





Prison  
Service  
Order

# Investigating Deaths in Custody

ORDER  
NUMBER

1301

# **PSO 1301 INVESTIGATING A DEATH IN CUSTODY**

Amended A

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## Chapter 1 Introduction

### Overview

1.1 This chapter explains the purpose of the Order.

### Purpose of the Order

- 1.2 This order sets out procedures for investigations into all deaths which occur in prison custody and in the custody of services contracted by the Prison Service or as a result of any action which occurs while in the care of the Prison Service.
- 1.3 This PSO does not reflect the substantive changes likely to be necessary as work to strengthen investigation procedures into deaths, in particular to build in an independent element is taken forward within the Safer Custody Programme. Changes in practice and policy, following informal guidance, will be signalled in instructions to be issued at a later date.

### Mandatory provisions

1.4 *Mandatory provisions are highlighted in italics.*

### Main considerations

- 1.5 This Order should be read in conjunction with PSO 1300 Investigations and PSO 2710 Follow up to Deaths in Custody.
- 1.6 This Order has been drawn up in consultation with relevant parties from both inside and outside the Prison Service. It describes;
- • the conduct of an investigation;
  - • arrangements for pre-inquest disclosure of investigation reports for deaths occurring since 1 April 1999;
  - • and the handling of requests for reports and material prior to that date.
- 1.7 The framework for conducting any investigation is outlined in PSO 1300 'Investigations'. Investigations into deaths in custody fit within that framework as set out in chapter 2 to PSO 1300, but there are a number of additional aspects which require special sensitivity, notably liaison with the family of the deceased and coroners and the disclosure of investigation reports; hence the need for a separate PSO. Where there are differences between this PSO and PSO 1300, PSO 1301 takes precedence in terms of procedures to follow in investigating a death in custody.

### Superseded instructions

- 1.8 This Order replaces PSI 36/98, the protocol on disclosure issued in April 1999 and all previous model letters and formats used in training for investigations into deaths in custody.

#### **NOTE FOR ESTABLISHMENT LIAISON OFFICERS**

*ELOs must record the receipt of the Prison Service Order – Investigating Deaths in*

**Custody** in their registers as issue 154 as set out below. The PSO must be placed with those sets of orders mandatorily required in Chapter 4 of PSO 0001..

Issue no.	Date	Order no.	Title and / or description	Date entered in set	ELO signature
154	17/06/02	1301	Investigating Deaths in Custody		

**Brodie Clark**  
Director of Security

## Chapter 2 The purpose of the investigation

### Establishing an investigation

- 2.1 *All deaths in prison custody must be investigated.* In addition, it may also be appropriate to hold an investigation where someone dies as a result of events that have occurred while in prison care. For example, a prisoner may die outside prison, but there may be concerns over treatment received while in prison care. Any decision to investigate such a case should be the exception rather than the norm and where there are clear and serious grounds for initiating such action.
- 2.2 The aims of the Prison Service internal investigation into a death in custody are:
- • to identify the extent of compliance with policies and procedures;
  - • to establish whether there are any lessons to be learned; and
  - • to identify any action which needs to be taken.

Model terms of reference for an investigation into a death are shown in Annex A. These may need to be adjusted according to the individual circumstances surrounding the death. In the case of apparent suicides the investigation will examine whether suicide prevention procedures have been adhered to adequately. In all cases the investigation will examine whether the aftermath of the death was handled satisfactorily. Investigations will also identify any individual performance which may have affected the handling of the death.

- 2.3 Whatever the apparent nature of the death, it is important that an early assessment of the circumstances is conducted to decide what scale of inquiry is needed. The scope of the terms of reference and the scale of the investigation may differ according to the type of death. *The Commissioning Authority (CA) must discuss this with the governor/director and controller/ monitor* (see para. 3.2 for definition of CA).
- 2.4 *All deaths must be investigated by a team external to the establishment.* For an apparent suicide, a typical team would be a Senior Investigating Officer (SIO), supported by an Investigating Officer and administrative staff. An input may be required from a health care professional.
- 2.5 It should also be remembered that the internal investigation report will be disclosed to the Coroner and may form part of the inquest proceedings. It is essential that the information contained in the report is sufficient for this purpose.

### Natural Causes Deaths

- 2.6 *All deaths from natural causes must be investigated.* The purpose of this section is to clarify action to be taken in respect of an investigation into a death from natural causes.
- 2.7 The CA will need to make a judgement on whether a full investigation is necessary or whether a clinical review of the treatment provided while in custody – to be conducted by a health care professional external to the establishment - is sufficient. Where the CA has a partnership with external NHS trusts to provide medical care, they may invite a member of the in-reach team to provide this clinical review.

Otherwise, the CA may ask an appropriate member of the Health Care Team from another establishment to do so. If there is any doubt over the suitability of a person nominated or there are difficulties experienced in finding someone able to undertake such a review, the CA may wish to discuss further with the Prison Health Task Force.

- 2.8 In recent years, experience has shown that some apparent natural causes deaths warrant substantial investigation beyond just the clinical treatment given. This is especially so where there are issues about quality of care and compliance with procedures which emerge from the initial assessment. For example, some sudden deaths from apparent natural causes have been regarded by the families of the deceased with equal suspicion, as regards any possible failure of care by the Prison Service, as a self-inflicted death. It is essential that the Prison Service can demonstrate the level of care provided to a prisoner who has died through the findings of an investigation report.

- 2.9 The level of investigation will vary from case to case. There may be cases where, for example, there are issues raised which cover not only clinical treatment, but the standard of care provided by the prison as a whole. In those circumstances, it may be appropriate to appoint an SIO/IO to accompany the health care professional to provide a wider ranging report instead of simply a clinical review. On the other hand, it may not always be appropriate to hold a full investigation for every natural causes death, for example where a prisoner dies in an outside hospital following a terminal illness. If the majority of the care provided has been by the hospital then there may be little to investigate on the part of the Prison Service. However, before being transferred to hospital, a prisoner may have received substantial care from the prison Health Care Centre and it may be appropriate to investigate treatment provided while there.
- 2.10 It should be noted that natural causes deaths are increasingly subject to civil litigation and the Prison Service needs to be able to demonstrate, through an investigation report, the level of care provided. If no investigation has taken place, it is less likely to be able to do so and prisons may increasingly be found liable for such deaths and payment of subsequent costs.
- 2.11 *There must be an assessment of the clinical care given.* It is suggested that a clinical review follow, as far as is appropriate, the format of the investigation as set out in annex E. Such a review will need to include an examination of the relevant paperwork and interviews with staff. Local protocols and instructions will be examined and compliance measured against national policies.

## **Homicides**

- 2.12 2.12 *Homicides must also be investigated in accordance with the terms of this PSO.* These investigations may take place alongside the Police investigation. However, there may be issues over the primacy of these investigations (see para. 4.12).

### **Chapter 3 Key roles & tasks**

- 3.1 This chapter describes the roles and responsibilities of the main groups involved in the investigation of a death. *All sections in this chapter must be read by all who may be involved in investigating a death in custody at any stage.*

#### **The Commissioning Authority (CA)**

- 3.2 The Commissioning Authority (CA) will usually be one of the following:

the Director of High Security Prisons;

the Operational Manager for Women's Prisons;

the Operational Manager for Juveniles

an Area Manager; or

the Head of Prison Escort and Court Custody Services.

