HM PRISON SERVICE

Prison Service Order

ORDER NUMBER 2710

Issue No. 248

FOLLOW UP TO DEATHS IN CUSTODY

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EXECUTIVE SUMMARY

STATEMENT OF PURPOSE
This PSO contains instructions on action to be taken following a death in custody. It covers the immediate actions required; notifications; family, staff and prisoner needs; legal issues and investigations; and learning lessons. This PSO is issued to update the previous version which it replaces. It also replaces PSI 20/2004.
DESIRED OUTCOME
To ensure that Governors and Directors of contracted prisons have in place contingency plans for dealing with follow up action following a death in custody.
MANDATORY ACTIONS
Mandatory actions appear in italics
RESOURCE IMPLICATIONS
Procedures are already in place in accordance with the extant PSO. There are no additional mandatory requirements with resource implications.

IMPLEMENTATION DATE:	**4th. January 2006**
Michael Spurr **Director of Operations**	**Area/Operational Manager**

Further advice or information on this PSO or the systems contained within it can be sought from:

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1. Introduction

1.1 Every death in custody is tragic, is devastating for bereaved families and is upsetting for prisoners and staff. It is important to follow correct procedures after a death and to ensure that families, staff and prisoners are all given support. Mandatory requirements *appear in italics* in this PSO, which replaces the earlier edition issued on 29 May 2002. Governors/

Directors of contracted prisons are responsible for developing, implementing and maintaining their local contingency plans and protocols for handling the aftermath of a death in custody and ensuring that lessons are learnt and shared to help prevent further deaths. This PSO is supplemented by practical guidance and joint working protocols, which should also be used to inform local contingency planning. These will be made available on the Intranet (and provided to Contracted prisons), as follows:

- Family liaison following a death in custody, guidance and good practice. **Link to FLO guidance.**
- Prison deaths – ACPO protocol for police investigators. (To be placed on Intranet when finalised).
- Death in custody investigations by the Prisons and Probation Ombudsman: Joint working protocol between the Prison Service/Contracted Prisons and Prisons and Probation Ombudsman. This document cancels Prison Service Instruction 20/2004 "Death in Custody Investigations by the Prisons and Probation Ombudsman". **Link to PS/PPO protocol.**
- Presentation "Attending an Inquest: Guidance for staff and prisoners". **Link to inquest presentation.**

2. Immediate action on discovery of an apparent death

2.1 Governors/ Directors of contracted prisons must have in place contingency plans that explain what action must be taken and by whom on discovery of an apparent death.

2.2. *The first person on scene must summon help and request local emergency clinical assistance. If establishments use codes to alert clinical staff to the type of emergency and type of first aid equipment that will be needed, local contingency plans must explain clearly the code definitions. Local contingency plans must provide for the summoning of an ambulance and alerting key personnel and state clearly who should do this.*

2.3 *If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for Night Patrols. If the death has taken place elsewhere in the prison, follow the local strategy for clearing the area of other prisoners. Carry out emergency first aid procedures described in Annex C of PSO 2700 "Suicide and Self-Harm Prevention" until clinical staff arrive.* Prompt assistance - even a few minutes - may save a prisoner's life. *Give a concise report to clinical staff, who must then assume responsibility for the casualty.*

2.4 Many hospital trusts now train and licence paramedics and/or senior nursing staff to verify at scene in writing the fact of death and Coroners are giving this widespread recognition. If the attending clinical staff (either from the prison or ambulance crew from outside) are so qualified, it may not be necessary to call a doctor to the scene solely to certify death. *Local protocols must make clear what arrangements have been agreed with the local hospital trust, ambulance service, the police and the Coroner.*

2.5 Invite the relevant faith chaplain or, if unavailable and as appropriate, other religious leader to administer official rites, prayers or other ritual observances, bearing in mind the overriding need to preserve evidence in the event of a possible murder.

2.6 Once death has been verified by a qualified person, a member of staff must be posted to remain at the scene and keep a record of the names of all those entering the cell, which must be limited only to those directly involved with the incident. Pending the arrival of the police, all relevant evidence must be preserved, including unsent letters pending in out-going post and pin-phone records of recent telephone calls.

2.7 Relocate any cellmate(s), carrying out a cell-sharing risk assessment, considering the need to preserve evidence for the police investigation (he/she could be under suspicion at this stage) and ensuring that he/she has appropriate care and support. Make sure that he/she removes nothing from the cell and issue with temporary kit until the police authorise return of his/her property. Note the names of prisoners in adjacent and opposite cells or, if the death occurs elsewhere in the prison, the names of others present.

