01502 PROCEDURE - DEATH IN PRISON CUSTODY AND OTHER STATE DETENTION – MANAGEMENT OF POLICE RESPONSE

This document should be read in conjunction with Policy 01500 - Sudden Deaths and Procedure 01501 – Coroners and Sudden Death which explains the context within which this procedure is implemented and the description of the Categories used.

1. About this Procedure

1.1. This procedure explains the process through which officers and staff of Hampshire Constabulary will respond and manage a report of death occurring within a prison custody environment.

1.2. The primary responsibility of Officers/Staff attending a report of a death in prison custody will be the maintenance/saving of life. The protection and preservation of any scene or evidence will only become a priority once it has been established that death has occurred (see 3.4)

1.3. It is the responsibility of the Prison Authorities or relevant Custodians to ensure that following a death any scene is secured and preserved as soon as possible, in accordance with local policy/instruction and so maintained pending arrival of the police.

1.4. This procedure also provides guidance for dealing with related deaths such as those which occur in Military Establishments and/or relevant Secure Medical Units.

2. Risk Assessments and Health & Safety Considerations

2.1. Police staff attending a report of a death in prison custody should ensure they comply with HM Prison Service protocols/procedures when operating within a HMP Prison Service establishment, or an Establishment operated by HM Prison Service on behalf of another Government Agency/Department; or those Establishments ‘Contracted out’ under private Government tender.
2.2. All Police Officers or Staff whose role requires them to handle a 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.

2.3. A Post Incident Manager will arrange welfare support for the Police officers or staff involved, appropriate to the specific needs of the case and its impact on those involved.

3. Procedure

3.1. The objective of this procedure is to ensure a transparent and high standard of investigation from the outset. All investigations must be consistent, effective and meets the needs, concerns and expectations of all parties involved including Courts i.e. Coroners / Criminal, families of the deceased, relevant communities and the larger general public. This is to ensure that public trust and confidence in the police investigation is maintained.

3.2. In addition to liaison with HM Prison Service there may also be a need to undertake appropriate liaison with other agencies who may have a statutory interest or other involvement in the death such as the Health & Safety Executive and Premier Custodial Group Ltd. This is necessary so as to ensure Hampshire policy and procedure for dealing with deaths of this nature are supported.

3.3. The following approach should be applied when responding to the report of a death in prison custody.

3.4. Scene Preservation

3.4.1. Once efforts to save life have been exhausted all personnel should be excluded and the scene(s) secured and protected.

3.4.2. ALL Scenes need to be identified; if more then one exists, all will need to be protected and secured; consider the victim, the cell, hospital wing if body has been moved and the scene of any assault/attack. A scene log shall be commenced ensuring all relevant information is documented accordingly.

3.4.3. No unauthorised entry to the scene shall be permitted unless under direction of the attending CSI or appointed CSM.
3.4.4. Consideration must be given to the risk of cross contamination. Officers should not have contact with more then one potential Crime Scene or Suspect. If in doubt seek advice from the CSM / CSI should be sought.

3.4.5. Correct Scene Management will ensure the integrity of any subsequent criminal and or forensic investigation.

3.5. Prevent M.E.A.L

3.5.1. Attending officers/staff should be aware and adopt the M.E.A.L. principles:

   M - Movement of Evidence

   E - Evidence being obliterated

   A - Additional material being added to the scene

   L – Loss of Evidence

3.6. Scenes of Crime

3.6.1. Scenes of Crime staff should be called and attend all reported deaths in prison custody unless otherwise directed by the SIO.

3.6.2. A Crime Scene Manager (CSM) should be contacted and attend the location accordingly. In consultation with the SIO the CSM should ensure that a Forensic Strategy is drawn up, this will assist the SIO in determining the management of scenes, the availability and best method for the forensic recovery of evidence. In the event that a SIO determines that a CSM is not required to attend then the above responsibility should be given to a dedicated Crime Scene Investigator (CSI).

3.6.3. The Forensic Strategy will act as a consistent and considered approach in determining where the investigation is at any given time. In this way the integrity of the investigation and decision making process will be professionally documented.

3.6.4. It is appreciated that in the case of a death involving ‘natural cause’ occurring within a medical facility of an establishment or a hospital that the role of CSI may be limited to areas such as Post
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Mortem support, such decisions will be a matter for the SIO once the full circumstances have been assessed.

3.7. Certificate of Death

3.7.1. A qualified Medical Practitioner (who may be a prison doctor or police surgeon) must attend and certify Death. (See 3.4.1 and 3.4.3 accordingly).