#### **Commissioning an investigation**

- 3.3 *Upon notification of a death in custody, the CA must commission an investigation. The CA approves and owns the report in its final form; is responsible for deciding the extent of disclosure; and for considering any request for access to other material relating to the death. The CA is responsible for agreeing any ensuing action plan with the governor/director and in ensuring that its progress is followed through and, where appropriate, reporting any relevant matters to Safer Custody Group (SCG) at HQ.*
- 3.4 *As owner of the report, the CA must take the initiative in offering the report to the coroner. He/she must arrange for the pre-inquest disclosure of the report, act as the central point of reference in matters relating to the report and taking advice where necessary (ie SCG, Legal Adviser's Branch (LAB), Treasury Solicitors, etc.)*
- 3.5 The CA's first duty is to set the terms of references (see model at Annex A), commission the investigation (including SIO) and allocate the necessary resources, (this also includes the members of the Investigation Team). The CA will also issue with the terms of reference a copy of the Prisoner Profile Report (see para. 3.46 and Annex I). It is also a matter for the CA to decide, dependant upon the details of the case, what the timescale should be for the completion of the report. It is suggested the usual time-scale for completion of the Initial Assessment should be no more than three weeks and eight weeks for the completed report.
- 3.6 *The CA must be satisfied that adequate resources have been allocated for the investigation to be completed to a satisfactory standard. The CA must notify the Investigations Co-ordination Unit (ICU) of the commencement of the investigation in accordance with PSO 1300.*
- 3.7 On receipt of the initial assessment the CA may determine whether the terms of reference need to be extended. He/she may also wish to consider at this stage and

on the basis of the information before them whether there may be a need for a separate disciplinary investigation to be conducted in this case on completion of the investigation (see also paras. 4.17-19). Where possible, a copy of this initial assessment is to be forwarded to SCG for their information.

- 3.8 On receipt of the completed draft report the CA will indicate to the SIO whether the investigation has been completed to a satisfactory standard or whether any further investigation is required.

- 3.9 *When the report is completed and accepted by the CA, an action plan must be requested from the governor/director where recommendations have been made. Recommendations requiring service-wide consideration will be passed to the appropriate policy section(s) within headquarters. The CA owns the report in its final form and is responsible for ensuring that any action plan is followed up. The CA will report back to SCG on the progress of the implementation of recommendations made within the establishment. SCG will analyse this information to identify common trends among deaths in custody. SCG will pursue any policy changes at headquarters with the appropriate policy section and report in turn to the CA on progress or actions taken there.*

### **Disclosure of the investigation report**

- 3.10 The CA will arrange for a copy of the completed report (including appendices) to be sent to each of the following: Safer Custody Group; the Treasury Solicitor; ICU; and the coroner. Where the report concerns the death of a juvenile in custody, the CA should also arrange for a copy to be sent to the Youth Justice Board (YJB). Where the CA seeks to use an independent advisory panel to inform the investigation, he/she will also need to make a copy of the report available to the panel members.

### **Next of kin/family**

- 3.11 As owner of the report it is essential that the CA takes the initiative in offering the report to the coroner and in arranging for pre-inquest disclosure of the report to the next of kin/family. The CA acts as the central point of reference in matters relating to the report and taking advice from SCG.
- 3.12 *The copy to the coroner must be accompanied by the model covering letter (see Annex B) which informs them of our intent to offer pre-inquest disclosure to those whom the coroner regards as having a proper interest in the inquest (normally the family and their legal representatives). The model letter also includes an example of the Understanding of Confidentiality that properly interested persons are required to complete and return.*
- 3.13 On receipt of confirmation by the coroner that he/she is content for disclosure of the report in part or in full, the CA will write to the relatives of the deceased, using the standard model letter (Annex C), including a copy of the Undertaking of Confidentiality (Annex D), to be signed and returned to the CA.
- 3.14 It is important that communication with the coroner and the family is initiated by the CA. It is Prison Service policy to offer pre-inquest disclosure routinely. The model letter also offers relatives a choice on the method of disclosure, ie through the post, in person by the SIO or a combination of both. It is important that families are given this choice.
- 3.15 On receipt of the completed (signed) Undertaking of Confidentiality from the properly interested party, the CA will inform the SIO of the preferred method for disclosure. Where a meeting is requested, the SIO will contact the family to arrange the meeting in liaison with the establishment as necessary. Where families, for whatever reason, are not prepared to sign the Undertaking of

Confidentiality form, the CA should notify the SIO who will offer to meet with the family to talk through the report and its content but without handing over a copy of the report. If the undertaking is received and has been amended to include reference to other third parties who family or their legal representatives intend to disclose the report, it cannot be accepted. *The family or their legal representatives must be informed that any third party must make application to the Coroner for disclosure as properly interested persons.* Another undertaking should be sent out for correct completion. It is, however, accepted that for the purposes of the inquest, counsel engaged to act on the family's behalf are legal representatives and do not need to be treated as third parties.

- 3.16 *Where there is a dispute over who is the next of kin, the parties must be referred to the coroner for a ruling. The CA will be guided only by the Coroner's ruling.*
- 3.17 Where the family and/or legal representatives have agreed to the conditions of pre-inquest disclosure, the CA will decide the extent of disclosure. The aim is to give as full disclosure as possible. If in doubt, the CA may liaise with SCG who will consider whether there are any elements to the report which are prohibited from disclosure.

### Third parties

- 3.18 Where a request for pre-inquest disclosure is received from a member of staff who is a Trade Union member or from their legal representatives, a similar process will apply. *The CA must write to the coroner using an adapted version of the model letter (Annex B) to ask whether the coroner considers the staff member as a properly interested person* Where disclosure is agreed the member of staff or their representatives will need to sign the Undertaking of Confidentiality. Trades Unions are third parties to an inquest and do not have an automatic right to the disclosure of the report.
- 3.19 Where the coroner consents to the disclosure of the report to members of staff or their legal representatives, the CA may feel that it is appropriate only to disclose the Part 1 of the report together with copies of officers' statements from the annex.

### Disclosure issues

- 3.20 Most commonly, documents which are not disclosed will be those elements of the report which are not our property eg, police statements, external probation reports, etc; references to third parties, (eg other prisoners, but not staff) who are irrelevant to the circumstances of the death and whose identity should not be made known; costs of the investigation; and recommendations regarding staff performance, including commendations or disciplinary action (these should be contained in a separate section in the report so that their removal does not leave "gaps" in the main body). The IMR should not be removed from an investigation report. The family have a right under the Access to Health Records Act to the medical records of a family member who has died and, as such, the IMR should be disclosed to them.
- 3.21 The Prison Service commitment is to offer and provide pre-inquest disclosure of investigation reports as soon as possible after completion of the report and no later than 28 days before the inquest. Although the interval between the death and the inquest will normally permit this, the coroner is entitled to complete the inquest as speedily as possible. Therefore speed and promptness in offering the report to the coroner and in making arrangements for pre-inquest disclosure are essential. It is important that families and their legal representatives do not have cause for complaint against the Prison Service. Where any part of the report is not to be disclosed to the family, this will need to be brought to the attention of the coroner in the letter from the CA (see annex B).
- 3.22 Where requests are made for disclosure of additional material relating to the death, the CA may want to consult with SCG for advice. If additional information is requested prior to the inquest, but after the disclosure of the investigation report, the consent or comments of the coroner may be obtained before disclosure is given. If so, the CA should consult with SCG and, if appropriate, Treasury Solicitors. Each request will, however, be considered on its merits on a case-by-case basis against the application of, at present, the Code of Practice on Access to Government Information (the Code) and, if appropriate, the Data Protection Act. In some instances it may be necessary to seek further legal advice. The general presumption is that, subject to any comments by the coroner, this information will be

disclosed if requested by the next-of-kin or their legal representative unless the criteria for non-disclosure set out in para. 3.20 applies.

