finger'. At the FAI, the SPS lawyers say "we're not here for you, we're here for the organisation". It's not about development or making it better, it's for who's to blame."

"Lawyers doing battle – you feel like a pawn."
(staff members)

A few staff felt that the SPS lawyer was more critical than the family lawyer and that it was an exercise in shining a light not on the Prison Service itself but on the individual officer; diverting attention onto staff and away from the organisation. Even for those staff who had never been required to attend, FAIs were viewed with apprehension based on staff anecdotes:

"Never participated in an FAI, always been mindful of the FAIs, pulling paperwork together, speaking with families, aware I could've been called to an FAI, preparation has always been with the idea that I could be subject to an FAI, and have that as the lens when dealing with a death in prison."
(Staff member)

For those staff who felt they had been supported well by the establishment following a death in custody, to then encounter a lack of support, or even feel attacked or targeted during an FAI appeared to be a demoralising experience. Staff were unsure how to make the FAI experience more positive. There was an acceptance that it was the job of the family's solicitor to establish the facts by asking awkward and testing questions.

"You feel uncomfortable, you try to do your best at the time and you try and save people's lives but you're always asked what more you could have done."
(staff member)

Acknowledgement of potential impact of COVID-19

It must be noted that the time frame chosen by the Review (deaths which occurred between January 2018 and December 2020) includes the onset of COVID-19 and the associated restrictions that have resulted from, and continue in relation to, the global pandemic.

However, this Review's findings echo the Cullen 2009 Report and the subsequent 2016 progress review into FAIs, regarding a lack of family involvement in the FAI process, despite the good practice approach noted in the Crown Office and Procurator Fiscal Family Liaison Charter.

Public versus private

At the end of every FAI, condolences are expressed to the family of the deceased, in a public acknowledgement of an individual's death and the impact this may have on those who knew them. FAI reports are available, and fully accessible, online.[43] The remit of the FAI is such that it rarely comments on the impact of the death on the deceased's family or staff and does not detail support offered either by the PF's office or by the SPS itself.

Many full reports of FAIs are accessible on the SCTS's website, but staff and families expressed that a more public-friendly version with follow-up publications related to progress against recommendations for deaths in custody would be helpful. Furthermore, HMIPS(2019b) recommended that an MOU be developed between relevant agencies on the appropriate methodology for inquiry and reporting, including the development of a joint management information system needed to support effective information capture, analysis, and dissemination.

Key recommendation

We recommend that a separate, fully independent investigation should be undertaken into each death in prison custody, triggered as soon as possible after the death occurs and when the next of kin have been informed. This would not replace the DIPLAR and SAER processes and would, we believe, complement the FAI process as a useful and credible source of evidence surrounding the circumstances of a death in custody. An independent investigation would also support compliance with Article 2 of the 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 the participation of the deceased's next of kin.

In line with these standards, we recommend that any independent investigation mechanism should have the following attributes:

Independence

Investigations should be carried out by a body wholly independent of the Scottish Ministers, the SPS or private prison operator, and the NHS. The body's functions and remit – including, for example, the timescales for investigations, the parties that must be involved in an investigation, and related complaints/appeals processes – should be set out in statute and explicitly linked to human rights standards. To ensure independence and facilitate maximum accountability and oversight, the body tasked with carrying out investigations should be accountable to the Scottish Parliament, with appropriate reporting requirements also set out in statute. Those who have been impacted by a death in custody must be involved in setting the functions and remit of this body.

Participation of next of kin

The investigation process must involve the families, carers, or next of kin of those who have died in prison custody. In principle, families of a deceased person can be represented at an FAI, and the DIPLAR and SAER policies allow for some family participation. In practice, however, family participation in these processes is minimal: Armstrong et al. (2021) found that families are rarely involved in FAIs in terms of being legally represented, presenting at inquiries, or providing evidence, and that their involvement in all these ways has declined since 2016. Crucially, an independent investigation would allow families of a deceased person to raise any concerns or questions related to the care their family member received or the treatment they experienced when in prison at an early stage. It would also explore why the person died rather than simply how. We believe this would not only play a vital role in ensuring family participation, which in turn would strengthen understanding around the circumstances of a death, but would increase wider public confidence and transparency into how deaths in prison custody are responded to in Scotland. Family involvement could also include a requirement to invite families to comment on proposed recommendations and what will change as a result.

