



01501 PROCEDURE–CORONERS AND SUDDEN DEATHS

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Equality Impact Assessment			High		
Owning department			Major Crime		

1. About this Procedure

- 1.1. This document explains the procedure to be followed by police officers in dealing with sudden deaths and other deaths where the Coroner's involvement is necessary.

2. Risk Assessments / Health and Safety Considerations

- 2.1. All police officers whose role requires them to handle a dead body must wear the approved protective clothing to do so, and must follow the relevant Health & Safety guidance. See the Health & Safety channel of the intranet for risk assessments.
- 2.2. Any relatives of the dead person who are either present or contacted must be dealt with calmly and sensitively in order to minimise distress to them and disruption to the investigation.
- 2.3. The supervisor of officers and staff investigating a sudden death must give consideration to the deployment of a Post Incident Manager or the use of Trauma/Risk Management (TRiM) as appropriate in order to minimise the impact on officers' welfare.

3. Procedure

3.1. General

- 3.1.1. There are three principle categories of sudden death that, once established, help guide the officer to a relevant response level (see the relevant section below for further information on each category).

- Category One - Deaths involving suspected offences;
- Category Two - Violent and Unnatural deaths (not falling in Category One);
- Category Three - Natural deaths.

- 3.1.2. There are additionally three further categories

- a. Category Four – Deaths in Multiple Fatalities / Disasters
- b. Category Five – Inquest



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c. Category Six – ‘Out of England’ and Deaths from Abroad

- 3.1.3. The category of death will be designated by the Force Control Room Inspector at the time a call is received.
- 3.1.4. An officer attending the scene may escalate the response by increasing the category (from a Category Two to a Category One, for instance), or by requesting the attendance of a supervisor at the scene. It may only be reduced by a senior officer (SIO or attending Detective Inspector).

3.2. Scene Attendance

- 3.2.1. The attending officer will make initial enquiries to confirm that the person has died. The requirement to preserve life supersedes all other considerations, including potential loss of evidence. All officers should feel empowered to commence CPR in accordance with their training if they assess that there is a prospect of saving a life. They will call for the assistance of an ambulance in these circumstances.
- 3.2.2. However, where possible, steps should be taken to achieve any immediate life support with the least possible disturbance to the scene, which will be treated as a crime scene in **all** cases until an assessment has been made.
- 3.2.3. Police officers are able to verify death in cases where it is obvious that life is extinct. However, this will be limited to cases of decapitation or extreme decomposition. In all other cases, a medical professional will be required to verify death to avoid the very real risk of making the wrong decision.
- 3.2.4. Officers are reminded that they each have an individual responsibility to consider making direct contact with other emergency services if their presence at the scene is required.
- 3.2.5. In cases where a police officer cannot verify death, the ambulance service will be called in most cases. The attending medical staff will complete a form which will be handed to the police. In the case of deaths in police custody, and suspicious deaths, this function will be fulfilled by a police surgeon.
- 3.2.6. The attending officer is a professional investigator, and there is an expectation that the officer will use their training and experience to establish the facts of the death. In a Category One death, the expectation is that they will arrange



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verification death and protect the scene. In many cases, initial enquiries completed by uniformed attending officers identify suspects and lead to early arrests, and officers are able to conduct fast track enquiries while a Senior Investigating Officer is being deployed.

- 3.2.7. In all cases, including those classified as Category 3, officers will consider whether the cause of death could be a crime, and they will make enquiries to corroborate the information that they are given. There is an expectation that they will seek advice from a supervisor in cases of doubt. The supervisor may decide to revise the category upwards, or consult with a CID supervisor.
- 3.2.8. Officers will conduct a thorough search of the body in all cases other than Category One deaths. This is to check for signs of injury that could have caused death, or signs of defence wounds or of neglect.
- 3.2.9. In all cases, officers are required to provide evidence of the identity of the deceased, and to provide evidence of when the person was last seen alive.
- 3.2.10. The evidence of identification may come from a family member or other person in a close relationship with the deceased who is prepared to view the body. This can be arranged at the mortuary through the Coroner's Officer. In cases where there is no-one to identify the body of viewing would be inappropriate (due to the condition of the body, for example) the identification can be completed by DNA comparison, fingerprints or dental examination. Further guidance is available from the Coroner's Officer.
- 3.2.11. Officers will make enquiries to identify the deceased's GP and when the deceased was last seen by the doctor. Where a doctor has medically examined the deceased within 14 days of their death, a death certificate citing the cause of death may be issued. A certificate removes the need for a post mortem, thereby averting a great deal of unnecessary distress for the families. If the death occurs during surgery hours, officers will ring the Doctors Surgery and establish whether a certificate may be issued.
- 3.2.12. In cases where the police attend a death in A&E, or accompany a dying person to hospital, the officer should request that the admission blood sample is not destroyed.
- 3.2.13. In all cases, the officer will complete form G28 prior to booking off duty, and the sergeant will ensure that the form is email to the relevant Coroner before the officer goes off duty.