- 3.23 If a request is made for disclosure of material before the investigation report has been completed, normal policy will be to resist such disclosure until such time as pre-inquest disclosure of the report has been completed and the party is thus better able to identify what further information is required.
- 3.24 *Where it has not been possible to disclose the report to the next of kin prior to the inquest, the CA must ensure that it is disclosed post inquest, complete with personal disclosure by the SIO if requested.*
- 3.25 Where requests are received for disclosure of investigation reports and/or material relating to the death for cases which occurred prior to introduction of the new disclosure policy, ie prior to April 1999, each will be considered against the Code. Under the Code the presumption is in favour of full disclosure. Where disclosure is requested and is judged by the CA to be appropriate, the CA will notify the governor of the establishment where the death took place. Where practicable the Governor will arrange for witnesses who gave evidence to the investigation to be notified of our intention to disclose the report or as much of it as we are able. If required, the CA may discuss individual cases with SCG.

## The Senior Investigating Officer (SIO)

- 3.26 *The SIO required to investigate any death must have been trained specifically for the task of investigating a death in custody.*
- 3.27 The SIO has a number of key tasks which are performed on the authority of the CA. Throughout the investigation, the SIO should keep ICU informed of progress of these various tasks and other duties.
- 3.28 The first task is to carry out the commission set out in the terms of reference from the CA (see para. 2.1). The initial assessment is designed to give the CA early notice of any areas of difficulty or where immediate action needed; it is not intended for inclusion in the completed report. *A standard format for the completed report is provided in Annex E and must be adhered to.* Note that this format differs slightly from the standard investigation model in PSO 1300 but is important that this investigation model is followed in order to ensure consistency in our handling of disclosure.
- 3.30 A crucial stage in the conduct of the investigation is the SIO's contact with the family to advise them of his/her role and to invite them to contribute to the investigation at a time and place convenient for them. It is important that the SIO takes the initiative rather than waiting to see if the family wish to make contact. If necessary, the Governor will advise on any family reaction to the death which needs to be taken into account.
- 3.31 Taking information from the family is a highly sensitive task. The SIO may wish to be accompanied by a representative of the establishment. It may often be more appropriate if this representative is not someone who was directly involved in the incident. The SIO may also wish to brief them regarding disclosure before the visit to agree what is said. Although the family may not wish to make any formal statement, a note of what occurs should be taken and a confirmatory version of that should be sent to the family afterwards. *The SIO must advise the family if information which they provide warrants passing to the Coroner or the Police.* The meeting should take no longer than necessary, and should be followed up if the family wishes. Great care should be taken in preparing for the meeting, using whatever background information is available, and anticipating any likely difficulties sensitively.
- 3.32 A family may not, initially, want to talk to a member of the Prison Service, but that should not be taken to mean that they do not want to talk at all. The SIO should be prepared to offer further opportunities for the family to have some input into the report before it is completed. It is also advised that contact be maintained, where possible, with the family after the completion of the report. The SIO can have an important role to play, for example, in providing advice and support to the family up and until the inquest takes place.
- 3.33 The second task is to check the draft report with the Governor/Director/ Controller for factual accuracy and with those who may have been criticised for a response which will normally form part of the report. Where SIOs wish to check out any matters of drafting or completeness of the report, SCG will be able to advise.

- 3.34 The third main task is to assist in the pre-inquest disclosure of the report to the family, as directed by the CA, and where the family have agreed to such a meeting. The meeting will normally be carried out with a representative of the establishment, or the Controller/Monitor of a contracted service present, who can provide information more generally about the establishment. The SIO should take a note of the meeting and send a copy to the family, Governor, the CA and SCG. Where a family has refused to sign the Undertaking of Confidentiality but accepts the offer of a meeting with the SIO to be talked through the report, the SIO should again take a note of the meeting. In these circumstances the family are not entitled to take the report away with them
- 3.35 If the SIO has grounds to believe that his/her safety may be endangered through personal contact with the family (ie where there is a threat of physical violence). It may be necessary to decline to meet with the family for disclosure and instead send the report to the family with an offer to respond in writing to any requests for clarification or queries. The SIO should first consult with the CA before taking such action. The CA may in turn wish to seek advice on this matter from SCG.

- 3.36 The SIO may be required to give evidence at the inquest and the Coroner may allow questioning by the family or their representatives. The SIO should be notified of the inquest date by the CA. On completion of the inquest the SIO's involvement in the case should normally cease; unless in exceptional circumstances there is a need for post-inquest disclosure because of a failure to disclose prior to the inquest. Any other requests for material relating to the death will not require the involvement of the SIO and should be forwarded to the CA.

### **The Governor/ Director**

- 3.37 The duties of the head of the establishment in the follow up to a death in custody are set out in PSO 2710. As indicated in PSO 2710 contact with the family/next-of-kin should be handled as sensitively as possible taking account of the circumstances surrounding each individual case. Families should be informed that an internal investigation will be carried out and that the SIO will be contacting them to explain the investigation process and purpose and to offer them the opportunity to raise any issues or concerns.
- 3.38 It is important that a distinction is made between the SIO's and the establishment's role in dealing with the family and relatives. Primary responsibility for offering support and advice up to and in some cases after the inquest rests with the establishment.
- 3.39 Where an external investigation is being conducted, the establishment should provide the investigating team with all assistance. A local investigation liaison officer must be appointed as the link between the establishment, the investigation team and the coroner (see also PSO 2710). The liaison officer should arrange for collation of all relevant documentation (see annex F); assist the SIO in the provision of an office and interview room and also ensure the availability of witnesses.
- 3.40 Where a family has accepted the offer of a pre-inquest disclosure meeting with the SIO, a member of the establishment should also attend. The choice of representative and location of the meeting will be determined according to the individual circumstances. In some instances it may be preferable for such a meeting to be held at a neutral venue.
- 3.41 If any request for disclosure of the investigation report or any other relevant material concerning a death is received at an establishment, this should be referred to the CA to consider further with SCG.

### **The Safer Custody Group (SCG)**

- 3.42 SCG is responsible for the policy on suicide prevention and the handling of deaths in custody. As such it sponsors the training of SIOs for deaths in custody investigations and formulates the policy on investigations and disclosure.
- 3.43 SCG's primary role in the conduct of investigations into deaths is in providing advice to the CA, SIOs and Governors.
- 3.44 SCG is available to SIOs to provide advice on initial assessments and draft reports and on any procedural matters which may arise according to the particular

circumstances of the death. SCG liaises with CAs and advises on the handling of disclosure; giving advice, if required, on the extent of disclosure which the CA should permit.

