SCOTTISH PRISON SERVICE

Death in Prison Learning Audit & Review (DIPLAR) Guidance

This document outlines the Scottish Prison Service Policy/Guidance in relation to Death in Prison Learning Audit and Review (DIPLAR)

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Unlocking Potential - Transforming Lives.

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Scottish Prison Service Policy/Guidance in relation to Death in Prison Learning Audit and Review

Associated Policies/GMA:

GMA 022A/23	Training for Operational Staff in Overdose Prevention, Intervention and Administration of Intranasal Naloxone (Nyxoid)
GMA 019A/23	Interim Critical Incident Management Process (ICIMP)
GMA 042A/22	HMIPS Revised DIPLAR Process
GMA 040A/22	Recording of Next of Kin details and consent to contact
GMA 039A/22	Death in Custody – Family Contact Process
GMA 027A/22	Use of Belts for Those Presenting as a Risk of Suicide
GMA 023A/22	DIPLAR Meetings – Update to Process for Deaths by Apparent Natural Cause (HQ Attendance)
GMA 006A/22	Release of Monies, Property of a Deceased Prisoner
GMA 003A/22	Deaths in Custody Files (Amended) (Legal Services)
GMA 039A/21	Release on Compassionate Grounds – Revised Guidance for Submission of Applications and Administration Process
GMA 025A/21	Procedure Following a Suicide or Attempted Suicide Using a Ligature (Revised)
GMA 018A/21	DIPLAR COVID 19 Death in Custody – Supplementary Guidance
GMA 028A/23	Revised Death in Prison Learning Audit & Review DIPLAR) Policy & Guidance - August 2023

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Introduction

DIPLAR is the SPS process for reviewing all deaths in custody and provides a system for recording any learning and identified actions.

NHS colleagues are key contributors within any DIPLAR and will be responsible for any health related actions identified as a result of the DIPLAR.

This document is a user guide to the full DIPLAR process.

The aim of a DIPLAR is to learn from the incident, consider the circumstances and the immediate actions taken. The process also focuses on how the incident affected staff, other prisoners, the person's family and the establishment as a whole.

The DIPLAR must be held when there is a death in prison custody or when an individual in our care dies in hospital or any other location external to the prison. (The DIPLAR does not include those who die in Police custody). At the conclusion of the DIPLAR the findings will be shared with the deceased's family.

The Governor should appoint a DIPLAR Co-ordinator following a death in custody to co-ordinate the meeting, comply with timescales, support completion of the DIPLAR paperwork and monitor local actions identified for completion.

DIPLAR meetings should be held within 12 weeks of the death in custody.

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. The final DIPLAR documentation will be submitted to support any FAI.

NHS Boards are committed to delivering care that is safe, effective and person centred. Significant Adverse Event Reviews (SAERs) are carried out following events that have resulted in unexpected death or harm. These are focused on analysing factors that have contributed to the circumstances of the adverse event.

All communications with HQ Health regarding DIPLARs must be via email using HQDIPLAR@prisons.gov.scot

Family Engagement

Following a death in prison custody the family will be notified by the Police who will advise them of the contact details for the establishment duty manager.

The Governor/ Deputy Governor will then contact the family within 24 hours.

The Governor will then appoint a member of the management team to be the main contact with the family along with providing them with the Family Support Booklet which will also confirm the contact details for Chaplaincy and NHS.

A record will be kept of all engagement with the family and any particular questions or concerns that arise. This should be recorded on Appendix 3.

The DIPLAR will consider all aspects of the engagement with the family and ensure all contact with them is recorded including the family being informed of how they may raise any questions or concerns to be discussed at the DIPLAR.

Responses to any family questions or concerns should be agreed and recorded in Section and the action included in the Action Plan. The DIPLAR should be clear who will provide feedback to the family.

DIPLAR Attendance

The following people must attend all DIPLAR meetings:

- Chair
- Establishment's GIC/Deputy Governor
- NHS Senior Member of Staff
- Local DIPLAR Co-ordinator
- Minute Taker
- Chaplain
- HQ Health representative
- First Line Manager (FLM) for the area in which the prisoner was located
- Personal Officer or member of staff who worked closely with the deceased
- Lead Professional/Named Person for anyone under 18
- All staff involved in the incident must be invited and all efforts made to support their attendance.

HQ Health will extend an invite to HMIPS for all DIPLARs for lay person representation and they will attend where possible.