43 www.scotcourts.gov.uk.

Finally, 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 legal processes that take place following a death in custody.[44] This accords with the recommendation made by Dame Elish Angiolini (2020: para 25.24). Dame Angiolini recommends that, in Article 2 cases (where a person has died in Police custody), there should be access for the immediate family of the deceased to free, non-means-tested legal advice, assistance, and representation from the earliest points following the death and throughout the Fatal Accident Inquiry.

This would include to support their participation in any NHS SAER, DIPLAR, independent investigation, and/or FAI.

Adequacy

In Scotland, the primary means by which Article 2 ECHR compliance is achieved following a death in prison custody is through the FAI process. An FAI is a public examination of the circumstances of a death conducted before a sheriff. The purpose of an FAI is to establish the circumstances of the death and to consider the steps (if any) that might be taken to prevent other deaths in similar circumstances.[45] Despite this, Armstrong and colleagues (2021) found that in over 90% of all FAIs, no finding of a reasonable precaution is made, no finding of defect is made, and no recommendations are made to improve practice or prevent death.

The COPFS, which is independent of Scottish Ministers, is responsible for presenting evidence. Other parties, such as the SPS, NHS, or next of kin of the deceased, may also lead evidence. Completed DIPLAR documentation is often produced as evidence in court, alongside other documentary and oral evidence from various witnesses and experts. Although DIPLAR documentation is no doubt useful, it represents the SPS/private prison and NHS-agreed account of events and their assessment of improvements needed. An investigation undertaken independent of any authorities involved in the death could only aid the FAI process by ensuring as far as possible that all relevant facts are brought to light and that any failings are identified and lessons are learned.

Expert consultant Phil Wheatley noted in his evidence to us that:

> **The heavy reliance on the FAI as providing the only proper process for discovering the facts and learning lessons has, in my view, prevented the SPS from learning lessons from suicides, and the lack of expert prison knowledge by all those who play key roles in the FAI process has meant it has neither provided a timely and thorough analysis of individual deaths nor an effective way of drawing together the learning from other similar cases … The addition of an important role for Non-Executive SPS Board members may help, but a much bigger impact could be achieved if there was a genuinely independent organisation to inquire into all prison deaths.**

The body tasked with undertaking independent investigations into deaths in custody should also be tasked, in statute, with the duty to monitor the implementation of learning arising from investigations and FAIs effectively, including the dissemination of good practice. This includes the duty to collate and analyse recommendations, learning, and examples of good practice to ensure that systemic problems are identified and addressed promptly and appropriately and that good practice is replicated across the prison estate.[46] To be meaningful, the body undertaking this process also needs to include a National Oversight Mechanism to ensure accountability, namely to review and monitor progress on recommendations made and hold agencies to account. This concept is also echoed in the Angiolini Review (2017).

44 Independent Review of Complaints Handling, Investigations and Misconduct Issues in Relation to Policing: Final Report (www.gov.scot)

45 Section 1(3)(a) and (b) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the 2016 Act).

46 The INQUEST report, "Deaths in prison: a national scandal", January 2020, called for the establishment of a National Oversight Mechanism to monitor learning and implementation arising out of post death investigations, inquiries, and inquests.

Within that framework there should be a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.[47]

Promptness and reasonable expedition

Families and staff told us that the long periods of time between a death and the FAI can be distressing. This was also highlighted in the Follow-Up Review of Fatal Accident Inquiries undertaken by the Inspectorate of Prosecution in Scotland (2019: Para 81). Armstrong et al. (2021) reported that FAIs are taking longer today than before the legislative changes made in 2016: between 2005 and 2008, the average time between the death of a person in custody and the publication of the FAI determination was 509 days; between 2016 and 2019, it had increased to nearly 700 days, with many FAIs for deaths in these years yet to be published. The authors' view, which this Review supports, is that delays in FAI hearings, as well as the way these are drawn out once begun, could exacerbate grief and trauma for loved ones, and that delayed timescales also undermine the possibility for scrutiny of any problems that are unearthed. They also note that FAIs, by focusing on individual cases, are not able to problematise this nor interrogate the structural and systemic issues underlying deaths in prison. In contrast, an independent investigatory body would have the ability and remit to review cumulative learning across cases.

Any independent investigation should be completed within a matter of months. This could provide some level of closure for families prior to the FAI and, crucially, would support and complement the learning process for SPS, NHS and private prison operators, helping to ensure that failings are identified and acted upon swiftly to minimise the chances of repeated or systemic failures occurring.

