Ministry of Justice

HM Prison & Probation Service

Policy name: Follow up to Deaths in Custody Policy Framework

Issue Date: 01 November 2024 **Implementation Date**: 01 January 2025

Replaces the following documents (e.g. PSIs, PSOs, Custodial Service Specs) which are hereby cancelled: Chapters 12 & 13 PSI 64/2011 Management of prisoners at risk of harm to self, to others and from others (Safer Custody); PSI 58/2010 Prisons and Probation Ombudsman

Action required by:

☐	HMPPS HQ	☒	Governors
☒	Public Sector Prisons	☐	Heads of Group
☒	Contracted Prisons	☒	HMPPS-run Immigration Removal Centres (IRCs)
☐	The Probation Service	☒	Youth Custody Estate
☐	HMPPS Rehabilitation Contract Services Team	☒	Women's Estate
☐	Other providers of Probation and Community Services		

Mandatory actions:

All groups referenced above must adhere to the requirements section of this Policy Framework, which contains all mandatory actions.

For information:

By the implementation date, Governors[1] must ensure that their local procedures achieve the required Outcomes and comply with the Requirements as set out in this Policy Framework.

Governors must ensure that any new local policies that they develop because of this Policy Framework are compliant with relevant legislation, including the Public Sector Equality Duty as prescribed by the *Equality Act 2010*.

How will this Policy Framework be audited or monitored:

Audit and monitoring: Public Prisons - Prison Group Directors will monitor their establishments' compliance with the framework's requirements.

Privately Managed Prisons - monitoring of compliance will be through the standard contract management processes.

[1] In this document the term Governor also applies to Directors of Contracted Prisons.

Quality assurance is provided by the HMPPS Operational & System Assurance Group.

External scrutiny is provided by His Majesty's Inspectorate of Prisons and the Independent Monitoring Board

Resource impact: Nil

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Deputy / Prison Group Director sign-off: Cohen Lewis, Deputy Director Safety

Approved by OPS for publication: Helen Judge and Kim Thorden-Edwards, Co-chairs Operational Policy Sub-board April 2024

Revisions

Date	Changes

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1. Purpose

1.1 This Policy Framework seeks to support establishments to effectively manage the vital processes that come following a death in prison custody. It replaces Chapters 12 & 13 of PSI 64/2011 Safer Custody, and the relevant chapters of PSI 58/2010 The Prisons and Probation Ombudsman. The Safety Policy Framework replaces the chapters of PSI 64/2011 relevant to the management of prisoners at risk of harm to self, to others and from others.

1.2 Following a death in prison custody it is vital that the incident is reported promptly and accurately, including the appropriate notification of the next of kin. Management of a death in custody must follow the instructions in the Incident Management Manual Policy Framework and all relevant stakeholders must be informed.

1.3 Staff must co-operate fully with all investigations following a death, including those by the police, the Prisons and Probation Ombudsman (PPO), the Health and Safety Executive (HSE), and Inquest. Prisons are required to have a nominated member(s) of staff to liaise with and assist stakeholders with their investigations.

1.4 Prisons are required to have a nominated member(s) of staff to liaise with family members. In order to maintain role clarity and professional boundaries, it is advisable that the member of staff undertaking the investigations / inquest liaison role does not undertake the Family Liaison Officer (FLO) role.

2. Evidence

2.1 This framework describes our established processes for meeting the legal and procedural requirements on prisons following a death in custody.

3. Outcomes

3.1 This framework aims to ensure that there is an effective process in place which ensures that:

- in response to a death in custody, HMPPS will take a fully transparent approach and offer every assistance to independent bodies investigating the circumstances of the death;
- the family of the deceased are appropriately informed and supported through an effective FLO system;
- learning is taken from the findings of investigations, and appropriate action taken to mitigate future risk;
- following a death all those involved, including staff and other prisoners, are offered appropriate support; and
- establishments are supported by the national Safer Custody Casework team to ensure a consistent HMPPS approach to the management of deaths in custody.

4. Requirements

Following a death in custody all relevant stakeholders are informed. Where appropriate, their work is facilitated (if applicable) and a record of contact is maintained.

4.1 Following a death in custody, the actions outlined in this Policy Framework must be followed. This includes the facilitation of any work needed to be undertaken by

stakeholders such as participation in investigations by the police, PPO, HSE, or the Local Safeguarding Children Board.