- 3.45 SCG will provide advice to the CA on the handling of requests for retrospective disclosure of material relating to deaths which occurred before the publication of the pre-inquest disclosure protocol for deaths from 1 April 1999.
- 3.46 SCG maintains copies of completed investigations for central monitoring and development of the deaths in custody database, in liaison with ICU. The Prisoner Profile Report (PPR), (see annex I), which is to be completed during the course of the investigation, requests core data used by SCG for research and training purposes. Once an SIO has been appointed to investigate a death in custody, the nominated Commissioning Authority will issue the PPR together with the terms of reference. Upon completion of the investigation, the PPR should be submitted together with the written Investigation Report.
- 3.47 On completion of the inquest SCG receive a note prepared by the Treasury Solicitor. This will be available for circulation to CA, Governor, SIO, and relevant policy holders if required. Casework arising out of a death in custody is normally handled by SCG in consultation with the operational line.

#### **The Investigation Co-ordination Unit (ICU)**

- 3.48 The role of ICU is described in PSO 1300. For procedural and handling purposes investigations into deaths in custody are dealt with by ICU in the same way as other investigations. *CAs must keep ICU informed of the commencement and progress of each investigation (see para. 3.4) and SIOs must keep ICU informed of the progress of the investigation (see para. 3.15).*

#### **The Family**

- 3.49 Since the family circumstances of each prisoner are unique, each family should be treated with the consideration and respect required by their particular needs.
- 3.50 The first contact between the Prison Service and the family following a death may be tense and defensive on both sides. The role of the SIO as a more neutral enquirer can therefore form a welcome bridge between the prison and the family.
- 3.51 There are at least four distinct phases of involvement of the family - and in absence of family, friends - of a prisoner who has died in custody: first notification; the internal investigation; pre-inquest disclosure; and the inquest itself.
- 3.52 The Governor will arrange for the family to be notified as soon as possible after a death in accordance with PSO 2710 which includes advising the family of contact arrangements with the establishment and the role of the SIO in the subsequent internal investigation. The family will be invited to visit the prison, and where possible to see the place where the death occurred if they wish. Any reasonable request to meet staff or prisoners should be granted if they are willing, though care will need to be taken to avoid confrontation or undue stress to those involved

3.53 The SIO will contact the family at the earliest opportunity. Although ultimately the choice of whether to take up this invitation rests properly with the family, it is important that the offer is made. In some instances the family may wish their legal representatives to attend. Such requests should be granted but it is essential that the ground rules of any such meeting are agreed clearly at the outset.

### **Treasury Solicitors**

3.54 3.54 Treasury Solicitors act as the legal representatives for the Prison Service. They provide a service similar to that of an ordinary solicitor. PSO 2710 provides details of the main role of Treasury Solicitors in a death in custody case, ie the provision of advice and support prior to and at the inquest. They will also liaise direct with the establishment on matters relating to the preparation for the inquest. Any request from the next of kin or their representatives for information made direct to the establishment should not be referred to Treasury Solicitors but, as explained elsewhere in this PSO, should be referred to the CA for advice and action. Subsequently, the Treasury Solicitors will provide the CA and SCG with an account of the inquest with details of the main evidence disclosed so that the CA is aware of any sensitive areas when considering granting access to material after the inquest. A copy of this report is available on request. They will also assist in, and advise on, disclosure only if instructed to do so, working with SCG (and possibly Legal Adviser's Branch) as necessary.

## Chapter 4 Conducting an investigation into a death in custody

- 4.1 PSO 1300 'Investigations' gives detailed advice on preparation for and conduct of the investigation process. The guidance here highlights additional issues which need to be considered specifically in the context of the sensitive handling of a death and afterwards. Although this guidance refers specifically to self-inflicted deaths, it also applies to investigations into homicides or clinical reviews into natural causes deaths.

### Preparation

- 4.2 *The terms of reference must make clear the extent of the investigation, expected timescales and resources necessary for allocation to the investigation.* SIOs should check whether, on the basis of their initial assessment, the terms of reference are adequate and, importantly, whether there is a need for additional specialist input to the team. Where identified this should be taken up with the CA.
- 4.3 Early contact with the investigation liaison officer is essential so that all relevant documents can be assembled and arrangements can be made for access to witnesses. Annex F shows essential documents which would normally be relevant to a death in custody and those which may be desirable. The SIO should ensure that the investigation liaison officer is familiar with this list.
- 4.4 The medical aspects of the case will require particular care both from the point of view of expertise and of handling medical confidentiality. Normally the CA will nominate a health care professional to assist the team. In order to gain a comprehensive understanding *the SIO must have full access to all material including medical papers and the relevant parts of these will need to be included in the report.* Arguments that such material is medical-in-confidence do not apply in investigations into deaths in custody.
- 4.5 The SIO, in conjunction with the establishment, will ensure that an invitation to give evidence to the investigation is issued (model notice in Annex G).

### Conducting the investigation

- 4.6 The SIO will form an early impression of the circumstances of the death sufficient to advise the CA as to any amendments to the terms of reference or any immediate action needed. This may involve the referral of any matter for internal disciplinary investigation or, possibly, to the Police for criminal investigation. This initial assessment will be given in confidence to the CA as quickly as possible.
- 4.7 The aim of the investigation should be to combine thoroughness with conciseness. The main purpose is to assess compliance with published instructions, taking account of any recent standards and other audits, inspections and previous recommendations following an investigation into a death in custody or self-harm at the establishment.
- 4.8 The investigation should be completed within the time frame outlined in the terms of reference. If more time is required, for example, due to a witness not being available, then this should be negotiated with the CA.

- 4.9 Interviews with witnesses will need handling with sensitivity. Staff and prisoners who have been closely involved with the deceased may be quite affected by the death. It is important that the investigating team keeps distinctly clear from the support role that Care Teams and Staff Care & Welfare have to offer.
- 4.10 Interviews with staff should not be conducted as disciplinary investigations (with the issue of DAPS 1), but under general investigations procedures. Staff may be reluctant to co-operate with the investigation or may feel threatened if they consider that there is a risk of disciplinary action as a direct result of information given to the SIO. The SIO should liaise with the local POA representative or other staff associations as a matter of good practice.

- 4.11 Where the SIO identifies witnesses who appear to need further support, these concerns should be relayed to the Governor. Particular care should be taken where evidence is taken from a Samaritan trained prisoner Listener. Listeners are bound by confidentiality even after the death. They should not be placed under pressure to disclose, but may be able to offer a general view without breaking confidentiality. For such interviews arrangements should be made for a Samaritan volunteer to accompany the Listener.
- 4.12 *Before starting any interview, it must be made clear by the SIO that a transcript of the interview will form part of the investigation report and will be disclosed*
- 4.13 The handling of material where parallel investigations (ie Police, Coroner's officer) are being conducted requires the application of simple rules. The requirement of the Coroner to have unimpeded access to all relevant material, including the full internal investigation report, is paramount. Statements of fact may be shared between the Prison Service and the Police and the Coroner where it avoids unnecessary duplication. But the Prison Service investigation is not a criminal investigation nor is it aimed primarily at discovering how a prisoner died, which is a matter for the inquest jury. Witness statements taken by the SIO are not taken under PACE conditions, even where tape recordings of interviews are made, and indeed may be given immediately following a death with no specific advice having been given by the SIO beforehand.
- 4.14 Similarly, statements given to the Police or to the Coroner will have been given specifically for their purposes, and their integrity could be in doubt if it was known that they could be passed on to the Prison Service. The rules are therefore that each investigation should, as far as possible be kept separate according to its purpose, and that those who contribute should be clear as to the use which will be made of their contribution. The Protocol on Disclosure gives further guidance on the handling of witness statements. Where the Police are conducting an investigation it should, of course, have primacy over the internal investigation, but should not prevent the SIO from carrying out his/her investigation unless specifically directed not to by the Police because of any possible criminal proceedings or if they remove any evidence or information necessary for the continuation of the internal investigation. Where prison documents are removed by the Police, copies are to be retained by the establishment. It is recommended, however, that where ever possible the police accept copies, while the originals are retained at the establishment. Where originals are removed by the police, a signed receipt for these documents must first be obtained.