The following people may attend if appropriate e.g. were involved in the incident or had recent engagement with the individual.

- Health or Social Care Providers
- Social Worker
- Escort Provider
- Scottish Ambulance Service
- Police Scotland
- Any other relevant staff or agencies (Including from previous establishment if recently transferred prior to death)

Role of the DIPLAR Co-ordinator

The Governor will appoint a DIPLAR Co-ordinator which may be the local Suicide Prevention Co-ordinator.

It is the responsibility of the DIPLAR Co-ordinator to monitor compliance with the DIPLAR process, timescales and PRL standards ensuring:

- The DIPLAR meeting is held within 12 weeks of the death in custody
- The draft DIPLAR report is prepopulated as far as possible with known information and a copy forwarded to HQDIPLAR@prisons.gov.scot one week in advance of the DIPLAR meeting
- The draft DIPLAR report is uploaded to the Establishment Working Area in SharePoint within 4 weeks of the DIPLAR meeting for HQ Health to review
- The final DIPLAR report is uploaded to the Establishment Working Area in SharePoint within 8 weeks of the meeting

The DIPLAR must be completed at the earliest opportunity and should only record the facts of the incident, actions agreed, timescales and person responsible. It should not include any details of progress against them. Actions will be transferred by HQ Health onto the DIPLAR National Learning & Action Plan once the final DIPLAR is received and DIPLAR Coordinators will then record progress against actions each month.

The local DIPLAR Co-ordinator must attend all DIPLARs. They are responsible for:

1. Arranging the DIPLAR meeting
2. Preparing the draft DIPLAR Report
3. DIPLAR Meeting
4. Submission of draft DIPLAR report for review
5. Submission of final DIPLAR report
6. Further ongoing responsibilities

1. Arranging the Meeting

Step 1: Liaise with HQ Health via HQDIPLAR@prisons.gov.scot to agree a suitable date for the DIPLAR. Where it is a natural cause death, agree a date that suit all key local attendees and advise HQ Health. (A minimum of 4 weeks notice should be provided)

For all other deaths, identify a selection of provisional dates that suit all local key attendees and advise HQ Health via HQDIPLAR@prisons.gov.scot

HQ Health will co-ordinate the attendance of the Independent Chair and HMIPS

Step 2: Issue a meeting invite to all attendees, using the template attached at Appendix 1. A minimum of 2 hours should be allocated for the meeting

Step 3: Issue a pre-meeting invite for 30 minutes immediately prior to the DIPLAR meeting to the Chair, GIC and HQ Health. This will allow the Chair to be provided with all information in relation to the circumstances surrounding the death to support a full DIPLAR discussion

Step 4: Issue invites to all appropriate external partners who can contribute to learning e.g. the Escort Provider, Police Scotland and Social Work

Whilst attendance virtually on MS TEAMS should be supported, it is beneficial for as many individuals as possible to attend in person.

2. Preparing the draft DIPLAR

Step 1: Forward DIPLAR template and request input to the relevant sections in advance of the meeting. This should provide ample time to respond no later than 2 weeks prior to the meeting. The email should identify the section to be completed and the timescale for return.

- Single Point of Contact for Family (Section 3.1 to 3.7)
- Chaplaincy (Section 3.8)
- NHS (Section 3.9, 8.2 and Part 3 - NHS Timeline)

Pre-populate remaining additional SPS sections where the information is available, including the SPS Timeline of Significant Events.

Step 2: Collate feedback and follow up where there are requests outstanding or need for further information.

Step 3: Forward a copy of the draft DIPLAR to HQDIPLAR@prisons.gov.scot 1 week in advance of the meeting to provide background information for HQ Health and the Independent Chair.

Step 4: Prior to the meeting forward the completed draft DIPLAR to all attendees via secure email. The following standard wording must be used in every email:

The attached draft DIPLAR must only be used for the purposes of the DIPLAR meeting and is not for forward distribution. Please treat as sensitive information in line with your management of information policy

3. DIPLAR Meeting

In advance of the meeting:

Step 1: Attend Pre-meeting with GIC, Independent Chair and HQ Health

Step 2: Check the meeting room is set up to support all attendees including those attending virtually

Step 3: Test any required IT equipment in advance

Step 4: Have the establishment's National DIPLAR Learning and Action Plan available at the meeting to refer to and record any recurring actions or themes on the DIPLAR report. (Part 4 - DIPLAR Learning & Action Plan)

At the meeting:

Step 1: Provide the Chair with a copy of the DIPLAR Meeting Checklist to ensure the DIPLAR process is adhered to

Step 2: Capture all relevant information throughout the meeting to update the draft DIPLAR report. This can be supported by the use of a minute taker or using the record function where MS Teams is being used.