Learning from deaths in custody is identified, disseminated and acted upon.

4.2 Prisons must have procedures in place to facilitate learning from deaths in custody, to prevent future occurrences and improve local delivery of prison safety.

4.3 All prisoners must be asked to nominate a next of kin who must be updated regularly.

Following a death in custody initial and on-going liaison takes place between the prisoner's nominated next of kin and the prison.

4.4 Following a death in custody, the next of kin must be contacted by an appropriate person. The next of kin must be given an accurate account of what has happened and be told about what will happen next, and an offer to contribute to funeral expenses must be made.

Definitions

4.5 For reporting and internal management reasons, a death in custody also includes those prisoners who die in a hospital or a hospice whilst released on temporary licence (ROTL) for medical reasons. Deaths in custody may also include exceptional cases where the individual dies in a court but is under the custody of HMPPS, or where an individual dies in hospital as a result of an injury sustained in the prison, for example following a serious assault or incident of self-harm.

4.6 While the deaths of prisoners released on (non-medical) ROTL, on early release on compassionate grounds and following discharge from custody are not deaths in custody, external investigations may still follow. It is therefore vital that the response to such deaths follows the same principles, and that all prison documents are retained where necessary.

Actions following a death in custody

4.7 Once a death has been verified by a qualified person, prisons must follow their local contingency plans on deaths in custody.

4.8 Any death in custody may be treated as suspicious by the police. When a death has occurred in a shared cell care must be taken when relocating cellmates, as there may be vital forensic evidence that must be preserved. The cell sharing risk assessment of the cellmate must be reviewed in line with the PSI 20/2015 - Cell Sharing Risk Assessment.

4.9 Any police investigation into the death must take primacy over all other investigations, and their advice sought over such issues as access to the cell.

Reporting

4.10 Following a death in custody, in line with the Incident Management Manual, the prison must promptly notify:

- the police;
- next-of-kin and any other person the prisoner has reasonably nominated to be informed. Where no known next of kin is identified, prisons must take reasonable steps to trace any family members;
- the Coroner;

- the Area Executive Director, Prison Group Director, the Executive Director of High Security Prisons, the Executive Director of Contracted Prisons, and/or Head of Prisoner Escort Custody Services, as applicable;
- The Managing or Duty Chaplain. Chaplains have a key role to play in supporting staff and prisoners, and in some cases may assist with family liaison - see below and PSI 05/2016 Faith and Pastoral Care for Prisoners;
- Press Office, making clear whether next-of-kin have been informed;
- National Incident Management Unit, first by telephone and later on NOMIS / IRS;
- Local Authority Director of Child Services where applicable.

This is not an exhaustive list. Please refer to the Incident Management Manual, which sets out in greater detail who must be notified following a death in custody.

4.11 Staff directly involved in the incident, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable. Consideration must also be given to the need to seek statements from those staff who have had relevant or recent contact with the prisoner. This will be particularly important in the event that these staff are not interviewed by the PPO but are required to give evidence at inquest.

Retention of documents

4.12 Prisons must retain, and securely store, all documentation relating to the deceased prisoner for investigations by the police, the PPO and the coroner. This excludes clinical records, for which see below.

4.13 There may be a considerable delay between the death and the inquest. The coroner may ask for documentation not requested by either the police or the PPO. It is therefore crucial that prisons retain all documentation available.

4.14 As soon as possible after the death, all documentation must be gathered together and securely stored. This will include:

- copies, or originals if not removed by the coroner, of the prisoner's core records, including NOMIS records
- ACCT documentation
- observation books
- staff detail documents
- local policies and protocols in operation at the time of the death must be retained, in particular policies on suicide prevention, IEP and segregation
- Healthcare Local Partnership Agreements
- any evidential CCTV footage, Body Worn Video Camera footage, pin phone records, cell bell logs, incident logs, control room logs and radio transmission recordings
- restraint assessments, bed watch logs
- any child safeguarding referrals / MMPR handling plans where applicable.

This list is not exhaustive and will depend upon the facts of the case. Advice regarding what documents may be relevant and therefore need to be retained can be sought from the Safer Custody Casework team.

4.15 Clinical records (including all health records such as medical Care Plans and dental records) are retained by the healthcare provider.