3.7.2. This will ensure the required standard of medical expertise is provided.

3.8. Senior Investigating Officer

3.8.1. All Deaths in Prison Custody should, in the first instance, be treated as a Category Two death (Violent and Unnatural deaths) unless initial information suggests to the FCR Inspector that a Category One investigation would be more appropriate (Deaths involving Suspected Offences). A death in Prison Custody shall only be investigated as a Category Three death on the directions of an officer of at least Detective Inspector rank and only after they have had the opportunity to review all information available to them.

3.8.2. The above is deemed necessary to ensure the effective assessment and management of initial investigations, with appropriate standards of integrity and impartiality being maintained to address public perceptions and concerns. In the absence of a Detective Inspector a substantive Detective Sergeant should be nominated who can meet this requirement (Category Two and Three deaths only).

3.8.3. If from the information given to the FCR Inspector a Category One death is determined then the on call Force SIO should be contacted in order for issues of primacy/ownership to be considered.

3.8.4. The SIO will also be responsible for ensuring that any subsequent interview strategy of prison staff is prepared and undertaken with appropriate professionalism, integrity and sensitivity. Any such strategy should take into account issues such as the vulnerability of staff involved and the need to manage the involvement of groups such as the Prison Officers Association.
3.8.5. The Interview Strategy should take into account the principles of securing ‘Best Evidence’ with consideration of witness types and handling as Vulnerable and Intimidated Witnesses and Significant Witnesses. All such decisions should form part of and be recorded in the SIO’s Policy Log.

3.9. Pathology

3.9.1. The Pathologist called to attend to deal with a death in prison custody should always be a Home Office Pathologist.

3.9.2. The consideration of the need to secure the services/attendance of a Home Office Pathologist shall be responsibility of the reviewing Detective Inspector. Current Authorised Professional Practice (APP) guidance dictates that all deaths involving suspected offences (Cat One deaths) require the post mortem to be conducted by an approved Home Office Pathologist, however in all other cases, such as deaths resulting from natural causes following a lengthy diagnosed illness or condition the need to utilise the services of a Home Office Pathologist may be significantly reduced or eliminated; as such it is imperative that the requirement be fully discussed with the Coroner at the earliest opportunity.

3.9.3. The above mirrors the standard provided for deaths in police custody. The SIO should be aware that any requested Pathologist may also wish to attend the scene; this should be undertaken in consultation with the CSM and the Forensic Strategy – See 3.5.2 accordingly.

3.10. Prison Intelligence/Liaison

3.10.1. Prison Intelligence Officers (PIO) will be contacted in every case where a death occurs within a HM Prison Service Establishment and will be required to attend where available to facilitate assistance/liaison with Prison Service authorities at the relevant Establishment.

3.10.2. Police and staff will be expected to operate and undertake their duties within a prison environment and structure. This will always generate a need to liaise and work with prison staff and management under difficult circumstances. The presence of the PIO is therefore viewed as essential to facilitate the requirements of the SIO and support the principals of the
existing Memorandum of Understanding between the NPCC and HM Prison Service.

3.11. **Policy Book**

3.11.1. It will be the responsibility of the SIO to maintain a record of his or her decision making either by way of a Policy Book or the use of RMS.

3.11.2. By this approach all policy decisions taken by the SIO and the rationale for those decisions will be recorded and maintained for future reference. In this way the integrity of the investigation decision making process will also be professionally documented.

3.12. **Family Liaison**

3.12.1. It will be the responsibility of the SIO to consider employing the services of a Family Liaison Co-ordinator (FLC) at an early stage of any investigation so as to develop a Family Liaison Strategy.

3.12.2. The appointment of a FLC / Family Liaison Officer (FLO) will be at the discretion of the SIO in liaison with the Prison Governor, taking into account all the circumstances of the case.

3.12.3. Sudden deaths, particularly within establishments such as prisons, can generate suspicion and concern amongst relatives as to the true circumstances surrounding the death. Family Liaison therefore forms an essential part of the investigation process. This should be undertaken in liaison with the Prison Service and in accordance with current Constabulary policy.

3.12.4. SIO should facilitate personally the appropriate delivery of any death message to the next of kin in liaison with the Prison Governor linking with their protocol and procedures to agree the best approach.

3.13. **Media Strategy**

3.13.1. It is the responsibility of the SIO in liaison with the Prison Governor to ensure an appropriate Media Policy and strategy is adopted in every case.
3.13.2. A Media Officer will be consulted and assigned to the investigation in order to develop the Media Strategy and manage any Media attention, in consultation with the SIO / Prison Governor.