4. Submission of draft DIPLAR for review

Step 1: Confirm that Governor/Deputy Governor and NHS are content with the updates made to the DIPLAR document following the meeting. (This should not be signed at this point as it is still a draft)

Step 2: Upload the draft DIPLAR as a Word version within 4 weeks of the DIPLAR meeting to the Establishment DIPLAR Working Area in SharePoint using the link below:

T-DIPLAR - Establishment DIPLARs - All Documents (mcas.ms)

Step 3: Notify HQ Health that the draft is available for review using the generic email address HQDIPLAR@prisons.gov.scot. This will include the review by both HQ Health and the Independent Chair where appropriate

Step 4: Once advised by HQ Health that the review of the draft has been completed, arrange for any suggested amendments to be considered locally and the document updated accordingly

Step 5: Agree the final DIPLAR report and arrange for appropriate local signatures. (SPS and NHS). HQ Health will arrange for the Independent Chair to sign where required.

5. Submission of final DIPLAR

Step 1: Upload the final signed DIPLAR as a PDF to the establishment working area in SharePoint within 8 weeks of the DIPLAR meeting. The reviewed draft in Word should not be removed as it may be required for evidence at the subsequent FAI.

Step 2: Email HQDIPLAR@prisons.gov.scot to confirm the final version has been uploaded.

The DIPLAR Report should be finalised at the earliest opportunity to allow HQ Health to transfer actions to the National DIPLAR Learning & Action Plan where progress against these can then be recorded

HQ Health will share the DIPLAR with Legal Services.

6. National DIPLAR Learning & Action Plan

HQ Health will transfer any actions onto the National DIPLAR Learning & Action Plan only when the DIPLAR is finalised and notify the DIPLAR Co-ordinator when this has been done.

No actions should be recorded on the National DIPLAR Learning & Action Plan until the final signed PDF has been received.

Progress against actions should only be recorded on the National DIPLAR Learning & Action Plan.

Update the National DIPLAR Learning & Action Plan on progress against DIPLAR Actions and FAI Recommendations by the 7th of each month.

Role of the DIPLAR Chair

Independent Chair / Governor

The Independent Chair will chair all DIPLARs with the exception of natural cause deaths. Their responsibilities are to:

Step 1: Check that all staff attending are comfortable with the DIPLAR process in advance of the meeting and have been offered appropriate support

Step 2: Confirm all required attendees are present. If not, decide if the meeting should go ahead or be rescheduled

Step 3: Welcome and advise those in attendance of the purpose of the DIPLAR meeting

Step 4: Use the DIPLAR Meeting Checklist to ensure that all required information is available and considered as part of the DIPLAR meeting

Step 5: Ensure that all in attendance have the opportunity to contribute

Step 6: Summarise learning points, best practice, and action

Step 7: Review the draft DIPLAR when received from HQ Health

Step 8: Review and sign off the final DIPLAR when received from HQ Health

Private Prisons will appoint an Independent Chair.

Governor in Charge/Deputy Governor

Chair the DIPLAR meetings for any natural cause deaths along with input from NHS colleagues and attend DIPLARs chaired by the Independent Chair

As Chair they have the same responsibilities as the Independent Chair. Additionally, they will:

Step 9: Confirm they are content with the draft DIPLAR and relevant actions prior to submission to HQ Health for review

Step 10: Consider suggested feedback on the draft DIPLAR when received from HQ Health

Step 11: Sign off the final DIPLAR report and Action Plan

Step 12: Monitor and ensure completion of relevant actions within the agreed timescales.

The Role of HQ Health

HQ Health have several roles within the DIPLAR process:

- Ensure a consistency in completion of reports across all DIPLARs.
- Ensure all DIPLARs are completed in line with the agreed PRL standards.
- Maintain the National Learning and Action Plan.
- Provide support and guidance to establishments in relation to DIPLARs.
- Share learning and recurring themes with NSPMG and Governors.