2.8 The body must be removed in accordance with local protocols agreed with the police and Coroner. Make sure that prisoners located nearby cannot see the removal of the body and that staff without a role in the procedures do not linger nearby. Once the body has been removed, seal the cell until the police give authority for it to be re-opened.

2.9 A protocol relating to police investigations of deaths in prison custody is being drawn up by ACPO. When finalised, it will be made available on the Intranet.

3. Reporting requirements

3.1. *Following a death, the establishment must promptly notify the following by telephone:*

- *The police.*

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- *The Coroner.*

- *The Area Manager/Director of High Security Prisons/Head of Prisoner Escort Custody Services or Controller in contracted prisons.*

- *National Operations Unit (NOU) in accordance with Chapter 2 "Reporting procedures" of PSO 1400: Incident Management Manual.*

- *Press Office, making clear whether next-of-kin have been told. Unless there are exceptional circumstances, Press Office will not release the news before the next-of-kin have been told.* Press office should be notified of deaths as soon as possible after they occur including those that take place at weekends or holidays but contact with the duty press officer at unsocial hours is unlikely to be necessary except where there is likely to be high-level media interest. *Establishments may, if asked, give a factual account to local media but must not name the prisoner before the next of kin have been notified* or may refer queries to Press Office. *All follow up calls from the national media must be referred to Press Office.*

3.2 *The establishment must provide NOU with an initial Incident Report via the Incident Reporting System (IRS) in accordance with PSO 1400.*

3.3 The establishment must also notify:

- *Next-of-kin and any other person the prisoner has reasonably requested be informed* (see part 4 below and Intranet guidance on family liaison). **Link to FLO guidance.**

- *prisoners, especially friends or associates and Listeners.*

- *relatives or co-defendants in other establishments.*

- *staff, whether employed or contracted.*

- *the Co-ordinating Chaplain and relevant faith Chaplain.*

- *the Care Team leader.*

- *the Suicide Prevention Team Leader, the Suicide Prevention Co-ordinator (or equivalent), the Safer Custody Coordinator (or equivalent) and the Area Psychologist.*

- *the Independent Monitoring Board.*

- *the local Samaritans branch.*

- *The Primary Care Trust (where relevant).*

- *the Visitors' Centre.*

- *The prison switchboard operators, who should also be told to whom calls about the death should be put through.*

- *The prison's police liaison officer.*

3.4 For convicted prisoners, the establishment must notify:

- *the Police National Computer, by writing to PNC Bureau, Room 205, New Scotland Yard, The Broadway, London SWIA OBG, giving name and date of birth, CRO or PNC number, date, place and cause of death, brief account of any suspicious circumstances, and date and court of conviction.*

- *the responsible probation officer in the prisoner's home area.*

- *If appropriate, the Parole Board*.

3.5 For unconvicted/unsentenced prisoners,

- *the committing court, solicitors and the probation officer responsible must be notified.*

3.6 For civil prisoners, establishments must notify:

- *the Official Solicitor*

3.7 For young offenders, establishments must notify:

- *the probation officer (and social worker where applicable) in the prisoner's home area.*

3.8 For juveniles, establishments must notify:

- *The appropriate Youth Offending Team.*
- *the Youth Justice Board.*
- *Juvenile Group.*
- *local and home social services* (If there is a Care Order in place, parental responsibility may be shared by the parent and local authority*).*

3.9 *For immigration detainees or those awaiting deportation, establishments must notify Detention Services on 020 8760 2543 (during office hours).* Establishments may also need to discuss any handling arrangements following such a death with Detention Services.

3.10. For foreign national prisoners, establishments must notify consular officials who may be able to assist in notifying next-of-kin living abroad.

4. Support for the family

4.1 Guidance on family liaison following a death in custody is available on the Intranet. **Link to FLO guidance.** It contains advice on the following mandatory requirements and practical advice and guidance based on good practice. It should form the basis of local planning and protocols.

