Death in Prison Learning, Audit & Review (DIPLAR) Process Guidance

Section 1: Introduction

1.1 In recent years there has been an increase in the number of people dying from natural causes in custody. In the 5 years from 2014-2017 there was a 27% increase in deaths by natural causes from the previous 5 years. This is in part due to an increasing ageing prisoner population however many are dying prematurely.

1.2 Many people who are in custody have complex physical and mental health problems and come from disadvantaged backgrounds with poor housing and low income employment. This highlights the health inequalities experienced in the community by many who come into custody.

1.3 According To the World Health Organisation report; Preventing Suicide, a Global Imperative, key factors that contribute to the occurrence of suicide include social exclusion, poverty, isolation, relationship issues, drug and alcohol problems, mental-health issues, access to methods to complete suicide, lack of treatment or risk identification, and lack of care.

1.4. Those in custody are often from the most deprived areas in Scotland, many have substance misuse problems, poor physical and mental health with a history of trauma and relationship difficulties. The prison population inherently carry a greater risk than the general population in terms of suicide before their sentence.

1.5. Scottish Government is committed to reducing the incidence of suicide and of self-harm and targets were set in 2002 in the Choose Life Strategy and Action Plan to reduce rates of suicides by 20% by 2013. The suicide rate in Scotland was reduced by 18% in the period 2000-02 to 2010-12. The number of deaths by suicide in Scotland reduced year on year from 2011 to 15 with a 24% decrease in those 5 years however deaths by suicide rose by 8% in 2016.

1.6. When a suicide takes place, it is necessary to understand what happened and learn from any lessons identified. Lessons learned are important to improve services and help staff recognise where risk exists. In the community, NHS Mental Health services participate in a suicide review process where an individual had contact with mental health services in the preceding 12 months.

1.7. The DIPLAR process enables SPS to contribute to the Scottish Suicide Prevention Strategy's theme to develop the evidence base through a reporting and learning system that analyses all suicide reviews to promote learning and improve strategies throughout Scotland.

1.8. The report from the National Suicide Prevention Working Group, Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland proposed several actions including:

(a) Reporting of suicide should be taken account of in the work on patient safety in mental health and in particular in the context of work to refresh the arrangements for conducting and learning from Critical Incident Reviews.

1.9. All deaths in prison custody may be subject to a Fatal Accident Inquiry (FAI) under the Inquiries into the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. It is therefore prudent for SPS and NHS to identify areas for improvement and potential learning in advance of any court hearing.

Section 2: Purpose & Scope

2.1 The DIPLAR is the joint SPS & NHS process for reviewing deaths in custody and provides a system for recording any learning and identified actions.

2.2. The DIPLAR ensures openness and transparency of practice and focuses on establishment and organisational self-improvement, whilst also providing a mechanism for primary and secondary assurance with regards to aspects of prisoner management. Information obtained will also contribute to the development of national suicide prevention policies and procedures and offers a means of communicating areas of good practice.

2.3. The aim of DIPLAR is 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.

2.4. 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 prior to the completion of suicide.

2.5 The DIPLAR should be held where there is a death in prison or where someone in our care dies in hospital. The DIPLAR does not include those who die in Police custody.

2.6 Where there is a death by suicide in prison and when the person was in contact with Mental Health services in the year before death, a review will be carried out by NHS Health Boards and the learning will be submitted to Health Improvement Scotland through their Board's Governance processes.

2.7 The DIPLAR process consists of 3 levels of review:

- Self-Inflicted Death in Prison Review (Suicide or intentional self-inflicted death includes cases where it is clear that the person's intention was suicide)
- Event of Undetermined Intent Review (Are cases where it is not clear whether the death was the result of intentional self-harm or accidental); and
- 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 level of DIPLAR review should be determined by the information available at the time of the death and jointly agreed by SPS and NHS.