Notification of Death in Custody

Step 1: Record details on appropriate management systems

Step 2: Request the cause of death details from the Medical Certificate / Post Mortem from COPFS and advise establishment

Step 3: Issue advisory email with guidance and confirm timescales to comply with PRL standards

Step 4: Co-ordinate the attendance of a HQ Health representative, the Independent Chair and inform HMIPS of the agreed date.

DIPLAR meeting

Provide guidance to establishments on SPS health related policies.

Note any actions relating to relevant policy areas and ensure these are considered as part of the policy review.

Share any common themes from other DIPLAR meetings.

Draft DIPLAR

Step 1: Co-ordinate the review of the draft DIPLAR by HQ Health and the Independent Chair

Step 2: Return feedback to establishment within 2 weeks where possible

Final DIPLAR

Once notified that the DIPLAR has been finalised and uploaded.

Step 1: Arrange for the Independent Chair to sign the final DIPLAR version where appropriate

Step 2: Transfer actions to the National DIPLAR Learning & Action Plan. Where there are no actions, this will be recorded. Note any actions for HQ Health or raise with other relevant SPS Directorates as required

Step 3: Forward a copy of the final DIPLAR to Legal Services for solicitors.

Further ongoing responsibilities

Step 1: Liaise with solicitors and COPFS regarding progress on DIPLARs and actions

Step 2: Ensure the learning from DIPLARs is shared across all prisons where appropriate

Step 3: Once the Fatal Accident Inquiry has concluded, notify DIPLAR Coordinators with any recommendations. Where there are no recommendations, this will be confirmed

Step 4: Update the National DIPLAR Learning & Action Plan with any recommendations from FAIs. Where there are no recommendations, this will be recorded

Step 5: Provide the NSPMG with quarterly updates on Actions and Identified Good Practice

Step 6: Share information on themes, learning, actions, and best practice with Governors.

Role of NHS

Step 1: Complete NHS sections in advance of the DIPLAR meeting including the NHS Timeline of significant events and return to DIPLAR Coordinator two weeks prior to the meeting

Step 2: Ensure appropriate representation to attend and contribute to the DIPLAR meeting

Step 3: Review draft report for accuracy prior to being submitted to HQ Health

Step 4: Consider any suggested amendments for NHS sections and finalise DIPLAR

Step 5: Arrange for appropriate NHS signatures and return to DIPLAR Coordinator within 2 weeks.

Role of the Chaplain

Prison chaplains can be perceived by families as being relatively independent of SPS staff, systems and processes and therefore (potentially) able to develop unique relationships amidst acute feelings of loss, anguish, distress, confusion, guilt, etc. The family may also experience anger or resentment towards ‘the prison’ at this time.

Step 1: Complete Chaplaincy section in advance of the DIPLAR meeting and return to DIPLAR Co-ordinator two weeks prior to the meeting

Step 2: Ensure appropriate representation to contribute to the DIPLAR meeting

Further responsibilities include:

- Actively contact the family within a few days of the death.
- Offer emotional and pastoral support, ongoing if necessary.
- Assist with returning property to the next of kin.
- Assist with the arrangement for funeral services / memorial services / tributes.

The Chaplain is not responsible for providing feedback to the family following the DIPLAR. A member of the Senior Management Team will be identified to provide feedback.

Additional Roles & Responsibilities

HMIPS

The Lay person role will be fulfilled by a member of HMIPS. Their role is to provide an independent perspective to the DIPLAR process and ensure that SPS and NHS complete the DIPLAR in an open and transparent manner, while considering all information available to ensure a comprehensive review with the conclusions and any follow up actions accurately recorded.

Where the lay person has any concerns, they should be raised with the Chair at the time of the DIPLAR.

DIPLAR Report Template

The DIPLAR report will be completed following all deaths in prison custody. All sections of the form must be completed. Where there is no relevant information to record in any section, this must be clearly indicated on the form. A draft will be prepared in advance of the meeting and emailed to HQDIPLAR@prisons.gov.scot

Guidance notes have been included within the DIPLAR Template to assist with completion, some further useful information has been provided below.

The DIPLAR will be shared outwith the SPS, therefore clear terminology should be used, and acronyms avoided.

The DIPLAR consists of 4 parts with sub sections detailed within:

Part 1 - Death in Prison Learning, Audit & Review Report

This section records all relevant information regarding the individual and the circumstances of their death, along with details of the impact on and support provided for staff, other people in custody and the family.

Personal Details

Where the individual had been relocated or transferred from another establishment within the last 3 months, relevant details should be recorded, including the rationale for the move and any potential impact this had.