### **The report**

- 4.15 The model structure for the report is given at Annex E. It is essential that the report differentiates clearly between matters which relate directly to the death and those which do not, but which the commissioning authority/governor will need to address. In addition, for clarity, the report should contain a glossary of Prison Service terms as at Annex H
- 4.16 There should be a logical progression through findings to conclusions and then to recommendations. The SIO should take care to ensure that the Findings, Conclusions and Recommendations sections are clearly distinct from each other. If

the SIO has particular concerns, but there is limited evidence to support them, such concerns should still be included in the report. But it should be made clear on what basis they are included and what the evidence is on which these concerns are based. It is quite proper for an opinion to be expressed, but the author should make quite clear that it is only an opinion. It is important that the report is thorough and detailed and that, where appropriate, it is prepared to be critical of either the establishment where the death occurred or other parts of the Prison Service.

- 4.17 One key area of the SIO's role is to make recommendations arising out of their investigation. The recommendations will need, of course, to be achievable and should reflect existing local and national policies. Where an SIO makes a recommendation regarding disciplinary action, it is important that it is contained in a separate section of the report and that the following wording is used;

“That consideration is given to a disciplinary investigation into the actions of....”

- 4.18 4.18 This and any other recommendation regarding staff performance should be located in a separate section regarding staff from general recommendations (see annex E). It is also essential that any disciplinary action is separate from and not part of the investigation into the death. As such it should be considered entirely independently by the CA from the investigation. It is recommended that, where possible, the disciplinary action does not take place until after the completion of the investigation into the death to allow all relevant information to be considered by the CA.
- 4.19 If any particular issues are identified by the SIO as sensitive and/or whose disclosure may require careful consideration, this should be made clear in the report to ensure that it is brought to the attention of the CA when considering disclosure. For example, a report may be extremely critical of a member of staff at the prison. This should be brought to the attention of the CA who should allow the person to make any comment before the report is finalised.
- 4.20 The report should avoid any suggestion that the SIO has pre-judged the inquest verdict. For example the term 'committed suicide' should not be used and the word 'apparent' should be used to qualify self-inflicted death.
- 4.21 Great sensitivity is required when describing any relevant personal background details of the deceased and family relationships. For example, a detailed criminal history of the person is often not relevant to the investigation. Also the deceased prisoner should be referred to by either their first name or as "Mr/Mrs/Ms" rather than using an impersonal surname. Such apparently minor references may cause distress to the family of the deceased.
- 4.22 With any bulky material such as the F2050, it will be necessary to include only the relevant parts of such material as annexes, summarising the content in the main body of the report
- 4.23 To assist in the central collation of information about deaths in custody SIOs should ensure that the core data sheet at Annex I is completed for each case.

#### **Disclosure of investigation reports and any additional material**

- 4.24 The main principles surrounding disclosure are in the Protocol at Annex J, as well as a flow chart and a short step-by-step guide for ease of reference at Annex K.

<b>Annexes</b>	<b>A</b>	<b>Model terms of reference</b>
	<b>B</b>	<b>Model letter from CA to Coroner</b>
	<b>C</b>	<b>Letter from CA to properly interested party</b>
	<b>D</b>	<b>Letter of undertaking of confidentiality</b>
	<b>E</b>	<b>Standard report format</b>
	<b>F</b>	<b>Essential documentation</b>
	<b>G</b>	<b>Model notice of investigation</b>
	<b>H</b>	<b>Example glossary of terms</b>
	<b>I</b>	<b>Data sheet</b>
	<b>J</b>	<b>Protocol on disclosure</b>
	<b>K</b>	<b>Step-by-step guide and flow chart</b>

**From: Commissioning Authority**

**To: Senior Investigating Officer**

**Direction** You are directed to investigate the circumstances of the death of [prisoner's name] at HM [establishment] on [date]; and to report. Your investigation is to be conducted in accordance with PSO 1300 and PSO 1301.

**Authority** You act with my authority in conducting this investigation.

**Objectives** Your investigation should find out what took place, its causes, the manner in which it was managed and how a similar occurrence may be prevented in the future. In particular you are to:

- (a) establish the facts pertaining to the apparent cause of death;
- (b) establish the degree of compliance with Prison Service policy & the local strategy for the care of the suicidal;
- (c) recommend whether any changes to the operation of the establishment's suicide prevention strategy should be made;
- (d) establish the degree of compliance with Prison Service policy on handling the aftermath of a death in custody and whether any changes to local strategies are needed;
- (e) recommend whether a separate investigation *should be considered* under the Code of Conduct and Discipline or whether the matter should be referred to the police;
- (f) [any additional objectives depending on the individual circumstances]

**Recommendations** Your report will make recommendations to prevent recurrence specifically related to the establishment and/ or the Service in general and on the better handling of such incidents in future. You may make recommendations on any good practice that is relevant to or becomes apparent during your investigation.

**Resources** I have appointed the following to assist you in your investigation:

**Timescale & Costs** You are to provide an initial assessment by [ ] and your final report by [ ] unless these timescales are revised by mutual agreement. Your final report must include an assessment of the total cost of the investigation.

**Signed..... Date.....**

**Commissioning Authority**

**MODEL LETTER FROM THE COMMISSIONING AUTHORITY TO THE CORONER  
PROPOSING PRE-INQUEST DISCLOSURE**

Dear

**[heading - Name of deceased, establishment, date]  
Pre-inquest disclosure of the Prison Service internal investigation report**

As Area Manager / Director of High Security Prisons / Head of the Prisoner Escort and Court Custody Service responsible for [name of the establishment / contracted service] I recently commissioned an investigation into the circumstances surrounding the death of [name of deceased] to discover what lessons there were for the Prison Service. I have now received the report which I forward in its entirety for your consideration as background information.

The Prison Service believes that where possible the full report should also be given before the inquest resumes to those whom you intend to treat as properly interested persons at the inquest hearing. Our experience has been that delaying such disclosure can breed unnecessary anxiety and suspicion. We would not however want to compromise or prejudice the inquest or the conduct of your investigations. We propose to make the disclosure on the basis set out in the draft letter attached. As you will see I do/do not intend to disclose the full report to the family. [Where appropriate – I do not intend to disclose the following documents for the following reasons].

Please let me know who you will be treating as properly interested persons, and of any reservations you may have about the disclosure of any particular material. [Where applicable] I will leave the decision on disclosure of material produced by the police to them.

I would be happy to discuss any concerns you may have.