4.2 Governors/Directors of contracted prisons must have in place a local protocol explaining what support will be offered to a family bereaved by a death in custody. They must also:

- *Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened.* It is good practice to appoint a dedicated family

liaison officer, who can be trained and prepared for deployment when required. **Link to FLO guidance (paragraph 4.7).**

- *Appoint a senior member of staff or a dedicated family liaison officer (and a deputy to cover absences) as a named point of contact for the family, to make and maintain contact with the family, beyond the inquest if necessary, and to provide information and practical support.* **Link to FLO guidance (paragraph 4.1).**

- *Ensure that there is support and supervision for the family liaison officer (see also part 5 below) overseen by the governing Governor on whose behalf the family liaison officer acts*. **Link to FLO guidance (paragraph 2.7).**

- *Send a letter of condolence to the family and invite them to visit the establishment.*

- *Arrange for the chaplain or other religious leader to offer to hold a memorial service for the family, other prisoners and staff, both employed and contracted (subject to any specific faith considerations and the views of the family, staff and prisoners).*

- *Offer to pay reasonable funeral expenses.* **Link to FLO guidance (paragraph 4.29).**

- *When the police so authorise, hand over personal possessions and monies to the appropriate person in a suitable manner, keeping a list of items handed over and obtaining a receipt.* **Link to FLO guidance (paragraph 4.24).**

5. Support for staff and prisoners

5.1 *Governors/Directors of contracted prisons must have in place a local protocol, which takes account of ethnic and cultural backgrounds, explaining what support will be offered to staff, both employed and contracted including the family liaison officer, and prisoners after a death in custody. Governors must take account of the mandatory provisions of Prison Service Order 8150, "Prison Service Post Incident care for Staff" which makes it mandatory to have in place an operational care team and team leader in every public sector establishment and contingency plans that must include procedures to activate the care team in the event of an incident.* The Suicide Prevention Team, Care Team, Chaplaincy Team, applied psychology staff, the Independent Monitoring Board, local Samaritans and other local support organisations should all routinely contribute to planning the strategy for supporting staff and prisoners after a death in custody.

5.2 PSO 8150 contains important information about the roles of care teams, critical incident debriefing facilitators, post incident counsellors and Staff Welfare Officers and support that can be provided confidentially. These are relevant following a death in custody and should be reflected in local contingency plans and protocols for care of staff, both employed and contracted, after a death in custody. PSO 8150 is to be revised during 2005.

5.3 After a death in custody many staff experience "normal" short-term stress reactions (distress and tearfulness, shock, feelings of guilt) and need to be reassured that these reactions are normal. Debriefings are generally found useful after a death in custody if they provide an opportunity to share experiences, dispel inappropriate feelings of guilt and self-blame and provide reassurance that stress is normal in these circumstances*. There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend.* The purpose is not to analyse or re-live the incident. Nor is it an opportunity to apportion blame or pre-judge investigation findings. The hot debrief should focus on reassurance, information sharing, normalisation and how staff can support each other. Particular reassurance is needed when the prisoner died after unsuccessful resuscitation attempts, when staff involved are more likely to feel a sense of failure. Staff wanting but unable to attend the debriefing should be followed up, as a group or individually. Refer to PSO 8150 for guidance about Critical Incident Debriefs and longer-term support and specialist treatment.

5.4 In addition to the support managers and the Care Team and Staff Care and Welfare can offer, an establishment can involve its Suicide Prevention Team, the Chaplaincy Team, applied psychology staff, the Independent Monitoring Board, local Samaritans and other local support organisations in its procedures for supporting both staff and prisoners after a death in custody.

5.5 Friends, associates and cellmates of the prisoner who has died or other prisoners who had been offering peer support or acting as Listeners and any friends or relatives in other establishments should also be offered support. Local Samaritans will make themselves available to debrief Listeners. Other peer support schemes can help, such as prisoner group sessions. *The Chaplaincy Team and, in particular, the Chaplain from the particular faith tradition of the prisoner must always offer support to, and to pray with prisoners and staff. This will include holding a memorial service for the deceased's family, prisoners and staff subject to any faith specific considerations and the views of the family, staff and prisoners.* Some self-inflicted death in custody statistics may be taken to indicate that there

is a potentially heightened risk of suicide and self-injury attempts following a death in custody, with several prisons having experienced "clusters" of deaths, sometimes with "copycat" features. Staff should be alert to this possibility and be vigilant, particularly with other vulnerable prisoners, especially known self-injurers, other high-risk groups or recent "at-risk" prisoners and those on recently closed or open F2052SHs or ACCTs, *which must be reviewed and documented as soon as practicable and within 24 hours.* Applied psychology, probation and mental health in reach staff should also be able to offer assistance to individual prisoners.