Public scrutiny

The regular review of data trends on prison deaths by an independent body would improve public assurance that everything possible was being done to prevent deaths in custody. Accordingly, the same public body as above should be tasked with a duty to collate, analyse, monitor, and make publicly available a report on the trends, systemic issues, recommendations, learning, and good practice arising from all deaths in custody and, crucially, track progress with implementation.

In keeping with the above recommendations, a comprehensive review should be conducted into the main causes of all deaths in custody and what further action might be taken to prevent such deaths, leading to the development of a single new framework for assessing and scrutinising the prevention of deaths in custody. A review and framework of that nature was beyond the terms of reference given to us for this Review.

Similar systems in other jurisdictions

Similar systems are in place in other UK jurisdictions and in the Republic of Ireland. As mentioned, in England and Wales, the PPO carries out independent investigations into deaths in custody.[48] The system in England and Wales has two weaknesses: first, the PPO is still not a formal statutory body, which puts it at risk of dissolution. The other is that the PPO can make recommendations but cannot make sure their recommendations are implemented. HM Inspectorate of Prisons for England and Wales has therefore agreed to include the PPO recommendations in their inspections. Unfortunately, this can leave a gap between the recommendations and the HMIP follow-up, as there are currently about four years between inspections of each prison. Independent investigation that incorporates a National Oversight Mechanism would remove this barrier.

47 https://www.inquest.org.uk/learning-from-deaths-in-custody
48 PPO-Terms-of-reference-2017.pdf

In the Republic of Ireland, the Inspector of Prisons carries out investigations into all deaths in prison custody. The objectives for investigations are to:

- establish the circumstances and events surround the death, including the care provided by the Irish Prison Service;
- examine whether any changes in Irish Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family has an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 ECHR, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.[49]

The Prisoner Ombudsman for Northern Ireland (NI) investigates all deaths in Prison Service custody in Northern Ireland[50]. In addition, the Ombudsman has discretion to investigate incidents of serious self-harm or deaths which occur after the individual was released from custody, to examine if any factors related to their time in custody may have contributed to their self-harm or death.

The aims of the Ombudsman's investigation are to:

- establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors;
- examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence;
- in conjunction with the Department of Health, Social Services, and Public Safety, where appropriate, examine relevant health issues and assess clinical care;
- provide explanations and insight for the bereaved relatives;
- assist the Coroner's inquest in achieving fulfilment of the investigation obligation arising under Article 2 ECHR.[51]

5.6.4 Key recommendation

- As set out in more detail above, a separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.
- The independent investigation should be instigated as soon as possible after the death and completed within a matter of months.
- The investigation process must involve the families or Next of Kin of those who have died in prison custody.
- The purpose of the investigation should be to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice, or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Article 2 of the ECHR. All investigations must result in a written outcome.
- In determining the process of investigation and the intensity of review required, the independent investigatory body must have regard to applicable human rights standards, including those set out in the online Appendices.
- The independent investigatory body must have unfettered access to all relevant material, including all data from SPS, access to premises for the purpose of conducting interviews with employees, people held in detention and others, and the right to carry out such interviews for the purpose of the investigation. Corresponding duties should be placed on SPS and other relevant

49 What We Do - Inspector of Prisons (oip.ie)

50 Prisoner Ombudsman for Northern Ireland (niprisonerombudsman.gov.uk)

51 Prisoner Ombudsman for Northern Ireland, Terms of Reference for Investigation of Deaths in Prison Custody. Available at: 99745fcc9307b1b3def31c044ce78c155aafb40d.pdf

institutions requiring the completion, retention and production of relevant information in their possession.
- The independent investigatory body must be required to produce and publish reports analysing data on deaths in custody, identifying trends and systemic issues, making recommendations and promoting good practice.
- The independent investigatory body should also be tasked, in statute, with the duty to monitor and report on the implementation of its recommendations. The views of bereaved families or next of kin should be taken into account in this process.
- Families or next of kin of those who have died in custody should have access to full non-means-tested Legal Aid funding for specialist representation throughout the processes of investigation following a death in custody, including at the FAI.