4.16 All documents must be retained for a period of 20 years after the inquest has concluded, for the purpose of potential legal proceedings.

Communicating the news of the death

4.17 A death in prison can have a profound effect on prisoners and staff, and prisons experiencing an apparent self-inflicted death are at increased risk of a further self-inflicted death. It is critical therefore that managers communicate the news of the death in a sensitive and safe way and identify and support people affected by the death. Establishment contingency plans must be followed, including deploying a postvention approach and formulating and following a suitable communication plan where appropriate. Further information on postvention can be found in the Samaritans document: 'After a suicide: a best practice guide for prisons.

Supporting staff

4.18 In line with the Post-incident Care Policy Framework, a hot-debrief must be held as soon as possible after the death. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. A list of those who attend any debrief must be kept, but the debrief must not be minuted.

4.19 Consideration must be given to inviting other staff members who may have had recent and/or close contact with the prisoner, including the key worker.

4.20 Governors are reminded that staff affected by a death in custody may require support at any time and on more than one occasion, including during police and PPO investigations, and during and after the inquest.

4.21 Samaritans are available to provide free, confidential listening support to all prison staff following a self-inflicted death if they feel they need someone to talk to.

Support for prisoners and Listeners

4.22 Prisons must ensure that they have procedures in place to support prisoners who have been affected by a death in custody. Appropriate care and support must be offered to the cellmate and any other prisoners affected by the death, including all those on open ACCT documents.

4.23 Listeners should be unlocked and allowed to offer support to prisoners on the wing where the self-inflicted death occurred and/or to provide support to other prisoners located on other wings who may have been connected to the deceased.

4.24 It is crucial that local Samaritans are able to see the Listener team as soon as possible after a death.

4.25 If a Listener is asked to see the police, Coroner's Officer, or an investigating officer after a death, Samaritans must be given the opportunity to be present at the interview.

Governors' actions

4.26 Following a death in custody Governors must:

- write a personal letter of condolence to the family, which must include an invitation to visit the prison;
- offer to contribute to reasonable funeral expenses;

- notify the Safer Custody Casework team when a disciplinary investigation arising from a death in custody is commissioned, or where the police are conducting an investigation into staff involved in the death;
- write to the family once the initial PPO report has been checked for factual accuracy and the action plan has been returned to the PPO, and again following the conclusion of the inquest; and
- 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).

4.27 Following police authorisation, arrangements must be made to hand over the prisoner's personal possessions and money to the appropriate person. Items must be listed and appropriately packaged, i.e., not in an HMPPS plastic bag. It is advisable to ask the person to sign for receipt of the possessions. The person must be told if any items are being retained as evidence at the inquest and cannot be released immediately.

Liaising with families following a death in custody

Identifying next of kin

4.28 PSI 07/2015 Early Days in Custody sets out the requirement that prisons keep an up-to-date record of a next of kin or nominated person to contact for each prisoner. Prisoners may identify more than one next of kin or family member whom they wish to be contacted.

4.29 All families are different; they can include chosen as well as biological members and will have their own dynamics. Any approach to the family must be undertaken in accordance with individual needs and may include providing different members of the same family with information.

No identifiable next of kin

4.30 When a prisoner has no recorded next of kin, reasonable steps must be taken to trace any family. This may include:

- liaising with the coroner and the police
- contacting the relevant embassy if applicable
- checking with other prisoners
- reviewing prisoner records for visits, letters, phone calls etc.
- contacting the prisoner's solicitor
- contacting the local authority (for looked-after children)

4.31 When there is no identifiable next of kin, or where the prisoner's next of kin has disowned the body, the coroner will inform the local authority which, under Section 46(1) of the Public Health (Control of Disease) Act 1984, has a statutory obligation to dispose of the body. The local authority concerned may ask for a contribution from the prison towards the cost of disposal, and prisons are encouraged to meet such costs. When the prisoner dies in hospital, the hospital may be asked if they wish to contribute to the local authority's costs.

Informing next of kin

4.32 Wherever possible, a trained FLO and another member of staff must visit the next of kin or nominated person in person, to break the news of the death. This must be done as soon as possible in order to try to ensure that the family do not find out about the death from another source. A Deployment Manager must be appointed immediately to oversee the briefing, deployment and debrief of the FLO. All decisions regarding informing the next of kin must

be clearly documented in the FLO log.