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It is not acceptable to delay this process. The Coroner needs to be informed, and senior officers need to review the investigation to ensure that it has been sufficient.

3.3. Category one – Deaths Involving Suspected Offences

- 3.3.1. This category includes those deaths where police suspect another person has been involved in the death and have a duty to detect crime (e.g. murder or manslaughter, child deaths, RTIs (see 27201 Procedure – Road Death Investigation), drugs deaths caused by another, work related death, questioned deaths in health care settings and deaths on military premises).
- 3.3.2. In Category One deaths the Duty Detective Inspector or RPU SIO must attend and ensure a high standard of investigation and objective evidence gathering.
- 3.3.3. Enquiries into Category One deaths will be overseen and managed by a force Senior Investigating Officer (SIO) in compliance with the murder Investigation Manual and MIRSAP.
- 3.3.4. If the death is re categorised to a Category Two death after initial investigations then the SIO, or nominee, will provide the Coroner with a statement of the reasoning for the down grading. A down grading decision can be taken at any time but must be made by a Detective Inspector, or above, and recorded appropriately.
- 3.3.5. In all category one deaths a Crime Scene Manager will be consulted at an early stage to maximise the forensic potential at each scene.
- 3.3.6. For all category 1 and 2 deaths where there are children residing in the household of the deceased person, consideration should be given to making a child at risk referral to the central referral unit in order to ensure that information is shared with partner agencies and appropriate safeguarding can be implemented.
- 3.3.7. In all cases, the location of a Category One death is a crime scene. Other than for the purposes of verifying death, providing medical treatment to survivors and ensuring no suspect is hidden within the scene, entry will be strictly controlled by a scene guard, and a scene log will be maintained. However, in the case of sudden death of an infant, the CAIT DI or DS will give specific guidance on setting up and managing the scene.



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3.3.8. Having confirmed that the death is suspicious, the senior officer at the scene will ensure that the Force SIO is notified and briefed.

3.4. Category Two- Violent & Unnatural Deaths (Not within Cat 1)

3.4.1. There is no definition of a Violent or unnatural death but essentially it is applicable in any unexpected violent or unnatural death not falling within category one.

3.4.2. Category Two deaths will include the following examples although this list is not prescriptive:

- Accidental deaths (this will cover numerous examples);
- Drowning;
- Overdoses of non/prescribed drugs;
- Suicide;
- Fires;
- Poisonings;
- Neglect & self-neglect;
- Abortions;
- All young people under 18 years old;
- Deaths requiring outside agency assistance;
- Any bizarre or unusual death that will be closely questioned by both the family and the public.

3.4.3. In all cases a high standard of evidence gathering is necessary. This will include statements, and the attendance of a Crime Scene Investigator (CSI) to accurately record the scene and carry out appropriate forensic retrieval to dispel any later doubts if required. Where suicide is clear a CSI may not be required. (Digital images will suffice in suicides where evidence is clear). However, a CSM can give specific advice in relation to ligatures and interpreting the scene.

3.4.4. A Detective Sergeant (DS) must attend every Category Two death, with the exception of a road-related death or child death as detailed further below. Where it is impracticable for the DS to attend on the Isle of Wight due to call out arrangements, a Detective Constable (DC) will attend who will be supported by the mainland DS. When an Isle of Wight DS is back on duty, this role will be handed over to the Isle of Wight DS.

3.4.5. The DS is responsible for making a full assessment of the scene, in liaison with other specialist staff as necessary. Having also taken into account the wider circumstances of the death, the Detective Sergeant is responsible for determining whether or not the death is suspicious. Their



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rationale for this decision must be accurately recorded on RMS.