2.8 The DIPLAR consists of 3 sections:

- Death in Prison Learning, Audit & Review Report
- A Timeline of significant events, and
- A joint SPS/NHS Learning & Action Plan

Section 3: SPS Critical Incident Response & Support (CIRS) Policy

3.1. Immediately following any death in prison and before a DIPLAR meeting is convened, the Critical Incident Response & Support (CIRS) process must be initiated. The private prisons will initiate their own critical incident support processes.

3.2. The main objective of the CIRS model is to help SPS and NHS employees make sense of the reactions they are experiencing following an incident and to assist them feel more in control of what is happening to them. Also, to ensure that there is early recognition of employees who are experiencing a marked psychological response and provisions are put in place to access specialist short-term therapeutic intervention.

3.3 Whilst CIRS is an SPS policy,m NHS staff involved will be invited to an initial CIRS meeting. If additional support is required the NHS staff member will be referred through normal NHS human resource processes.

3.4 When a Critical Incident has occurred within an SPS establishment the CIRS process is initiated. An initial staff support meeting should take place as soon as possible after the incident and before staff go off duty. All staff involved in the incident should be offered the opportunity to attend including NHS and external partners. The purpose of the meeting is to ascertain the wellbeing of staff, not to talk about the incident.

3.5 A CIRS Meeting then takes place between 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 follow up and support.

3.6 Attendance at any part of the CIRS meetings is not compulsory; however, SPS strongly encourages staff to consider attending. The information from this process is used to assist SPS Occupational 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.

3.7 If a staff member identifies that a crime may have been committed or there has been a potential breach of policy during a CIRs meeting the responder would inform a manager and this would be investigated through normal processes.

Section 4: NHS Process for Possible Suicides & Adverse Events

4.1 Suicide reviews are the way that the NHS analyses what happened and recognise where anything can be done to make things safer for other people at risk. Where an individual had contact with Mental Health services in the 12 months leading up to a death by suicide, NHS must complete a suicide review and produce an action and learning plan which will be submitted to Health Improvement Scotland.

4.2 Health Boards report to HIS on how suicide review actions have improved the quality of care and reduced suicide risk. There are mechanisms to identifying and sharing learning across Health Boards.

4.3 Each NHS Health Board have a significant adverse event review process which may be implemented following a suicide, drug related or natural causes death in prison. Some Health Boards may require the significant adverse events review to

take place prior to the DIPLAR being completed. The timescales for completion of these reviews may differ between Health Boards.

4.4 Some NHS significant adverse events reviews may require the participation of SPS and on occasions may include a joint learning and action plan that is countersigned by both SPS and NHS.

Section 5: Self-Inflicted Death in Prison Learning, Audit & Review (DIPLAR) Process

5.1 The DIPLAR process enables a review of a death by suicide through a roundtable collaborative multi-agency learning and reflective session.

5.2 Suicide or intentional self-inflicted death includes cases where it is clear that the person's intention was suicide (e.g. a note that was left or something that the deceased had said or done). Suicide or intentional self-inflicted death also includes cases where the evidence establishes that a person died as a result of self-inflicted injuries, even if it is not clear that suicide was the intention - so this category will include a death that was the result of a 'cry for help' that went wrong, because the death was caused by the deceased harming him/herself intentionally.

5.3 In advance of a post mortem result or FAI a cause of death will be categorised using evidence available at the time. Where police have concluded no criminal act has taken place it is reasonable to determine a death by suicide where a ligature has been used.

5.4 Following a self-inflicted death in custody the establishment should complete an immediate operational debrief of the incident to ensure processes were adhered to and whether any immediate action is required. The establishment should also start the CIRS process. NHS staff should report the incident through NHS clinical governance adverse event management processes (e.g. Datix/incident reporting system). The NHS may complete an adverse event review either prior to or following the DIPLAR.

5.5 The Governor-in-Charge (GIC) or Director should instruct the local SPS Suicide Prevention Co-ordinator to arrange a DIPLAR meeting. The DIPLAR should convene no later than 12 weeks after the death to ensure that any actions arising from the incident are dealt with in a timely manner. The SPS Suicide Prevention Coordinator should send invitations to all those required to attend the DIPLAR meeting.