4.33 To ensure there is no delay in informing the next of kin, where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison to inform them.

4.34 If a face-to-face notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable.

4.35 Before a visit to the family, a risk assessment must be completed to ensure it is safe for the FLO team to attend the property. If necessary, the police can be informed and if required be asked to escort the team or remain nearby.

4.36 In the case of a suspected homicide the police are also likely to deploy their own FLO so a co-ordinated approach must be in place, with the police taking the lead role in determining this approach.

4.37 Before meeting the family, the FLO must:

- be familiar with the details of the death;
- be familiar with the prisoner's history;
- gather as much information about the family as possible, such as any known family composition or group dynamics, cultural or lifestyle considerations, religious beliefs, or possible communication requirements in terms of language or disability;
- be familiar with any information that could affect the liaison role, such as community tension, previous police involvement with the victim and/or family members; and
- liaise with the Coroner's Officer if time permits.

4.38 It is vital that accurate information about the prisoner's death is given to the next of kin. Inaccurate information given at this stage can cause unnecessary distress and suspicion and can undermine the prison's ability to build a relationship with the family. If there is information that cannot be released, for example because the police have asked for something to be kept back, the FLO will need to explain why this is necessary and give a commitment to provide the information at a later date.

4.39 The visit to the family must not be unduly delayed by the gathering of the information set out above.

4.40 Depending on the family's reaction to the news of the death or to the visit, a judgement will need to be made as to how much information can be given at this first meeting. At the first meeting the family must be informed of the death, written contact details must be given, and arrangements must be made for a subsequent meeting. Either at this or a subsequent meeting the following will need to be covered:

- arranging to identify the deceased (if not already done)

- arranging to view the deceased if they wish to do so.
  It is better to arrange this before the post-mortem if possible by liaising with the Coroner's Officer. The FLO may offer to accompany the family when they view the body if they wish and, if appropriate, do so first in order to warn the family what to expect

- the family must be told of their right to have a medical representative present at the post-mortem and that they should ask the Coroner's Officer about this

- giving or facilitating initial practical support for the family, facilitating their wishes to visit the scene
- telling the family about organisations that can offer practical advice and bereavement support
- arranging the next meeting and giving the family written contact details
- leaving appropriate written material with the family to reinforce what they have been told
- telling the family that the PPO will be conducting an independent investigation into the death and that the PPO's Family Liaison Officer will also contact them, usually after the funeral, and explain the difference between these roles.
  The FLO should give the PPO the full contact details for the next of kin (including address and phone number) and the funeral date as soon as possible.

4.41 If the family ask questions about the inquest they should be referred to the Coroner's Officer and to 'A Guide to Coroner Services for Bereaved People' available on the MOJ website which provides an accessible and comprehensive guide to the inquest process and the involvement the family can have.

The role of the Family Liaison Officer

4.42 Prisons must have a nominated Family Liaison Officer (FLO). The grade of this member of staff is less important than having the right person who is able to handle what can often be a very difficult situation sensitively.

4.43 The following personal qualities make individuals suitable for selection:

- good interpersonal skills
- good communication and listening skills
- confident and self-assured
- empathetic
- able to negotiate complex relationships
- able to manage their own stress
- able to work alone with minimal supervision and with delegated authority
- flexible and non-judgemental
- emotionally resilient
- understands the importance of confidentiality.

4.44 In order to maintain role clarity and professional boundaries, it is advisable that those working in the local Safety team do not undertake the FLO role.

4.45 The role of the FLO is to be a named point of contact for the family. Their role will start from the point that the news of the death is broken to the family. They will then maintain contact with the family and provide information and practical support where appropriate. If the family do not want contact with the prison, their wishes must be respected.

4.46 In order to ensure that families have appropriate support, a Deputy FLO must be appointed so that if the FLO is unavailable, for example due to leave or work patterns, contact with the family is not affected.

4.47 An HMPPS FLO training course is available. While FLOs can be appointed without this training, it will need to be completed when possible as it gives FLOs extremely beneficial

guidance.

4.48 It is vital that FLOs have good support from senior management in order to conduct their role effectively. Guidance on the support that should be provided can be found on the HMPPS intranet.