- 3.4.6. It is believed that nationally a number of homicides are not identified by the police each year. It is therefore crucial that the attending DS seeks to corroborate all information at the scene by independent means, and considers all deaths as a potential homicide until proven otherwise.
 - 3.4.7. Where the death is judged to be suspicious, the Detective Sergeant/ RPU SIO (if they require assistance)/ Marine SIO will notify the relevant Detective Inspector for professional support and guidance in relation to the apparent circumstances of the death.
 - 3.4.8. This officer will notify the Force SIO if they also consider the death to be the result of a crime.
 - 3.4.9. It is not necessary to notify a DI in the event of non-suspicious Category Two deaths. In all such cases, the Duty Response and Patrol Inspector and/ or Force Silver Commander will be available to coordinate additional resources and/ or assist with the management of any community impact.
 - 3.4.10. Category Two deaths involving the sudden and unexpected death of children under 18 years of age are managed by a Child Abuse Investigation Team Detective Inspector via the Force Control Room. See further below.
- 3.5. **Category Three – Natural Deaths**
- 3.5.1. The majority of deaths attended by the police fall into this category.
 - 3.5.2. As detailed above, having verified the death and confirmed that there are no injuries or suspicious circumstances, the attending officer will complete a G28 form for the coroner and arrange for the body to be taken to the relevant mortuary.
- 3.6. **Category Four – Deaths in Multiple Fatalities / Disasters**
- 3.6.1. Deaths in this category may be as a result of a crime (for instance in a terrorist attack or a road traffic collision) or as a result of a natural disaster.
 - 3.6.2. A Senior Investigating Officer (SIO) will be appointed, and where appropriate, a Senior Identification Manager (SIM) will also be appointed (for example, in cases where bodies have become disrupted).



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- 3.6.3. The SIO may come from Investigations or the Joint Operational Unit as appropriate to the incident type. In some cases, it may be advisable to appoint an SIO from one discipline and have a Deputy SIO from a different discipline (e.g. a Major Crime SIO and an RPU D/SIO).
- 3.6.4. The SIM will liaise with HM Coroner and will provide advice on how the victims will be identified.
- 3.6.5. Force Policy 05105 – Family Liaison – DVI and Mass Disaster and Authorised Professional Practice (APP) on Disaster Victim Identification should be consulted.
- 3.6.6. Deaths in this category will be reported to the Coroner on multiple G28 forms.
- 3.7. **Category Five – Inquests**
- 3.7.1. The Coroner may decide that further investigation is required in cases that have not previously been reported to the police, and may ask the police to carry out enquiries on his or her behalf.
- 3.7.2. Such an investigation is likely to be allocated within a Police Investigation Centre.
- 3.8. **Category Six – ‘Out of England’ and Deaths from Abroad**
- 3.8.1. Where a deceased dies outside of England and Wales, the coroner must still hold an inquest if the dead body comes to lie within his or her jurisdiction and if the circumstances of the death require it. The Coroner with jurisdiction is usually the Coroner for the district of the intended burial or cremation of the deceased.
- 3.8.2. The Coroner must be informed in all cases by the completion of a G28 report and submitting where:
- The body of a person is verified dead whilst lying within the Coroner’s jurisdiction;
 - There is reasonable cause to suspect that the person has died a violent or unnatural death, or a sudden death resulting from an unknown cause, or has died in prison, or under such circumstances as to require an inquest to be held.



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- 3.8.3. This category includes deaths that happen on ships that dock within a Coroner's area. The Coroner may ask the police to attend in cases where the death may be violent, unnatural or suspicious, where they will be expected to conduct an investigation in line with those conducted for Category One or Two deaths, securing all relevant evidence.

4. Miscellaneous Provisions

4.1. Undertakers

- 4.1.1. The bodies of the deceased become the property of the Coroner. There is a legal requirement that the remains will be medically examined, and therefore the Coroner requires that they be removed to a mortuary. This will be done by a contracted undertaker, requested by the Force Control Room.
- 4.1.2. Some families request that their loved ones are transported by a family undertaker. Officers at the scene will sensitively explain that while the contracted undertaker is taking their loved to the hospital, families are able to choose a different undertaker for the funeral arrangements.
- 4.1.3. This is an area where officers may encounter issues around post mortem examinations and the requirement in some cultures and religions for the body to be buried within a timescale. Officers will do all they can to minimise the distress and display sensitivity, whilst complying with the legal requirement to seize the body.
- 4.1.4. Officers encountering difficulties should seek assistance from their supervisors and the Force Control Room in the first instance.
- 4.1.5. If officers are unable to sensitively resolve the issue, they may call the Coroner (including out of hours). The call out details will be held within the Control Room.
- 4.1.6. The handling of decomposed bodies will be carried out in consultation with a Crime Scene Manager.
- 4.1.7. In certain circumstances, the recovery of the body may require specialist assistance. A Body Recovery Team can be requested via the control room.