5.6.5 Other recommendations

The Review is aware that consideration of the FAI process is strictly beyond its remit, but following a HRBA consider it important to note these points as very important to the families.
- A review of the FAI process to consider a less formal and adversarial approach involving views from family members.
- The timing between the death occurring and the FAI must be reduced.

6. Overarching Conclusions and Recommendations

The Review is deeply indebted to the families, people currently in prison, prison staff, and NHS staff who contributed their views, which inevitably involved having to go back over extremely painful memories.

The Review recognised the needs and rights of all people working and living in prison and, in accordance with the human rights-based approach, we place the rights of those most affected by a death at the heart of our decision making in relation to our recommendations.

The fundamental findings of the Review are:

- practices and experiences relating to deaths in custody varied widely across the whole of the prison estate, through to the FAI, despite the best endeavours of those drafting guidance to promote consistency;
- current processes and practices did not meet the key tests set out in human rights legislation for investigations, namely that they should be:
  - independent
  - adequate
  - prompt
  - open to public scrutiny and involve the next of kin.
- family engagement was lacking at every step of the journey, where humanity and compassion are at times compromised;
- the impact of the event and the need for more effective training and support was clearly appreciated;
- the investigation processes would benefit from greater independent scrutiny with enhanced family engagement at a much earlier stage;
- a national oversight mechanism to review data and report publicly on recommendations, learning, and good practice arising out of custodial deaths was lacking;
- a comprehensive review of deaths in custody and the further steps that can be taken to prevent such deaths was needed.

While the FAI procedure is outwith the scope of this Review, evidence provided to the Review by families and prison staff highlighted concerns about the adequacy of the FAI process. Following the human rights-based approach applied by the Review, it is important that the voices of families be heard on this point. In relation to the tests that apply to right to life investigations, families pointed out the need for:

- independence – the experience and perceptions of the families were that the lack of independence, transparency, and engagement at an earlier stage generated suspicion;
- adequacy – families found their questions were not answered by any of the inquiry processes;
- promptness – while recognising the logistical challenges facing COPFS and SFIU, the delays currently incurred do not meet this test and leave families without closure for far too long;
- public scrutiny and involvement of families – the FAI process delivers the public scrutiny, but there is a lack of public scrutiny prior to the FAI and no public systematic evaluation of data and trends and action to reduce the risk of future deaths. The type of engagement with families was a strong concern at every step of the inquiry processes.

There is no published systematic evaluation of data and trends and action to reduce the risk of future deaths.

Recommendations

Key Recommendation: A separate independent investigation should be undertaken into each death in prison custody. This should be carried out by a body wholly independent of the Scottish Ministers, the SPS or the private prison operator, and the NHS.

- The independent investigation should be instigated as soon as possible after the death and completed within a matter of months.
- The investigation process must involve the families or Next of Kin of those who have died in prison custody.
- The purpose of the investigation should be to establish the circumstances surrounding the death, examine whether any operational methods, policy, practice, or management arrangements would help prevent a recurrence, examine relevant health issues and assess clinical care, provide explanations and insight for bereaved relatives, and help fulfil the procedural requirements of Article 2 of the ECHR. All investigations must result in a written outcome.
- In determining the process of investigation and the intensity of review required, the independent investigatory body must have regard to applicable human rights standards, including those set out in the online Appendices.
- The independent investigatory body must have unfettered access to all relevant material, including all data from SPS, access to premises for the purpose of conducting interviews with employees, people held in detention and others, and the right to carry out such interviews for the purpose of the investigation. Corresponding duties should be placed on SPS and other relevant institutions requiring the completion, retention and production of relevant information in their possession.
- The independent investigatory body must be required to produce and publish reports analysing data on deaths in custody, identifying trends and systemic issues, making recommendations and promoting good practice.
- The independent investigatory body should also be tasked, in statute, with the duty to monitor and report on the implementation of its recommendations. The views of bereaved families or Next of Kin should be taken into account in this process.
- Families or next of kin of those who have died in custody should have access to full non-means-tested legal aid funding for specialist representation throughout the processes of investigation following a death in custody, including at the FAI.

Other recommendations

To address our findings, we have made 26 other recommendations and a small number of advisory points. The recommendations are grouped around five themes, reflecting the findings of the Review.