FLO log book

4.49 A log book recording contact with the next of kin must be opened following the death. Every contact with the family and their representatives needs to be recorded wherever possible. Log entries need to be an accurate and transparent record and should be written up as soon as possible after a meeting. The PPO will wish to see the log book as part of their investigation, so it is vital that all decision-making, for example if it is decided not to visit the family in person to inform them of the death, is clearly set out.

4.50 As a minimum, logs need to contain the following information:

- dates and times of all contacts and meetings;
- method of contact and venue, details of who initiated the contact;
- details of the purpose of the contact and any information exchanged;
- details of any non-family members present at the meeting (exercise discretion in finding out who they are);
- what the FLO has told the family;
- every request, question or complaint that the family makes, and follow up action;
- strategic decisions, for example, about the sharing of information and the reason;
- attempts to contact the family or their representatives, including those without success or which were refused or declined, and any reasons given.

Funeral arrangements

4.51 Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000. The only exceptions to this are where the family has a pre-paid funeral plan or is entitled to claim a grant from other government departments e.g., Department of Work and Pensions.

4.52 It must be made clear to the family what the prison's contribution does and does not cover, as set out below, to avoid confusion and distress to the family, and all such discussions and decisions must be recorded in the FLO log.

4.53 All funeral expenses must be paid directly to the funeral directors upon receipt of an original invoice. This invoice needs to be detailed and broken down sufficiently to identify the individual items covered and their cost. Any subsequent civil claim brought by family members following the death may include a claim for funeral expenses, so it is essential that it clear what the prison's contribution was.

4.54 As a guide, reasonable funeral costs may include:

- funeral director's fees
- hearse
- simple coffin
- cremation or burial fees (this does not include the cost of the burial plot)
- faith or belief leaders' fees (when someone from the prison's chaplaincy team is not available or the family chose their own leader).

Reasonable costs do not include the following:

- headstone
- embalming or chapel of rest for viewing the deceased
- flowers
- transportation for mourners
- clothes for the deceased and/or mourners
- a wake, or other hospitality related to the funeral
- obituary notices
- order of service sheets

4.55 A deceased prisoner's money must not be used to meet the costs of their funeral.

The funeral

4.56 Subject to the wishes of the family, it is appropriate for the FLO and other members of staff to attend the funeral. They may lay a wreath on behalf of the prison after seeking the wishes of the family. The FLO must not attend if there is a risk of upsetting the family or to their personal safety.

Repatriation of the body or ashes of a foreign national prisoner

4.57 Prisons must offer to pay reasonable repatriation costs of the body or ashes of a foreign national prisoner. This is an additional expense to that of the costs of the funeral described above.

4.58 Simple repatriation includes a zinc lined coffin, international embalming, and transfer to the airport. It is at the discretion of Governors as to whether costs such as freight charges, transfer of the body from the receiving airport, and any family travel, are met.

4.59 If the ashes are not to be sent as freight, Governors may wish to consider paying for a member of the family to collect the ashes.

4.60 Further information can be sought from the either the funeral director or the coroner.

Deceased prisoners' property

4.61 The deceased prisoner's property must be removed from the cell, stored and recorded in line with Prisoner's Property Policy Framework.

4.62 It is likely that in most cases the deceased will have limited property or money, and it will be clear who is entitled to this. In these cases, relatives must not be put to the trouble and expense of obtaining a Grant of Letters of Administration.

4.63 In circumstances where the deceased's property is larger (over £5,000) and/or there is a dispute as to who is legally entitled to it, property and money must only be handed over to the person who has been identified as legally entitled to receive it, known as the deceased's "legal personal representative" (LPR). This individual will need to obtain a Grant of Probate if the deceased left a will or a Grant of Letters of Administration if the deceased died intestate (without making a will).

4.64 Sometimes items such as letters, particularly 'suicide notes', are needed as evidence, which means that the people for whom the letters were intended may not be able to see them until quite some time after the death. It is for the coroner to decide whether or when to share a copy of any suicide note to the person it was addressed to, and the prison must not provide these documents. The coroner may decide not to share the letter for various

reasons such as the mental capacity or age of the addressee or that disclosure of the contents of the letter could be prejudicial to police inquiries. The original can usually be released some months after the inquest if no appeal follows. Copies of documents exhibited at the inquest subsequently become available to properly interested persons. If it is not clear who is entitled to these items or if there is a dispute among family members as to who is entitled, advice from the coroner should be obtained. Suicide notes may also contain a person's instructions for their funeral. The FLO can liaise with the coroner about this issue if required.