4.2. Property



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- 4.2.1. Where foul play is not suspected the officer reporting the death should search and secure property on the body. In order to protect officers from possible allegations of neglect or dishonesty, the following safeguards should be observed:
- 4.2.2. Where possible the clothing should be searched in the presence of a near relative of the deceased. Property found should be handed over to such relative immediately. (See roles and responsibilities further below).
- 4.2.3. If there is any difficulty in obtaining the presence of a relative at the searching, the police should try to ensure that some other person is present.

4.3. Child Death

- 4.3.1. The investigation of the sudden death of children and young people is a specialist area, requiring the deployment of officers with particular skills.
- 4.3.2. The Child Abuse Investigation Team (CAIT) have responsibility for the initial attendance at all sudden deaths involving people aged under 18. Although R&P are officers are likely to attend in the first instance, CAIT supervisors will also be deployed. CAIT operate a call out system for Detective Inspectors and Detective Sergeants for this purpose.
- 4.3.3. The duty CAIT Detective Inspector will be deployed to the location of the deceased person in the capacity of Lead Investigator.
- 4.3.4. The duty CAIT DS will be deployed in support of the DI, and in accordance with their requirements. In most cases, this will involve being deployed to the scene where the person died (or was taken ill, if the death occurred elsewhere).
- 4.3.5. The CAIT DI will brief the duty Force SIO in cases where the death could be considered to be suspicious.
- 4.3.6. Where the death is considered suspicious, the crime should be allocated to the Major Crime Team for investigation, and an SIO who is PIP 3 qualified (or working towards qualification) will be appointed.
- 4.3.7. Deaths of children that are not considered to be suspicious will be investigated and managed by the Child Abuse Investigation Team (CAIT).
- 4.3.8. If the offence is one of “overlay” (contrary to section 1(2)(b) of The Children and Young Persons Act 1933) in respect of



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the deaths of children under the age of 3 these will continue to be investigated by the CAIT

- 4.3.9. CAIT officers will take responsibility for complying with Working Together 2013, ensuring the Rapid Response Process is followed, completing any CDOP notifications, dealing with third party material and ensuring safeguarding of any siblings or other children identified to be at risk, regardless of whether the investigation is being managed by a CAIT or Major Crime SIO.
- 4.3.10. CAIT Detective Inspectors will attend all multi-agency strategy meetings and Rapid Response phased meetings in respect of the death.
- 4.3.11. Community Impact Assessment and media release should always be considered with any child death. This would be discussed with other partners at the rapid response meetings. When there is a sensitive issue raised it would normally be an agreed mediarelease with those partners.
* If it is obvious at the outset that the investigation is a homicide investigation, the Duty SIO should be contacted immediately by FCR and provide the immediate response rather than the CAIT DI. If the CAIT DI is called to such an incident they must immediately inform the duty SIO.
- 4.3.12. If a child under 18 dies as a result of a road traffic incident then a discussion will take place between RPU SIO and a CAIT DI to consider responsibilities for managing rapid response procedures for RTCs. RPU will lead all such investigations in respect of the road traffic collision and CAIT will lead regarding child death procedures. Agreement will be reached between the CAIT DI and the RPU Inspector regarding attendance at Rapid Response meetings. It is not required for both to attend.
- 4.3.13. The CAIT DCI will review all child deaths within 24 hours (or 48 hours over a weekend). If this DCI is not available it should be performed by another Investigations DCI. An OEL entry must be added in respect of the review. The purpose of this review is to ensure that procedures for responding to child deaths have been followed including statutory requirements regarding rapid response; sufficient resources have been allocated and ensure the welfare of those involved and in the case of non-suspicious deaths that the incident determination is correct.
- 4.3.14. Following the PM results the SIO will ensure an OEL entry is added to RMS titled "CDOP Summary" to include the status of the investigation and outcome of the PM. This summary



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should be updated following receipt of the PM report so it is available for the Head of CAIT/Investigations when attending the CDOP meetings.