Your sincerely

(signed)

Director of High Security / Operational Manager for Women/ Area Manager / Head of  
Prisoner Escort and Court Custody Service

attd: draft letter to properly interested persons and form of acknowledgement of liability

**MODEL LETTER FOR ADAPTATION TO PROPERLY INTERESTED PERSONS AS DETERMINED BY THE CORONER**

To Properly interested person as set by the Coroner

[Dear]

As you may know I commissioned an investigation into the death of [your ..... forename and surname] to see what lessons there were for the Prison Service. The report is now complete.

I understand from the Coroner that he would treat you as an interested person for the purposes of this inquest, and he is content for me to disclose the material in this report to you. If you would like me to do so could you, or your legal representative, please complete and return the attached form to enable us to arrange the method of disclosure requested. As you will see, we can arrange for the author of the report to meet with you to discuss and hand over the report or you may wish to read the report first.

You will wish to be aware that the disclosure of these documents is to enable you or your legal representative to prepare for the inquest. The use of these documents for any other purpose and, in particular, their disclosure to any third party (other than your legal representatives), could prejudice the outcome of the inquest. We would advise you not to share this information with anyone whom the Coroner has not ruled as being a properly interested party to the inquest.

Please do not hesitate to contact me if you have any query.

(Signed)

[the Area Manager / Director of High Security Prisons / Operational Manager for Women/  
Head of Prisoner Escort and Court Custody Service]

encl: Disclosure form plus spare copy for retention  
& s a e

Copy: The Coroner  
Hidden copy Safer Custody Group

**UNDERTAKING OF CONFIDENTIALITY**

Name of the deceased

Date of death

Place of death

I have read and understood your letter of..... I am aware that disclosure of the report to a third party (other than my legal representatives) may prejudice the outcome of the inquest. I would now like the internal investigation report disclosed to me. I have set out my preference for the method of disclosure below:

- a) *I would like to receive the report in person from the author to discuss it*
- b) *I would like to read the report first before meeting the author to discuss it*
- c) *I do not wish to discuss the report with its author*

*For a) and b) I can be contacted at the following address / telephone number to arrange a mutually convenient time and place.*

*Address .....*

*Phone No .....*

*Signature .....*

*Name (printed) .....*

*Relationship to the deceased ;  
.....*

*Date ...../...../.....*

The report should be prepared in two parts: Part 1: sections A - N, and Part 2: the Appendices. Adoption of this standard formatting will aid in consistency and facilitate disclosure handling.

**Part 1**

- A **Introduction** Include as standard: condolences to the family; thanks for assistance/cooperation of all involved
- B1 **Contents** Outline sections with page numbers
- B2 **Glossary of terms** (see example in Annex ...)
- C **Terms of reference**
- D **Executive Summary.** This should be a summary of all the key issues, including brief background and circumstances surrounding the death and the key findings and recommendations.
- E **Background.** Include prisoner's details and custodial history and relevant establishment history
- F **Investigation process** brief description of procedure and range of evidence and witnesses seen
- G1 **The incident and events leading up to the death**
- G2 **Post incident response**
- H **Level of compliance** with authorised procedures, taking account of recent Standards Audit, HMCI and Investigation recommendations
- I **Findings** Distinguish between issues directly related to the death and other issues of relevance
- J **Conclusions.** Distinguish between issues directly related to the death and, other issues of relevance
- K **Recommendations.** Distinguish between issues directly related to the death and other issues
- L **Good practice**
- M **Recommendations re staff performance**
- N **Cost of investigation**
- O **Data sheet**

-

## Part 2

Appendices Try to ensure good quality copying where possible. Legibility is a key issue for relatives when reports are disclosed. Number each appendix with a thick black pen clearly to aid cross-referencing.

**DEATH IN CUSTODY: ESSENTIAL DOCUMENTS**

1. Statements from staff and prisoners - eg, those first on the scene, others attending, last person to see the prisoner alive, Duty Governor, prisoners in adjacent cells, Medical Officer, others with knowledge of the individual ie personal officer/party officer/friends.
2. Prisoner's Core Record - F2050 (Including Security File, Visits Sheets and Property Cards).
3. Inmate Medical Record (including Care Plan), F2169 and F2169a
4. Incident Forms.
5. Incident Log - including copy of suicide note (if applicable).
6. Any F2052SH (current and previous documents).
7. Copy of Contingency Plans for a death in custody.
8. Wing Occurrence Book or F2060 Observation Book.
9. Copy of local suicide prevention policy and procedures.
10. Copies of previous three Suicide Prevention Team minutes.
11. Names of the prisoners in adjacent cells.
12. Reception Register.
13. Relevant details of staff duties, including night staffing.
14. Movement sheets.
15. Details of Core Day.
16. Copies of any other relevant correspondence found in the cell.
17. Specifications (map of wing/landing).
18. LIDS print-out for the deceased prisoner.
19. Medical Officer's Journal.
20. F191a medical Restriction Register.
21. PER Form
22. CARAT Casework file



## **DEATH IN CUSTODY: USEFUL DOCUMENTS**

## **ANNEX F (Cont)**

1. Relevant Governor's Orders and Notices to Staff.
2. Staff Training Records.
3. Copies of any HMCIP report (within the preceding twelve months).
4. Copies of any Standards Audit reports (within preceding twelve months).
5. Action Plans of any investigations into previous deaths (within the preceding twenty four months) at the establishment.
6. Registration procedures for F2052SH documentation.
7. Roll on Day: Receptions in and out.
8. Wing Applications Books.
9. Request/Complaint forms.
10. Details of prisoner's referrals to listener schemes.
11. Copy of Caring for the Suicidal in Custody Guidance Pack.
12. Copy of PSO 2700.
13. Risk Assessments for Bed-watches.
14. Bed-watch Log.
15. Names and times of Escorting Staff.
16. Governor Journal Entries.
17. Copy of PSO 2710.
18. F1352 Movement Books.
19. For Category A prisoners, referrals to HQ.
20. MSL's Breakdown.
21. Cell Clearance Forms.
22. Night Sheets.
23. Duty Governor's Book.
24. Segregation Forms.
25. Copy of Health Care Standards.

26. Food Refusal Book

**MODEL NOTICE OF INVESTIGATION TO BE PUBLISHED TO STAFF AND PRISONERS**

Notice to all staff and inmates

cc Trade Union representatives  
Chairman, Board of Visitors

**Death of [forename and surname - not number] on [date]. Prison Service Investigation**

I have been appointed by [name] [Area Manager / Director] to investigate the tragic death of [forename and surname] to discover what lessons there may be for the Prison Service. I will be helped by [name of team]. My investigation is quite separate from the Coroner's inquest or any police investigation, which have different aims and purposes.

My terms of reference are as follows

[terms of reference]

I will be reviewing all relevant material and seeing those who were involved. If you believe that you have information which can help me in this, please let me know, using a sealed envelope if you wish. I will be working from [location].

I will be co-operating closely with the Coroner who will also be offered a full copy of my report. A copy will also be offered to those whom the Coroner believes to have a proper interest in preparing for the inquest including the family, omitting any material where such disclosure could do substantial harm. You should also appreciate that it is Prison Service policy to publish any eventual report following the inquest save where such publication could do substantial harm. If you have any concern about this disclosure please raise it with me. A copy of the PSO and protocol which I and the Area Manager / Director will follow is available in the library and the staff information room.