4.65 Where there is no identifiable next of kin see the Prisoners' Property Policy Framework for guidance on the storage and/or disposal of unclaimed property and money.

Returning property to the family

4.66 The FLO must return the deceased's property and monies to the family as soon as the coroner authorises it. A list of the items handed over must be kept and a receipt obtained from the family.

4.67 The FLO must consult the family about how they would like to retrieve their relative's belongings. Some families like to collect them themselves from the prison, others appreciate having them delivered to their home. Some families like to have clothes laundered; others want them just as they are. In either event, pack them neatly in a suitable bag or container, not a black sack or a bag recognisable as prison issue.

Ending contact with the family

4.68 Contact with the family will need to be brought to an end at an appropriate time; this may not be until some time after the inquest. While it is important that the FLO tries to establish a good relationship with the family, they should take care not to allow the family to become over reliant on them. It is a professional relationship, not a friendship. Ending contact with the family needs to be well timed and executed while remaining caring and considerate. Some families retain contact with the prison for some time after a death either to commemorate anniversaries or they become involved with prison activities. They must continue to be treated with respect and consideration and if the FLO moves on, they will need to pass details of the case and relationship with the family to their successor.

Investigations following a death in custody

HMPPS investigations

4.69 It is important that HMPPS takes a proactive approach to learning from deaths in custody and acts quickly to address issues that emerge. It is essential that, where it is suspected that staff have not acted in line with their responsibilities, an investigation takes place as soon as possible in line with the Conduct and Discipline PSI 06/2010. The PPO investigator must be informed of any investigation and/or disciplinary action taken and the outcome where available.

Early Learning Review

4.70 After each death that is apparently self-inflicted, and any other unexpected death which is not obviously from natural causes, the Prison Group Director (PGD) (or Senior Contract Manager in contracted prisons) must ensure that an Early Learning Review (ELR) is conducted. The ELR is usually undertaken by the Group Safety Lead or a member of their team, but where this is not possible or appropriate, another reviewer may be appointed (in order to ensure objectivity this should generally not be someone employed at the prison at which the death occurred).

4.71 An Early Learning Review is a brief examination of:

- the circumstances of the death;
- the identification and management of risk in the period leading up to it; and
- the response to the incident.

4.72 The ELR is undertaken shortly after the death with the aim of identifying any lessons that can immediately be learned in order to improve local practice and prevent further deaths. This includes capturing examples of good practice, as well as finding areas of poor practice and/or non-compliance with policy and suggesting ways to improve them.

4.73 It is important to recognise that deaths are the subject of a number of independent investigations (see below) and these processes have primacy over the ELR, which must not involve any action that may compromise them.

4.74 The ELR itself does not constitute an investigation, because it is conducted at speed, on the basis of limited information, and for operational learning purposes only. For this reason, while it will be conducted in accordance with the same principles, it is not governed by HMPPS policy on investigations as set out in PSO 1300.

4.75 If the ELR reveals information that requires investigation, the reviewer must immediately pass it to the appropriate authority. Any indication of wrongdoing by a member of staff must be reported to the Governor to consider what action to take in accordance with PSI 06/2010 (and/or to the employer where the individual concerned is not directly employed by HMPPS). Any suggestion of criminal action must be reported to the police.

4.76 In order to complete the review in a timely way, and so as not to compromise the investigations described above, the reviewer will largely rely on an examination of written records and will not conduct interviews with staff involved in the incident or the care and management of the individual concerned.

4.77 In many cases the healthcare provider will also be undertaking a review of the case, and where possible it is good practice for the reviewer to discuss and, where appropriate, to share information about the case with the healthcare reviewer. Some caution is necessary

around such collaboration, as HMPPS and the healthcare provider may have different interests in the subsequent inquest and any litigation that may arise from the death.

4.78 The ELR report is designed to provide a concise summary of relevant evidence and to identify learning points. In order to do this, it must be honest and open about where things have gone wrong, but it is important that it provides an objective account in a neutral tone and does not apportion blame to individuals.