6. Investigations and Inquest

6.1 All deaths in prison custody are subject to:

- A police investigation (on behalf of the Coroner and, if necessary, a criminal investigation)
- An investigation by the Prisons and Probation Ombudsman
- A Coroner's inquest before a jury

Staff must co-operate fully with these processes. This includes those staff not directly employed by the Prison Service, and also those who are working within an establishment or headquarters, on a contract or on a temporary basis, such as a locum doctor.

6.2 A protocol relating to police investigations of deaths in prison custody is being drawn up by ACPO. When finalised, it will be made available on the Intranet to inform local contingency planning and protocols with the local police and Coroner.

6.3 A protocol relating to death in custody investigations by the Prisons and Probation Ombudsman, agreed between the Prison Service/Contracted Prisons and Prisons and Probation Ombudsman is available on the Intranet. **Link to PS/PPO protocol.** *This must form the basis of local contingency planning and protocols with the Prisons and Probation Ombudsman. This protocol cancels PSI 20/2004.*

6.4 A presentation giving guidance to staff attending an inquest is available on the Intranet and is recommended as part of an establishment's preparation for an inquest, either for individual study or as a presentation to the group of staff who are to attend an inquest. **Link to inquest presentation.** Paragraphs 6.6 to 6.8 below set out key points about the nature of inquests and legal representation for the Prison Service and its staff.

6.5 In preparing for and handling the investigations and inquest, Governors/Directors of contracted prisons must appoint an investigations and inquest liaison officer to:

- *Write to the Coroner with details of the death. Deaths of prisoners that occur outside the prison, for example, in hospital, must also be notified to the Coroner.*

- *Liase and provide contact point with the Coroner, Coroner's Officer, Safer Custody Group, Treasury Solicitor, Prisons and Probation Ombudsman, police (via the prison's police liaison officer) and Press Office as necessary.*

- *Draw together the documents (which will be found in a variety of locations) that the investigating teams will need as soon after the death as possible to minimise any allegations of interference.*

- *Hand over copies of all documents requested by the investigating teams. (If the Coroner requests original documents, his/her officers must be asked to sign a receipt and copies retained by the establishment).*

- *Keep a record of all documents handed over and to whom.*

- *Retain copies (or the originals if not removed by the Coroner's officer) of the F2050, any F2052SHs or ACCTs, the Clinical Record (ask the Head of Healthcare to assemble all the health records, including dental records and Care Plans into the Clinical Record) and store in a locked cabinet with signed access only until after the inquest.*

- *Give investigation teams a note of the address of any prisoner whom they may wish to interview, who has been transferred or released since the death.*

- *Liase and assist the investigating teams in accordance with agreed national and local protocols.*

- *Ask Safer Custody Group to arrange legal representation for the establishment through the Treasury Solicitor, check that the Area Office has sent copies of investigation reports to the Treasury Solicitor and ensure that the Treasury Solicitor has copies of any other documents required for the inquest*.

- *Notify the Trade Unions, Chair of the Independent Monitoring Board, Staff Welfare Officer, Safer Custody Group, Press Office, Area Manager or Controller in contracted prisons, Care Team, Chaplain and (if appropriate) the Women's Team and Juvenile Group, of the date of the inquest and, if criminal charges are brought, the trial).*

- *Make sure that staff and prisoner witnesses are aware of what to expect at the inquest and given advice and support.*

- *Tell Samaritans if a prisoner Listener is called as a witness so a Samaritan can attend the inquest and support and advise the Listener on confidentiality.*

- *Arrange attendance of a senior member of staff at any pre-inquest hearing arranged by the Coroner.*

- *Arrange a pre-inquest briefing for staff (including at least one senior member of staff) with the Treasury Solicitor's representative (and Counsel if instructed). The legal representative of any relevant staff association or individual member of staff can also attend.*

- *Organise the attendance of staff (including at least one senior member of staff) and prisoner witnesses at the inquest; staff should not wear uniform to the inquest but dress smartly.*

- *Notify the Governor or Director and Controller of contracted prisons, Area Manager or Director of High Security Prisons or Head of Office for contracted prisons or Head of Prisoner Escort Custody Services, Safer Custody Group, Care Team, Chaplain, Press Office and (if appropriate) the Women's Team and Juvenile Group of the inquest verdict as soon as possible, seeking advice from Press Office if a press statement is required.*

- *Take a note of the key points of the inquest and submit a short report to the Governor or Director and Controller of contracted prisons, the Area Manager or Director of High Security Prisons or Head of Office for Contracted Prisons or Head of Prisoner Escort Custody Services and Safer Custody Group.*