If you know of someone who might have relevant information but may not be able to read this, please let them, or someone who can help them, know.

Senior Investigating Officer      [date]

F2050	Main core record
F2052A	History sheet/general observations
F2169	First Reception Health Care Screening Form
F2000 IMR	Inmate Medical Record
F1005	Request for previous (back) record from last establishment to discharge him (If applicable)
F2052SH	Self harm at risk form
Care Plan	Nursing care plan as in NHS
YOI	Young Offenders Institute
HMP	Her Majesty's prison
Off	Prison Officer
ASO	Acting Senior Officer
SO	Senior Prison Officer
PO	Principal Prison Officer
Gov	Governor Grade (of which there are 5, Governor 1 being the highest)
NOO	Night Orderly Officer (the person in charge of the establishment at nights)
OSG	Operational Support Grade (Auxiliary)
Pad	Prisoner's cell
Line	Piece of material or string used to deliver or collect something to or from another cell
Listener	Prison Samaritan
Night Cloggy	Night Patrol (OSG)
Nicking	A disciplinary charge

Observation Book

A general compilation of staff observation of prisoners in a particular area

Pegging (Peg)

An arrangement which allows managers to determine whether or not the Night Patrol (OSG) has patrolled during the night

Body Receipt/PER

Documentation confirming that a prisoner has been handed over, eg from Prison Service to Group 4 for court appearance, etc.

Screw

Prison Officer

TWOC

Taking without the owners consent

DAPS F1

Prison Service Disciplinary System - caution - witness

DAPS F2

Prison Service Disciplinary System - caution - person being investigated

NOU

Prison Service National Operations Unit

Hot Debrief

A debriefing of staff immediately following an incident

**DATA SHEET  
(ONLY AVAILBALE IN HARD COPY)**

**ANNEX I**

DEATHS IN PRISON CUSTODY - PROTOCOL ON DISCLOSURE

**A Protocol containing guidance on the Prison Service policy of granting access to material relating to a death in custody**

**Introduction**

1. This guidance applies to all deaths in prison custody and in the custody of services contracted by the Prison Service, or as a result of any action which occurs while in the care of the Prison Service.
2. It is concerned with the voluntary disclosure of information to those with an interest in the death. It is not concerned with the supply of information to the Coroner or the police, and disclosure [AC1] must not inhibit such supply.
3. The Prison Service is committed to the principles of open government set out in the Code of Practice on Access to Government Information (the Code) and, where appropriate, the Data Protection Act. We should always be willing to disclose information about our activities, unless there is a good reason in a particular case for restricting such disclosure, such as to protect security, ensure the fair conduct of proceedings, or to protect the source of certain information which was supplied in confidence.
4. Although we are under no legal obligation (at present) to disclose, it is Prison Service policy to be as open as possible. Since 1 April 1999, when the protocol came into force, reports of investigations into deaths occurring on or after that date should have been offered to the prisoner's family and/or their legal representatives as a matter of routine. This revised version of the protocol draws upon experience gained since this policy came into force.
5. Disclosure of material may take place in two stages: before and after the inquest.

Comment:

Before the inquest : the Prison Service will offer the report of its internal investigation into a death, subject to the restrictions outlined below, to those persons ruled as having a proper interest in the inquest by the Coroner and who, therefore, are eligible for the disclosure of the report. This will generally include the family of the deceased.

After the inquest : any further disclosure of material will conform to the requirements of the Code, applied on a case-by-case basis. It should be noted that prior to the inquest it will not be necessary for the family to request disclosure. The Prison Service will offer disclosure of the investigation report as matter of routine. However, it will remain a requirement for the family (or their representatives) to make a request for the disclosure of any material after the inquest has been heard or for disclosure of reports into deaths which occurred prior to 1 April 1999. This will, however, not apply where an inquest has been held before disclosure could take place.

6. Responsibility for decisions on disclosure to third parties of the internal report, and related material, rest with the Commissioning Authority (CA) for investigating the death. Normally this will be the Director of High Security Prisons, the Operational

Managers for Women's Prisons or Juveniles, the Head of Prison Escort & Court Custody Services, or the Area Manager.

## **Background**

7. There is a statutory requirement to hold an inquest to investigate any death in custody. The purpose of an inquest is to ascertain who the deceased was and how, when and where he came by his death. It is not concerned with the attribution of civil or criminal responsibility for the death. Inquests are inquisitorial, i.e. not adversarial. There are in law no parties to the matter and no issues to be litigated between them. However, where a death occurs in controversial circumstances, it can be difficult to avoid an adversarial approach arising, particularly where the deceased was in legal custody.
8. Voluntary disclosure of information held by the authorities in advance of the inquest should help to provide reassurance to those involved, ie the bereaved, that a full and open investigation has been conducted, and that they and their legal representatives will not be disadvantaged at the inquest. Advance disclosure may also remove a source of friction between interested parties and facilitate concentration on the facts surrounding the death.

9. The Prison Service considers that failure to provide pre-inquest disclosure to families in cases relating to deaths in prison custody can be counter-productive to the effectiveness of the inquest system. It has given rise to unfounded suspicion that matters are being deliberately concealed by the Prison Service, and has therefore distracted attention from the real issues, making it more difficult for inquests to achieve the purpose required in law.

#### **Procedure for pre-inquest disclosure**

10. The Senior Investigating Officer (SIO) with responsibility for investigating a death will inform contributors to the investigation that the completed report will normally be disclosed to the Coroner and to persons properly interested in the inquest, ie the family. To assist in this a model Notice for Staff and Prisoners has been prepared (see Annex G to PSO 1301).
11. When the investigation report has been completed, the Commissioning Authority (CA) will forward the report in its entirety to the coroner using the model letter (see Annex B). This letter announces our proposal to disclose the whole report where possible and asks the Coroner whether there are reservations on any specific material. If there are the Prison Service will be bound by any such reservations expressed by the Coroner. The Coroner is asked for confirmation on who will be treated as properly interested persons. Note that this is entirely a matter for the Coroner and not the Prison Service.
12. On receipt of confirmation from the Coroner, the CA will write to those determined as properly interested persons offering disclosure using the model letter in Annex C. Pre-inquest disclosure must be on a clear understanding that the material is provided in confidence solely for the purpose of enabling interested persons to prepare for the inquest. This should be clearly understood and agreed by all interested persons before disclosure takes place. The family might not realise that disclosure to a third party through, for example, a newspaper report based on an interview with them in which they disclose material from the investigation report might be regarded as prejudicing the jury.
13. The family will be offered the choice of a personal meeting with the SIO and a member of the establishment to discuss the report, either at the point of receipt of the report or later when they have had time to consider it (Annex D).
14. In those cases where a named member of staff has been criticised in the report the CA will ensure that the individual is aware of that criticism before disclosure takes place. In some cases, where the criticism is severe the CA must consider whether it is appropriate to disclose this information in consultation with SCG and, where there is the possibility of disciplinary action, with Personnel Management Group.
15. Following disclosure of the investigation report any requests for disclosure of other material, prior to the inquest, will be considered by the CA in consultation with Safer Custody Group (SCG) and with the coroner, if necessary.
16. The main principles for pre-inquest disclosure apply to requests from any third party including Trade Unions. However, there will be handling differences in terms of what may be disclosed (see Chapter 3.19 of PSO 1301).