Theme 1: Family contact with the prison and involvement in care

- **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.
- **Recommendation 1.2** The Scottish Prison Service and the NHS should develop a comprehensive joint training package for staff around responding to deaths in custody.
- **Recommendation 1.3** The Scottish Prison Service should develop a more accessible system, so that where family members have serious concerns about the health or wellbeing of someone in prison, these views are acknowledged, recorded and addressed, with appropriate communication back to the family.
- **Recommendation 1.4** When someone is admitted to prison, the SPS and NHS should seek permission that, where prison or healthcare staff have serious concerns about the health or wellbeing of someone in their care, they are able to contact the next of kin. If someone is gravely ill and is taken to hospital, the next of kin should be informed

immediately where consent has been given. This consent should be recorded at every admission to prison to allow for cases in which someone becomes unable to give consent.

Theme 2: Policies and processes after a death

- **Recommendation 2.1** The SPS and NHS should jointly develop enhanced training for prison and healthcare staff in how to respond to a potential death in prison, including developing a process for confirmation of death.
- **Recommendation 2.2** The SPS should provide improved access to equipment such as ligature cutters and screens to save vital time in saving lives or preserving the dignity of those who have died.
- **Recommendation 2.3** The NHS and SPS should address the scope to reduce unnecessary pressure on the Scottish Ambulance Service when clinical staff attending the scene with appropriate expertise are satisfied that they can pronounce death.
- **Recommendation 2.4** The SPS should review the DIPLAR proforma to ensure they evidence how the impact of a death on others held in prison is assessed and that support is offered.
- **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.

Theme 3: Family contact and support following a death

- **Recommendation 3.1** The Governor in Charge (GIC) should be the first point of contact with families (after the Police) as soon as possible after a death. An SPS single point of contact other than the Chaplain should maintain close contact thereafter, with pastoral support from a Chaplain still offered.
- **Recommendation 3.2** SPS and NHS should review internal guidance documents, processes, and training to ensure that anyone contacting the family is clear on what they can and should disclose. SPS should work with COPFS to obtain clarity as to what can be disclosed to the family without prejudicing any investigation, taking due account of the need of the family to have their questions about the death answered as soon as possible.
- **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 opportunity should be spelled out in a family support booklet jointly created and reviewed by the SPS and the NHS.
- **Recommendation 3.4** To support compliance with the State's obligation to protect the right to life, a comprehensive review involving families should be conducted into the main causes of all deaths in custody and what further steps can be taken to prevent such deaths.

Theme 4: Support for staff and other people held in prison after a death

- **Recommendation 4.1** The NHS and SPS should develop a comprehensive framework of trauma-informed support with the meaningful participation of staff, including a review of the Critical Incident Response and Support policy, to ensure accessibility, trained facilitators, and consistency of approach. This should ensure that staff who have witnessed a death always have the opportunity to attend and that a system of regular and proactive welfare checks are made.
- **Recommendation 4.2** The SPS and NHS should also develop, with the meaningful participation of people held in prison, a framework of trauma-informed support for people held in prison to ensure their needs are met following a death in custody.

Theme 5: SPS and NHS documentation concerning deaths

- **Recommendation 5.1** The SPS and NHS should ensure that every family are informed of the DIPLAR and, if applicable, the SAER process, and their involvement maximised. This includes the family:
  - having the process (including timings) and their involvement clearly explained;
  - being given the name and number of a single point of contact;
  - knowing when their questions and concerns will be considered; and
  - receiving timely feedback.
- **Recommendation 5.2** 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.
- **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.
- **Recommendation 5.4** The full DIPLAR process should be followed for all deaths in custody, with a member of staff from Prison Service Headquarters in attendance.

In addition, the families and staff involved in the Review raised a number of points they would like to see addressed to the organisations in the report as advisory points.

- **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 (Nugent, 2018). The NHS and SPS should commission the independent development and support of such a platform.
- **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.
- **Advisory Point 3** Consideration should always be given by the SPS and NHS to whether other people held in prison who knew the deceased may have relevant information to offer and how best to include their reflections in both DIPLAR and SAER processes where appropriate, in particular whether discrimination of any kind was perceived as a factor in the death.
- **Advisory point 4** The SPS and NHS should review the DIPLAR report form to include a separate section where observed systemic or recurring issues are recorded by the independent chair to ensure holistic improvements to broader systems and processes are more easily recognised and addressed.
- **Advisory point 5** The SPS and NHS should also consider developing a separate section in the DIPLAR document to ensure information on family involvement and the content of discussions is recorded, including any questions raised by the family and the response to them.
- **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.

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