3.13.3. Where an SIO remains in charge of an investigation there must be a proper Media Policy adopted in consultation with both agencies. Where the investigation reveals suspicious death at an early stage then Hampshire Constabulary Media Policy as directed by the SIO will apply. However, where death is deemed not suspicious, a policy entry should be made by the SIO with the Prison Service assuming responsibility of lead agency in terms of Media Policy supported by the police as appropriate.

3.13.4. The Prison service has their own press department with whom the governor will liaise.

3.14. Deprivation of Liberty Safeguards (DoLS)

3.14.1. The ‘Deprivation of Liberty Safeguards’ (DoLS) is an adjunct to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests for example if they are kept in a nursing home or hospital and are suffering from dementia. Extra safeguards are needed if the restrictions and restraint used will effectively deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards. Nursing/Care homes must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation. Hospitals can also authorise detention of patients for treatment if it is urgently required. The Court of Protection may make a similar order authorising deprivation of liberty in a domestic setting (outside hospitals and care homes) in relation to personal welfare.

3.14.2. The Supreme Court has ruled that a person who is under DoLS must be treated as being in ‘State Detention’. Following this case, the Chief Coroner for England and Wales has provided guidance to Coroners this requires the Coroner for the relevant jurisdiction to investigate the death and hold an Inquest in relation to everyone who dies whilst subject to an authorised DoLS.

3.14.3. Where a person dies who is cared for whilst subject to an authorised Deprivation of Liberty Safeguards, it should be clearly
documented and held by the nursing/care home or hospital. Officers should make enquiries in the event of a sudden death in either of these settings to confirm the deceased patient’s status.

3.14.4. Where it is apparent that the patient died as a result of natural causes and is expected, the care home or hospital will often contact the Coroner directly who will determine whether or not to refer the matter for police attendance.

3.14.5. In instances where the police are contacted directly and it is apparent that the patient died as a result of natural causes, the Coroner can be contacted via the control room in order to decide if police attendance and investigation is required. Where the Coroner, or the circumstances of the death, requires police attendance, a G28 should be submitted to the Coroner in the normal manner.

3.14.6. Where the death is not the result of natural causes the Coroner is required to hold a ‘jury Inquest’. This may involve the investigation of safeguarding issues or lack of care by staff. The police must support this inquest through investigation into the death and the submission of a Coroners file to the relevant Coroner’s office in accordance with the timescales set out by the Coroner.

3.14.7. The law on this matter is subject to review. Further force policy will be released in the event of a change to this process.

4. Roles and Responsibilities

4.1. It is essential for Detective Inspectors who have Prison Establishments within their geographical area of responsibility to ensure appropriate levels of liaison and communication are maintained. To achieve this they should receive support from Prison Intelligence Officers in developing informal points of contact and reference to assist in implementation of this procedure.

4.2. Detective Inspector Force Intelligence Bureau (FIB) is responsible for ensuring that suitable training for both Prison Staff / Prison Intelligence Officers is maintained in order that staff from both organisations are kept up to date in relation to relevant procedures. Consultation and input from CSMs should be considered at any training day sessions with the Prison Service and PIO. This will ensure that an incident being
dealt with in the first instance by Prison Staff can and will be correctly managed without the loss of any key evidence or forensic material.

5. Administration

5.1. The completion of documentation relating to the recording and investigation of any death within a prison environment will follow existing Constabulary processes/procedures. This includes notification to the Coroner and the subsequent supply of information through the use of Form G28. Where applicable, the recording and retention of relevant material relating to the investigation in accordance with the relevant legislation provided for under the Criminal Procedure & Investigations Act 1996 should be maintained.

6. Monitoring / Evaluation

6.1. This protocol will be monitored by the Head of Investigation Command.

7. Review

7.1. This procedure will be reviewed following any changes made to any existing national protocol published covering the management of deaths in prison custody (or associated establishments as detailed above).

8. Related Policies, Procedures and Information Sources

8.1. Related Policies

- 01500 Policy - Coroners and Sudden Deaths
- 05100 Policy - Family Liaison

8.2. Related Procedures

- 01501 Procedure - Coroners and Sudden Deaths

8.3. Information Sources

- Prison Service Memorandum of Understanding
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- AD203 Equality Impact Assessment
- ACPO protocol: Police investigations – Prison, Probation and Immigration related deaths in custody (Jan 2006)

Origin: Major Crime