## **Post-inquest disclosure**

17. Requests for material which emerged solely during the course of the inquest are a matter for the Coroner.
18. The requirement upon properly interested persons for non-disclosure of the investigation report to third parties does not apply after the inquest.
19. The main purpose of post-inquest disclosure is to fulfill the principles of open government set out in the Code. Hence the aim is to disclose the full internal investigation report, where possible, on request. However the status of witness statements given to the internal investigation, particularly those given without a formal caution, is complex, and needs careful consideration. Requests for such material will be considered on a case-by-case basis, but will normally allow for those staff who are contactable to be notified of any intention to disclose a report and, if required, to make any comment further to their statement.
20. Requests for additional material will be considered on a case-by-case basis by the CA in consultation with SCG who have lead policy within the Prison Service. Requests will be considered against the Code with the presumption of full disclosure wherever possible, subject to the limitations set out below.

## **Limitations on disclosure:**

### **Pre-inquest**

21. The report of the internal investigation into a death in prison custody, and statements taken from witnesses in the course of its preparation are the property of the Prison Service. The Coroner has only limited powers in relation to pre-inquest disclosure of such material. However the Prison Service should take account of and respect the views of the Coroner on the disclosure of such material so as to avoid prejudicing the outcome of the inquest.
22. The Prison Service will not pass on to third parties material supplied to them by the police or other agencies since that is a matter for them.
23. There are some kinds of material which require particular consideration:

### **Prejudice to other process**

- a) There may be some cases where there is a risk that disclosure of certain material might have an impact on possible subsequent proceedings, whether criminal, civil or disciplinary. To avoid damage to such proceedings or the possibility of any inference being drawn from removal of references to them, the relevant section of the report will contain a statement that, to avoid possible compromise to the independence of any process, the Prison Service does not make public in pre-inquest disclosure its intentions regarding commendation, referral to the police, or for disciplinary investigation.

### **Sensitive or personal information**

- b) There may be material which contains sensitive or personal information about the deceased, or other material which may cause concern or distress to the family of the deceased, for example letters left by the deceased. Such material should be handled with appropriate care and sensitivity in consultation with the Coroner where necessary.
- c) The names of witnesses should not be disclosed where an application to the Coroner for anonymity is being considered. If anonymity was preserved at the inquest it should not be disclosed later, unless the issue was decided by a higher court.
- d) In handling requests for access to medical records there are particular sensitivities. They should be disclosed to the Coroner and the Police. The Access to Health Records Act defines those who are entitled to the full medical records. *This includes the family.* The Coroner may decide that public interest in ensuring the proper conduct of the inquest may justify the disclosure of the medical records or their relevant parts to properly interested persons. Any such request should therefore be referred to the Coroner for decision.

#### **Irrelevant material**

- e) There may be material which will be of little relevance to an inquest. However in order to avoid any unnecessary suspicion of secrecy, and for ease of handling, the investigation report and its annexes should be treated as a whole as far as possible.
- f) Personal information about third parties which is not material to the inquest - for example, details of other prisoners' disciplinary punishments - should be deleted from documents to be disclosed.

### **Security or other information whose disclosure would cause real harm to the public interest**

- g) In the investigation report there may be security or other information the disclosure of which beyond the Coroner could do real or substantial harm to the public interest, e.g. information which could endanger named individuals or vital systems. This should be omitted.
- 24. Where it is necessary to omit information when disclosing material this should be made clear and brief reasons should be given, drawing on the above guidance, for example at a) above.
- 25. Where there are concerns about these or other matters advice may always be sought from legal advisers.

### **Post-inquest**

- 26. After the inquest the limitations on disclosure outlined above will continue to apply. Although the information requested is no longer required for an inquest, it is important that where a request is made by the family that the information is disclosed fully and voluntarily. However, where possible, material which is potentially harmful or which infringes the right to privacy of an individual and which was not disclosed at the inquest should not subsequently be placed in the public domain. The Prison Service will need to be able to show that it acted reasonably, consulting where necessary in each case, to conform to both its legal and public service requirements. When releasing material the Prison Service may also have to take account of any relevant comment made by the jury or the Coroner at the inquest regarding the performance of the Prison Service and its staff, if appropriate. Requests for information from third parties need to be considered against the Code.
- 27. After the inquest there will be no disclosure of medical records by the Prison Service, nor will any summary of their contents be provided, to anyone other than those granted access under the Access to Health Care Records Act 1990. Any request should be referred to the lawful owner or his or her personal representatives.

### **Timing and costs**

- 28. In most cases it is not anticipated pre-inquest disclosure of documentary material before the inquest will involve substantial additional costs. Though not required to do so the Prison Service should normally meet reasonable costs which are necessary for the family to receive disclosure of the report.
- 29. Except where necessary, it is anticipated that where the material facts and documents have been made public at the inquest it should be possible to provide material from the main report for subsequent inquiries within a month. There will be some cases where necessary omissions, for example medical records which were not disclosed at the inquest or sensitive material which has no bearing on the operation of the Prison Service, call for further time to prepare the report for wider disclosure. The aim should nevertheless be that all material should be available within three months of the inquest. Where the death occurred before 1 April 1999

and disclosure is being requested under the Code the Prison Service will aim to disclose within three months of receipt of the request.

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- 30. This protocol should be read in conjunction with Prison Service Order (PSO) 1300 on Investigations; PSO 1301 Investigating a Death in Custody; and PSO 2710 'Follow-up to a Death in Custody'.

## STEP BY STEP GUIDE TO PRE-INQUEST DISCLOSURE

***PSO 1301 states that we are required to disclose internal investigation reports into a prisoners death in custody to their family in advance of the inquest in accordance with the Code of Practice on Access to Government Information (the Code).***

1. Following a death in custody, the Commissioning Authority (CA) will authorise an investigation by a Senior Investigating Officer (or Health Care Professional).
2. On completion of the investigation, the report will be sent to the CA (and SCG) for comments.
3. When the final draft is agreed, copies will be sent to by the CA to all relevant parties (see para. 3.7 of PSO 1301 for details).
4. The CA will write to the Coroner, enclosing a copy of the final report and informing them of the intention to disclose it to the prisoners' family if regarded as Properly Interested Parties (PIPs).
5. The Coroner informs the CA that the family are regarded as PIPs and the CA writes to the family to offer disclosure on return of a signed Acknowledgement of Liability.
6. If a request from a third party (ie trade union/staff federation) for the disclosure of the report is received, the CA should write to the Coroner seeking advice as to whether they are PIPs. If so, the CA should proceed as at para. 5. If not, the request must be refused. Coroners will consider these requests on a case by case basis.
7. On the return of the Acknowledgement of Liability from the family, the CA will consider what, in the report, should be disclosed (with SCG if necessary) and instruct the SIO to make contact with the family to arrange disclosure prior to the inquest.
8. On return of the Acknowledgement of Liability from the third party, a version of the report should be disclosed (by post), prior to the inquest. The CA should liaise with SCG on information to be excluded before forwarding it.
9. Any requests for disclosure of other information in relation to a death in custody should be referred to the CA (and SCG) for advice.

**FLOWCHART SHOWING PROCEDURE FOR HANDLING DISCLOSURE OF INFORMATION FOLLOWING A DEATH IN CUSTODY**