- *Arrange for a post-inquest de-brief meeting for those who attended the inquest, inviting also available members of the Suicide Prevention Team. Remember too that some prisoners and the family of the deceased prisoner may also need support.*

- *Send any subsequent letter to the establishment from the Coroner under Rule 43 of the Coroners' Rules with the establishment's comments to Safer Custody Group for reply.*

- *Review the inquest findings with the Suicide Prevention Team, Area Suicide Prevention Coordinator, Area Psychologist and Safer Custody Group outreach team member.*

Legal representation

6.6 The inquest is an inquiry, not a trial and seeks to establish facts. It cannot apportion blame to named individuals and the verdict does not in itself determine any issue of civil or criminal liability. It is inquisitorial rather than adversarial but, after litigation relating to the Amin case (following the death of Zahid Mubarek at Feltham) and other legal judgements, inquests are now confirmed as the prime means by which the State meets the investigative aspects of the "right to life" requirements of Article 2 of the European Convention on Human Rights and are in consequence open to greater family and legal involvement and greater media scrutiny. Coroners are increasingly using their authority under Coroners' Rules to draw attention to issues that arise during particular inquests.

6.7 The Treasury Solicitor acts as legal representative for many government departments and agencies and instructs counsel when necessary. The Treasury Solicitor represents the Prison Service and its employees generally in all matters concerning inquests and will, as part of that task, provide legal advice and assistance to individuals who are involved as witnesses to the inquest or where the Coroner has granted an individual "properly interested person" status. Legal representation is recommended for all inquests. The Treasury Solicitor does not act for contracted prisons or their staff but he can act for members of the Independent Monitoring Board called as witnesses to an inquest, separately from the Prison Service. The purpose of legal representation in connection with an inquest is to ensure that all relevant facts and legal argument are presented; and to support and advise staff witnesses before and during the inquest, ensuring that proper and fair questions are put to staff. The Treasury Solicitor will prepare the necessary documentation and will attend, with Counsel if instructed, a pre-inquest meeting with witnesses to run through their statements and answer any questions they may have about what to expect at the inquest.

6.8 Because the Treasury Solicitor acts for the Prison Service as a whole, separate legal representation for individuals should not normally be necessary. Conflicts of evidence sometimes arise but the Treasury Solicitor still represents all employees concerned collectively provided there is no conflict of interest. An example of when separate legal representation might be needed is if on an important point there is a dispute of facts between what the Prison Service says and what the employee says, or where the Coroner has identified an individual as being someone whose actions will come under closer scrutiny than most and has granted him/her 'properly interested person' status. If there is a conflict of interest, decisions as to the principle and funding of separate legal representation will be at the discretion of the Prison Service, and will be taken in accordance with the Civil Service Management Code, paragraph 12.2.3b which says

" Departments and agencies must permit civil servants involved in an inquest or fatal accident enquiry as a result of their official duty to be represented by the legal representatives of the department or agency, provided there is no conflict of interest. Otherwise assistance with legal representation is at the discretion of the department or agency". Whenever separate legal representation is agreed it will usually be provided through the Treasury Solicitor with appropriate "chinese walls" between the representative of the Prison Service and the person appointed to look after the individual staff member's interests. The Prison Service will not generally meet the costs of legal representation provided by trade unions or privately. Notwithstanding this, some staff members such as doctors and union members prefer to be represented through their professional, insurance or union bodies. For example, the Prison Officers' Association regularly asks for and is granted 'properly interested person' status to look after the interests of their members collectively. A protocol to assist in defining, identifying, and managing a "conflict of interest" is being prepared and will be published as a further **link** on the Prison Service Intranet when finalised. Meanwhile, there is no change of existing policy regarding legal representation.

7. Learning lessons

7.1 Local protocols must indicate how lessons will be learnt from a death in custody. These must include the means by which recommendations from the investigations (including, in the case of juveniles, any investigations by the Youth Justice Board and any Area Child Protection Committee Serious Case Review pursuant to Part 8 of "Working Together to Safeguard Children") and inquest are to be recorded, implemented and monitored at a local level. Local protocols must ensure that bereaved families are informed of follow up action and that they are invited to be involved where appropriate. Area Managers must make

provision for sharing recommendations and learning with other establishments and agencies (such as the Primary Care Trust) in their area and monitoring implementation of recommendations across the area. Safer Custody Group must progress recommendations with national and/or policy implications as necessary with appropriate senior personnel or policy groups; maintain a national database of completed reports; analyse recommendations; and identify and promulgate identified trends and good practice.