The following people must be in attendance at the DIPLAR meeting:

- SPS GIC/ Private Prisons Director / Deputy Governor (chair)
- NHS Services Manager for Prison Healthcare (co-chair)

- NHS Healthcare Manager/Clinical Manager-in-Charge
- Local Suicide Prevention Co-ordinator
- Health Strategy & Suicide Prevention Manager
- First Line Manager (FLM) for the area in which the prisoner was located

The following people should attend if appropriate:

- Personal Officer
- Prison Based Mental Health/Primary Care Nurse
- NHS Primary Care/Acute/Community Mental Health Services where there was contact with services in the preceding 12 months
- Chaplain
- Social Worker
- G4S where the death occurred in their custody (i.e. in hospital) or where they have relevant information to share.
- Any other relevant member of staff including workplace officer, healthcare professional or staff who attended the incident.

5.6 Where it is identified that a Code of Conduct investigation is required or is ongoing, the SPS Chair of the DIPLAR should seek advice from their local Human Resources team to determine what can be discussed as part of the DIPLAR meeting and if individuals under investigation can attend. The POA(S) should also be informed so they can decide if it is necessary for their attendance at the DIPLAR meeting.

5.7 To ensure the appropriate information is available for the DIPLAR meeting, the prison should complete the timeline of significant events and collate a brief overview of the deceased's history including custodial history, family background any contact with prison health service and any significant events.

5.8 NHS Healthcare should collate all relevant information from prison healthcare records and community records where appropriate to ensure the appropriate information is available for the DIPLAR.

5.9 The Practice Notes on the Role of the Chaplain following a death in custody detail that the Chaplain meets with the bereaved family to offer support. They should advise them that a DIPLAR will take place and offer to raise any concerns or questions that the family may have.

5.10 In considering the event, the DIPLAR should record the circumstances of the incident and the immediate actions taken, examine how the person was being managed in prison and how the incident impacted on staff, other prisoners and the family. It should then summarise the main events and issues from the incident and identify any learning points from a wide range of perspectives including management processes and procedures, policy, and staff training and awareness.

5.11 It is important to note that any DIPLAR report will be recognised as a public document and may be shared across SPS to help guide and develop practice. It may also be requested as evidence at a subsequent Fatal Accident Inquiry.

5.12 A record of learning and actions to be undertaken and associated timescales should be documented in the Joint Learning & Action Plan (Appendix 2).

5.13 SPS Establishments should upload the draft DIPLAR and Learning and Action Plan to the HQ DIPLAR working area on SharePoint for review by the SPS Suicide Prevention Manager within 4 weeks of the DIPLAR meeting.

5.14 SPS Establishments will be provided with any comments by the SPS Suicide Prevention Manager within 4 weeks of the draft DIPLAR being uploaded to SharePoint.

5.15 SPS Establishments should make any amendments to the document and this should then be signed by the SPS and NHS chairs of the DIPLAR and a pdf version uploaded onto the HQ DIPLAR working area on SharePoint and a copy sent to the NHS Health Board Lead.

SPS DIPLAR Working Area

5.16 Private prisons should submit the draft DIPLAR for review to the SPS National Suicide Prevention Manager using the DIPLAR mail enabled folder detailed below within 4 weeks of the DIPLAR meeting.

5.17 Once approved private prisons should send a copy of the signed DIPLAR report and the Learning & Action Plan to SPS HQ using the DIPLAR mail enabled folder. A copy should be sent to the NHS Prison Health Board Lead.

SPSDeathinCustodyReviews@sps.pnn.gov.uk

5.18 NHS Board Prison Leads may submit the DIPLAR report and Learning Plan through their own Incident Reporting Systems for approval.

5.19 Where NHS Boards complete their own significant adverse event review there should be consultation with the Governor to ensure SPS are fully aware and agree any actions with implications for the organisation.

5.20 The report will be tabled at the next SPS Local Suicide Prevention Co-ordinators Forum. The co-ordinators will discuss the conclusions of the report and the outcome of any local recommendations and action plan. The group will provide feedback to the establishment. The forum will provide a summary to the National Suicide Prevention Management Group (NSPMG). The NSPMG will consider whether any changes are required to the SPS Prevention of Suicide in Prison Strategy and consider any remedial action in advance of the FAI hearing.