- 4.3.15. The child death booklet should be completed by the attending CAIT DI for all child deaths and remains the property of the Police. It should be scanned onto RMS at the conclusion of the investigation and should not be sent to the coroner.

4.4. Intestate Deaths

- 4.4.1. Intestate deaths will be dealt with by the Coroner's Office, in liaison with the Local Authority.

4.5. Industrial Incidents – Work Related Deaths

- 4.5.1. In the case of sudden death apparently caused by factors involving a place of work, see 05800 Policy - Industrial Accidents.

4.6. Illicit Drugs Overdoses

- 4.6.1. The Detective Inspector for the area concerned will be informed of any case of sudden death involving the use of a drug other than a product available to the public without a doctor's prescription. That officer will take relevant steps to mitigate against the risk of other deaths in the area, consulting with relevant drug programmes and Corporate Communications as necessary.

4.7. Foreign Military Forces

- 4.7.1. Deaths of persons having a relevant association with a visiting Military Force which occur in circumstances in which they would ordinarily be reported to the Coroner, will be so reported in the normal way, but a Coroner shall not hold an inquest unless directed to do so by the Secretary of State.

4.8. Death in Police Custody/During or Following Contact

- 4.8.1. 01504 Procedure - Response to Death of a Member of the Public During or Following Police Contact refers.

4.9. Coroners Rules for Other Parties

- 4.9.1. Coroners' Rules require the Coroner to supply copies of depositions with other documents to interested parties, at his / her discretion. If it is known that either Magistrates' Court



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or civil proceedings are pending the Coroner should be informed accordingly. It will be for the Senior Investigating Officer to discuss with the Coroner as to whether any material should be withheld until after the hearing, so that any subsequent proceedings may not be prejudiced. In this way the Coroner can make an informed decision, on a case by case basis, regarding the relevance of material and whether or not it should be disclosed at that time.

- 4.9.2. Senior Investigating Officers should report to Headquarters any cases where a Coroner has not acceded to any such request, or where the supply of such documents to interested parties has been prejudicial to Magistrates' Court or civil proceedings.

4.10. Suicide notes

- 4.10.1. If during an investigation into a deceased a suicide note is found, the below should be followed:
- a. The suicide note **must not** be handed back to relatives
 - b. The suicide note is evidence and should be handled, logged and recorded accordingly.
 - c. The contents of the suicide note should not be immediately revealed or a copy given to relatives. The suicide note should be seized and passed to the coroner with the explanation to the relative's that it is coroner's evidence and that it will be returned to them after the inquest.
 - d. It should be borne in mind that any suicide note and any other items seized during the investigation of a deceased may be used in subsequent Coroners' hearings, so issues of disclosure should be properly considered.
 - e. The police may not supply a copy of the suicide note or reveal the contents to any person (including relatives) without the consent of the Coroner.
- 4.10.2. In cases where a note is believed to be held in electronic form (on a phone or a computer), and no crime is suspected, officers will endeavour to recover the contents in a timely manner so that the contents are available for Inquest. Advice can be obtained from CID.

5. Monitoring and Evaluation



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- 5.1. The Major Crime Support DCI is responsible for monitoring the operation of this procedure and will undertake regular evaluation of its operational effectiveness in consultation with the Coroner's office, the head of the Major Crime and the Head of CID.

6. Review

- 6.1. This procedure will be reviewed bi-annually.
- 6.2. The review will be conducted by Major Crime in consultation with relevant internal departments and external agencies.
- 6.3. The review will take account of changes in legislation and working practices, as well as the outcome of the evaluation in 6.1 above.

7. Other related Procedures, Policies and Information Sources

7.1. Related Policies

- 01500 Policy - Sudden Deaths
- 05800 Policy - Industrial Accidents
- 29600 Policy – Investigating Questioned Deaths in Healthcare Settings
- 21700 Policy - Referral of Investigations to Major Crime.

7.2. Related Procedures

- 01502 Procedure - Death in Prison Custody - Management Of Police Response
- 01504 Procedure - Response to Death of a Member of the Public During or following Police Contact
- 29601 Procedure - Investigating Questioned Deaths in Healthcare Settings
- 27201 Procedure – Road Death Investigation
- [AD203 Equality Impact Assessment](#)

Origin: Major Crime