If the death involves an under 18 year old, the individual's Lead Professional/Named Person must attend the DIPLAR and an assessment should be made as to whether the rights of children had been adhered to.

Apparent Cause of Death

Details from the Medical Certificate Cause of Death (MCCD) or Post Mortem will be provided to the establishment by HQ Health in advance of the DIPLAR meeting where possible. Where the MCCD is inconclusive, a Post Mortem is required which can take 10-12 weeks for the issue of the final cause of death.

Family Engagement

The DIPLAR should consider all aspects of the engagement with the family and ensure all contacts with them are recorded including the family being informed of how they may raise

any questions or concerns they wish to be discussed at the DIPLAR. Responses to any family questions or concerns should be agreed and recorded in this section and the action included in the Action Plan.

Incident Details

A full description of the incident should be provided including times, names of personnel involved and their role. If copying information from the SPS Immediate Incident Report, this must be adapted, and sense checked to ensure it provides the necessary information in an appropriate format.

Relevant Information and Intelligence

All aspects of PR2 should be checked for any recent or relevant information including anything of note, particularly in relation to Risk & Conditions and Visits. The Community Integration Plan should be checked for any Concern Forms. A request should be made to the establishment Intelligence Management Unit (IMU) for a review of intelligence and telephone calls relevant to the death in custody. Any intelligence entries or telephone calls assessed as relevant should be downloaded and passed to the DIPLAR Coordinator. The review of intelligence and telephone calls should only be carried out by the IMU.

Summary of Background

NHS should provide information relating to any contact with the individual including details of the reason for contact and the outcome.

Signature Section

No signatures should be added until the draft report has been reviewed by HQ Health and the Independent Chair, where appropriate. Signatures should only be added once any feedback has been considered and final amendments completed.

Part 2 - SPS Timelines of significant events

The SPS timeline should record the individual's date of admission, court dates, and changes of circumstances. It should also record any possible precipitating factors such as cancelled visits, concerning phone calls, positive drug tests or failure to progress or obtain parole.

Part 3 - NHS Timelines of significant events

The NHS timeline should record a summary of any relevant contact with health care services including community health & acute health services.

Part 4 - DIPLAR Learning & Action Plan

All actions should be specific, measurable, achievable, have a responsible person identified and have clear timescales for completion.

All sections must be completed. Where there is no relevant information to record, this should be clearly indicated on the form.

A record of learning and actions to be undertaken and associated timescales should be documented in the Learning & Action Plan and signed by the Governor/ Deputy Governor and NHS senior member of staff.

Action Points must read independently of the report as these will be transferred onto the National Action Plan. This should only be signed once the draft is reviewed by HQ Health and any suggested feedback considered.

For further information contact HQDIPLAR@prisons.gov.scot

Appendix 1

SCOTTISH PRISON SERVICE

DIPLAR Meeting Invite

Requesting attendance at the DIPLAR following the death of (Insert Name)

on (Insert date of death)

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 those involved in the management and care of the individual attend the DIPLAR meeting.

The aim of the DIPLAR is to learn lessons. It is designed to consider the circumstances of the incident and the immediate actions taken, examine how the individual was being managed, and how the incident impacted on staff, other prisoners, the individual'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 DIPLAR Report includes a section to draw conclusions and records any actions to be undertaken.

The DIPLAR Report 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.

SPS understands the impact deaths in custody can have on those involved and encourage you to seek appropriate support. Further details of available support will be sent out to all staff. Please ask if you require any further details or have any questions.

DIPLAR MEETING ARRANGEMENTS

Day and date:

Time:

Venue:

Please confirm your availability to attend to:

by no later than:

Appendix 2

DIPLAR MEETING CHECKLIST

This checklist is to assist the Chair of the DIPLAR meeting to ensure the DIPLAR process is adhered to and that all aspects of the death in custody are considered and recorded.

Once complete this checklist must be kept with the DIPLAR paperwork.