5.21 NHS Leads and the GIC / Private Prisons Director will identify those accountable for progressing and monitoring any actions from the DIPLAR.

5.22 The SPS National Suicide Prevention Manager will collate the information and provide a quarterly report on local and estate-wide trends and any learning that may inform policy development and improve service provision.

Section 6: Review of a Death by Undetermined Intent

6.1.'Events of undetermined intent' are cases where it is not clear whether the death was the result of intentional self-harm or accidental. For example, where a death is unexpected and there is no evidence of an underlying health condition or where the death may potentially be due to an overdose, it may not be possible to determine the cause of death until a post mortem. In cases of overdose a post mortem or FAI may not be able to conclusively determine the intent of the deceased and the death will therefore be recorded as an event of undetermined intent.

6.2 In advance of a post mortem result or FAI a cause of death will be categorised using evidence available at the time. Where police have concluded no criminal act has taken place and there is no underlying health condition the death may be considered an event of undetermined intent.

6.3 Where there is evidence of extreme drug use or where it is suspected it may be a drug related death these should be recorded as an event of undetermined intent until the results of a Post Mortem, toxicology or FAI.

6.4 Following a death by undetermined intent in prison the establishment should complete an immediate operational debrief of the incident to ensure processes were adhered to and whether any immediate action is required. The establishment should also start the CIRS process. NHS staff should report the incident through NHS clinical governance adverse event management processes (e.g. Datix/incident reporting system), and notify the SRLS where its criteria are met.

6.5 Where the death is unexpected and there is no known underlying health condition that could have contributed to the death, a DIPLAR should be carried out. The DIPLAR should convene no later than 12 weeks after the death to ensure that any actions are dealt with in a timely manner.

The following people must be in attendance at the DIPLAR meeting:

- SPS GIC/ Private Prisons Director / Deputy Governor (chair),
- NHS Health Care Manager/Clinical Manager-in-Charge (co-chair)
- Local Suicide Prevention Co-ordinator
- FLM for the area in which the prisoner was located

The following people should attend if appropriate:

- Personal Officer
- Chaplain
- Social Worker
- G4S where the death occurred in their custody (i.e. in hospital) or where they have relevant information to share.
- Any other relevant staff including workplace officer, health care professional or staff who attended the incident.

6.6 Where the death is suspected to be drug related there may be a delay in holding the DIPLAR if the results of the post mortem or toxicology are required by the NHS as part of the review.

6.7 To ensure the appropriate information is available for the DIPLAR meeting, the prison should complete the timeline of significant events and collate a brief overview of the deceased's history including custodial history, family background any contact with prison health service and any significant events.

6.8 NHS Healthcare should collate all relevant information from prison healthcare records and community records where appropriate to ensure the appropriate information is available for the DIPLAR.

6.9 The Practice Notes on the Role of the Chaplain following a death in custody detail that the Chaplain meets with the bereaved family to offer support. They should advise them that a DIPLAR will take place and offer to raise any concerns or questions that the family may have.

6.10 In considering the event, the DIPLAR should record the circumstances of the incident and the immediate actions taken, examine how the person was being managed in prison and how the incident impacted on staff, other prisoners and the family. It should then summarise the main events and issues from the incident and identify any learning points from a wide range of perspectives including management processes and procedures, policy, and staff training and awareness.

6.11 It is important to note that any DIPLAR Report will be recognised as a public document and may be shared across SPS to help guide and develop practice. It may also be requested as evidence at a subsequent Fatal Accident Inquiry.

6.12 A record of learning and actions to be undertaken and associated timescales should be documented in the Joint Learning & Action Plan (Appendix 2).

6.13 SPS Establishments should upload the draft DIPLAR and Learning and Action Plan to the HQ DIPLAR working area on SharePoint for review by the SPS Suicide Prevention Manager within 4 weeks of the DIPLAR meeting.

6.14 SPS Establishments will be provided with any comments by the SPS Suicide Prevention Manager within 4 weeks of the draft DIPLAR being uploaded to SharePoint.

6.15 SPS Establishments should make any amendments to the document and this should then be signed by the SPS and NHS chairs of the DIPLAR and a pdf version uploaded onto the HQ DIPLAR working area on SharePoint and a copy sent to the NHS Health Board Lead.

SPS DIPLAR Working Area

6.16 Private prisons should submit the draft DIPLAR for review to the SPS National Suicide Prevention Manager using the DIPLAR mail enabled folder detailed below within 4 weeks of the DIPLAR meeting.

6.17 Once approved private prisons should send a copy of the signed DIPLAR report and the Learning & Action Plan to SPS HQ using the DIPLAR mail enabled folder. A copy should be sent to the NHS Prison Health Board Lead.

SPSDeathinCustodyReviews@sps.pnn.gov.uk

6.18 NHS leads and the Governor / Private Prisons Director will identify those accountable for progressing and monitoring any actions from the DIPLAR.

6.19 The SPS National Suicide Prevention Manager will collate the information and provide a quarterly report on local and estate-wide trends and any learning that may inform policy development and improve service provision.

6.20 A copy of the DIPLAR report and the Learning Plan should be submitted to the SPS National Suicide Prevention Manager and NHS Prison Health Board Leads within 4 weeks of the DIPLAR meeting.

Section 7: Death from Natural Causes

7.1. Death from natural causes includes those 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. If it cannot be determined as natural causes in the absence of a post mortem result is should be recorded as an event of undetermined intent.

7.2. Following a death in prison from natural causes the establishment should complete an immediate operational debrief of the incident to ensure processes were adhered to and whether any immediate action is required. The establishment should also start the CIRS or equivalent critical incident support process.

7.3. Where a death has occurred due to natural causes there may still be benefit to completing a review. The DIPLAR is designed to consider the circumstances of the

incident and the immediate actions taken, examine how the person was being managed in prison, whether shared practice and service integration was in-situ; and how the incident impacted on staff involved in the incident or known to the person, other prisoners, the person's family, management processes and practice and the establishment as a whole.

7.4 The Practice Notes on the Role of the Chaplain following a death in custody detail that the Chaplain meets with the bereaved family to offer support. They should advise them that a DIPLAR will take place and offer to raise any concerns or questions that the family may have.

7.5 Where the death is due to natural causes, the Governor/ Director and the NHS Health Board Lead should determine whether there is benefit to holding a DIPLAR. If a DIPLAR is required it should be carried out no later than 12 weeks after the death to ensure that any actions are dealt with in a timely manner.

The following people must be in attendance at the DIPLAR meeting:

- Governor in Charge/ Private Prison Director /Deputy Governor (chair)
- NHS Health Care Manager/Clinical Manager-in-Charge (co-chair)
- FLM for the area the prisoner was located

The following people should attend if appropriate:

- Personal Officer
- Chaplain
- Social Worker
- Any NHS health professional that was involved in the individual's care if appropriate
- G4S where the death occurred in their custody (i.e. in hospital) or where they have relevant information to share.
- Any other relevant member of staff including workplace officer or staff who attended the incident.

7.6 SPS Establishments should upload the draft DIPLAR and Learning and Action Plan to the HQ DIPLAR working area on SharePoint for review by the SPS Suicide Prevention Manager within 4 weeks of the DIPLAR meeting.

7.7 SPS Establishments will be provided with any comments by the SPS Suicide Prevention Manager within 4 weeks of the draft DIPLAR being uploaded to SharePoint.

7.8 SPS Establishments should make any amendments to the document and this should then be signed by the SPS and NHS chairs of the DIPLAR and a pdf version

uploaded onto the HQ DIPLAR working area on SharePoint and a copy sent to the NHS Health Board Lead.

SPS DIPLAR Working Area

7.9 Private prisons should submit the draft DIPLAR for review to the SPS National Suicide Prevention Manager using the DIPLAR mail enabled folder detailed below within 4 weeks of the DIPLAR meeting.