DIPLAR Date:	
Prisoner Name and Number:	
Name of DIPLAR Chair:	

	Local DIPLAR Co-ordinator must ensure that the following Information is available at the DIPLAR meeting:	**Tick once complete**
1.	Talk to Me Paperwork – Any episodes of Talk to Me which occurred in the 6 months prior to the death including any Reception Risk Assessment forms.	
2.	Telephone Calls– Any relevant information relating to telephone calls which took place in the month prior to the death. Where there has been a large volume of calls, a request should be made for these to be downloaded with a brief summary of content annotated. The review of telephone calls should only be carried out by the establishment IMU.	
3.	Information held on PR2 including: • Record of visits in the 3 months prior to the death • Any relevant information held within Risk & Conditions and ICM domains. • Any incidents of MORS in the 6 months prior to the death • Any relevant Intelligence entries in the 6 months prior to the death. The review of intelligence should only be carried out by the establishment IMU • Any Rule 95 or Rule 41 paperwork in the 6 months prior to the death *[Ensure I.T. equipment is available for use if required]*	
4.	Personal Escort Record (PER) forms if appropriate.	
5.	Any social work reports including trial judge reports and background inquiry reports.	
6.	Recent parole and RMT decisions.	
	During the DIPLAR Meeting the Chair must:	
7.	Confirm all members who must be in attendance, as detailed in DIPLAR Guidance, are present. Where there is absence by exception, the Chair will decide if the meeting can go ahead or will require to be rescheduled.	
8.	Advise those in attendance of the purpose of the DIPLAR meeting.	

9.	Advise those in attendance of the support that is available to anyone who is affected by the DIPLAR.	
10.	Ensure that all in attendance have the opportunity to speak.	
11.	Ensure all relevant information and documentation is available for the DIPLAR meeting.	
12.	Where there was any identified failure in a process/policy, this must be recorded in the lessons learned section of the Action Plan and an action agreed.	
13.	Where there was any identified failure to follow policy or process, this must be recorded in the lessons learned section of the Action Plan and an action agreed.	
14.	Ensure each area of the DIPLAR documentation is completed.	
15.	Ensure questions or concerns raised by the family are considered and responses agreed and recorded in Section 12 and the Actions section.	
16.	Conclude the meeting by re-capping learning points and identifying good practice.	
	Following the DIPLAR Meeting the Local DIPLAR Co-ordinator must:	
17.	Share the draft DIPLAR and Action Plan with the Co-chair and NHS representative for comment.	
18.	Upload the draft word version of the DIPLAR onto the DIPLAR SharePoint site for review (within 4 weeks of the meeting)	
19.	Confirm to HQ that the draft is uploaded ready for review using HQDIPLAR@prisons.gov.scot	
20.	Consider feedback provided by HQ and the Independent Chair where appropriate and make any required amendments	
21.	Upload the final signed copy of the DIPLAR as a PDF onto the SharePoint site (within 8 weeks of the meeting)	
22.	Confirm to HQ and NHS that final signed copy has been uploaded using HQDIPLAR@prisons.gov.scot	

Appendix 3

FAMILY CONTACT RECORD

This should be used to keep a record of all contact with family members following a death in prison custody. It should record any information provided to them and by them. All questions or concerns they may raise in advance of the DIPLAR should be recorded in the relevant sections of the template along with details of any responses provided.
Once complete this record must be kept with the DIPLAR paperwork.

Prisoner Name and Number	
Establishment	
Date of death	
DIPLAR date	

Contact Record	
If there were any difficulties in communicating with the family due to language or disabilities, please record relevant details and steps taken to overcome these.	
Provide details of all contact with the family: dates, who contacted who and a summary of the contact	
Date/s	*Record of Contact/s*

Equality Statement

The SPS is an equal opportunities employer where all employees are treated with dignity and respect. We are fully committed to equality, diversity and human rights and to ensuring our culture, working environment, policies, processes and practices are free from bias. This policy applies to all employees regardless of protected characteristics, and, subject to any eligibility criteria, length of service, grade, working pattern or operational status.

Sustainability

Improving our environmental performance and doing things in a more sustainable way should be seen as integral to our core business practices.
In line with the SPS Sustainable Policy and to demonstrate compliance with the Scottish Government's commitment to improving environmental and sustainable development performance, please be mindful if printing this document – keeping paper usage to a minimum (print only version), printing on both sides, and recycling.

Inclusive Communications

It is our ambition to ensure that SPS documents are readable, accessible and engaging for staff.

In formatting this document, good practice principles around engagement and inclusive communications have been adhered to.

If you require this document in an alternative format please contact Human Resources.

Review and Monitoring

This policy will be reviewed every three years or sooner where applicable to reflect changing business and legislative requirements.

UK Civil Service Management Code

UK Legislation

EU Legislation

ACAS

CIPD Best Practice