7.10 Once approved private prisons should send a copy of the signed DIPLAR report and the Learning & Action Plan to SPS HQ using the DIPLAR mail enabled folder. A copy should be sent to the NHS Prison Health Board Lead.

SPSDeathinCustodyReviews@sps.pnn.gov.uk

Section 8: DIPLAR Reporting & Learning System

8.1. All DIPLAR reports and Learning & Action Plans will be submitted to the SPS National Suicide Prevention Manager for analysis. This will identify trends and common factors that may require additional action by SPS.

8.2. The Governor in Charge/ Private Prison Director and the NHS Health Board Lead for Prison Healthcare should monitor progress against the Learning Plan and ensure all local actions are completed.

8.3. The SPS National Suicide Prevention Manager will monitor all SPS actions from DIPLARs through the Local Suicide Prevention Co-ordinators and request quarterly progress reports from those establishments with outstanding actions.

8.4. The NHS Health Board Lead for Prison Healthcare will identify those accountable for progressing and monitoring actions from the DIPLAR.

8.5. The report will be tabled at the next SPS Local Suicide Prevention Co-ordinators Forum. The co-ordinators will discuss the conclusions of the report and the outcome of any local recommendations and action plan. The group will provide feedback to the establishment including any suggested changes to the document. The forum will provide a summary to the National Suicide Prevention Management Group (NSPMG). The NSPMG will consider whether any changes are required to the SPS Prevention of Suicide in Prison Strategy and consider any remedial action in advance of the FAI hearing.

8.6 An annual summary of DIPLAR finding and sections will be presented to the NSPMG and the SPS Executive Management Group.

This policy and guidance is part of the SPS Prevention of Suicide in Prison strategy, Talk to Me and will be reviewed by the NSPMG in light of any change to content or best practice.

References

Scottish Government Suicide Prevention Strategy 2013-2016
Suicide Prevention Strategy 2013-2016

Scottish Prison Service Website: Deaths in Prison
SPS Deaths in Prison

Healthcare Improvement Scotland: Suicide Reporting & Learning System
Reporting a suicide
Suicide Reporting and Learning System

Suicide Review
Suicide Reporting and Learning System

General Register Officer for Scotland: Suicide Rates in Scotland
Suicide Rates in Scotland

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976
FAI Legislation 1976

The Prisons and Young Offenders Institutions (Scotland) Amendment Rules 2011
Prison Rules 2011

SPS Critical Incident Response & Support Policy

Appendix 1

Death in Prison Learning, Audit & Review

DIPLAR Report

This DIPLAR report should be completed following a self-inflicted death or death by undetermined intent in prison.

Name: ……

SPIN: …… **CHI Number: ……..**

Date of Birth: …….. **Date of Death: …….**

Establishment: …….. **NHS Board: ……..**

Date of Review: ……

1. SPS and NHS will provide a brief overview of the deceased's history including custodial history, family background and any contact with prison health service.

2. SPS to provide a timeline of contact with services, any significant events in the months leading up to the death. (A timeline template is available in Appendix 4)

3. NHS to Provide a summary of contact with health care services including community Mental Health & acute health services if appropriate.

4. Record the specific incident and immediate actions taken including any external services including ambulance service and Police Scotland.

5. From available documentation and information from staff describe the prisoner's behaviour and mood in the month prior to death. (Including participation in programmes, work parties, any breaches of discipline, contact with mental health service etc.)

6. Did any information come to light after the prisoner's death or during the DIPLAR meeting that was not documented previously? (This may include recent stressors/triggers and informal comments to staff, prisoners or family).

7. How did the death affect the staff and prisoners involved, the prisoner's next of kin, family or close relations if known, and the establishment overall. (Include any specific action taken to support those affected). Did the family raise any concerns with the Chaplain to be discussed at the DIPLAR?

8. Detail any significant events or contributory factors that may possibly relate to the death in custody.

9. Findings/ Conclusion

Please record the names of all those in attendance

NAME	DESIGNATION

Appendix 2

DIPLAR

Learning & Action Plan

The joint Learning & Action Plan should be completed following the DIPLAR for Self-Inflicted Death & Death by Undetermined Intent in Prison.

Name: ……

SPIN: …… **CHI Number: ……..**

Date of Birth: …….. **Date of Death: …….**

Establishment: …….. **NHS Board: ……..**

Date of Review: ……

1. Identified good practice

2. Learning Points/Recommendations

3. Action Points

Action Point	Responsibility	By When

Signed: …….SPS Chair

Date: ……

Signed: ……NHS Chair

Date: ……

A copy of the signed DIPLAR report and the Learning & Action Plan should be submitted to the SPS National Suicide Prevention Manager.

If the death meets the Health Improvement Scotland criteria, the NHS board should submit the DIPLAR report and Learning & Action Plan to the Suicide Review & Learning System.

Appendix 3

Death in Prison Learning, Audit & Review

DIPLAR Report and Learning & Action Plan

This DIPLAR report should be completed following a Death from natural causes

Name: ……

SPIN: …… **CHI Number: ……..**

Date of Birth: …….. **Date of Death: …….**

Establishment: …….. **NHS Board: ……..**

Date of Review: ……

1. Was the death expected? **YES** **NO**

2. Please give details of why this death is considered natural causes

3. Was an application made for compassionate release? **YES** **NO**
   Please give details of the compassionate release application or decision not to progress the application

4. If the death occurred in hospital please give details of events leading up to the death including handcuffing (this will require information from G4S)

5. If the death occurred in prison please record the specific incident and immediate actions taken including the names of those staff involved.

6. How did the death affect the staff and prisoners involved, the prisoner's next of kin, family or close relations if known, and the establishment overall. Did the family raise any concerns with the Chaplain to be discussed at the DIPLAR?

7. Identified good practice

8. Learning points

Action plan

Action Point	Responsibility	By When

Please record the names of all those in attendance

NAME	DESIGNATION

A copy of the DIPLAR Report and Learning Plan should be sent to the SPS Suicide Prevention Manager

Signed: …….SPS Chair

Date: ……

Signed: ……NHS Chair

Date: ……

Appendix 4

Timeline of Significant events

The timeline should record the deceased's date of admission, court dates, changes of circumstances, history of being managed under Talk to Me or the Prevention of Suicide in Prison Strategy, incidents of self-harm or attempted suicide. It should also record any possible precipitating factors such as cancelled visits, bad phone calls, positive drug test or failure to progress or obtain parole.

Date	Significant Event	Identified Risk Factor? Yes/No

Appendix 5

Death in Prison Learning, Audit & Review (DIPLAR) Meeting

Request to Attend a Review into the Apparent Self-Inflicted Death of (……) on (……..)

INFORMATION

It is SPS policy to hold a Death in Prison Learning, Audit & Review (DIPLAR) meeting soon after any death in prison, and it is expected that all staff involved in the management and care of the individual attend the DIPLAR meeting.

The aim of DIPLAR is to learn lessons. It is designed to consider the circumstances of the incident and the immediate actions taken, examine how the prisoner was being managed, and how the incident impacted on staff, other prisoners, the prisoner's family, management, and the establishment as a whole.

In considering the case, the DIPLAR Report should record the above and summarise the main events and issues from the incident and identify any learning points from a wide range of differing perspectives including management, policy, and staff training and awareness. It will consider this from a local and national perspective. The Report includes a section to draw conclusions and records any actions to be undertaken.

The DIPLAR Report will be recognised as a public document. It may be used as evidence at the subsequent Fatal Accident Inquiry into the death. However, you are encouraged to fully participate in the Review, be open and honest, and provide as full an account as possible from your perspective.

DIPLAR ARRANGEMENTS

Arrangements have been made to hold the Review and it will take place on:

Day and date: ……..

Time: ……..

Venue: ……

Please confirm your availability to attend to…… by no later than…….

Appendix 6

Process Map Following a Self-Inflicted Death in Custody