4.79 The report must be submitted to the Governor and PGD / Senior Contract Manager. The PGD / Senior Contract Manager must ensure that the process described above has been followed, that relevant learning has been identified and that the report is of satisfactory standard. The final version of the report must be clearly marked as such and copied to the national Safety Team.

4.80 The PGD / Senior Contract Manager and Governor must discuss the report and agree the actions to be taken to address the suggested areas of focus identified within it. It is crucial that prompt action is taken to address any non-compliance and poor practice that has been identified. Progress on the agreed actions must be monitored by the GSL.

4.81 The Governor must ensure that the findings of the ELR and the actions that have been taken to address them are discussed with the PPO investigator in the case. This will allow the improvements that have been made to be reflected in the PPO report and may result in a decision by the PPO not to make recommendations.

4.82 The completed ELR report is a document that HMPPS holds that is relevant to the death and must be given to the PPO investigator. It must also be given to the coroner, via GLD. It is crucial that care is taken to ensure that it is the final version of the report that is shared, and that it includes an explanation of the status of the report that cautions against relying on it as an account of events.

Independent investigations

4.83 All deaths in 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, often before a jury.

All staff must co-operate fully with these processes.

Police investigation

4.84 The police investigation will have primacy over other investigations. The police have a memorandum of understanding with the PPO as to how an investigation will proceed when there is a possible or actual crime.

4.85 Different police forces will engage differently with Governors where they are actively investigating a potential criminal offence. Where this investigation relates to staff the Governor must seek to establish ongoing contact with the investigating officer to ensure that they are able to get regular updates.

4.86 The Safer Custody Casework team and the PGD must be notified if the police decide to interview any member of staff under caution and if staff are charged by the police with an offence in relation to a death in custody.

Prisons and Probation Ombudsman (PPO)

4.87 The PPO investigate all deaths that occur in prison and young offender institutions. Details of the PPO's purpose and remit are set out on their website (ppo.gov.uk). The PPO investigate the circumstances of the death and produce a report setting out their findings with recommendations made where it is felt that action is required to mitigate the risk of further deaths.

4.88 The Ombudsman is appointed through an open competition by the Secretary of State for Justice. The Ombudsman's office is operationally independent of, though it is sponsored by, the Ministry of Justice. The Ombudsman reports to the Secretary of State.

The investigation

4.89 The PPO are notified of all deaths in custody, Approved Premises, and Immigration Removal Centres. They are also notified of deaths (except homicides) that occur within 14 days of release from custody. The PPO may request copies of relevant documents during any of these investigations.

4.90 The PPO will begin their investigation immediately. They may suspend their investigation at any point where circumstances require it, for example due to a police investigation or while waiting for the cause of death.

4.91 Efficient liaison with the PPO is essential to demonstrate HMPPS's commitment to support the investigation, and failure to manage this effectively can result in criticisms and recommendations in the investigation report, shared with the coroner and family of the deceased.

4.92 The PPO must have unfettered access to documents and other evidence during their investigations. Staff must comply with requests for information and assistance from the PPO. All documentation should be given to the PPO electronically unless there are exceptional circumstances as to why this is not possible.

4.93 Should it be requested, the PPO may provide a copy of any of the documentation they receive to the family, where they consider it relevant to their investigation. With the exception of intelligence reports, staff must ensure that the PPO is provided with two copies of any documents that require redaction: one redacted, and one not. Staff must also ensure that a copy is taken of each document provided to the PPO and that such copies are stored in a locked cabinet. While GLD may assist in the preparation of redacted documents, it is HMPPS's responsibility to ensure that it is done.

4.94 A PPO liaison role will need to be established, most suitably within the Safety team, to assist the investigation, including:

- disclosure of documentation
- arranging interviews
- any further assistance to the investigator required.

4.95 The investigator must be offered a meeting with the Governor, Head of Safety, or other member of senior management to discuss emerging findings towards the end of their investigation.

4.96 The investigator must be made aware of, and if requested, given documentation about:

- any ongoing or completed investigations into the actions of staff, and

- any updated policy or processes introduced since or following that might address concerns around the death, including in response to the ELR. This may assure the PPO that the appropriate action has been taken and that recommendations around the issues are not required.

4.97 The PPO liaison role should not be undertaken by someone who is involved in the investigation (such as the FLO or the first on scene).

Opening visit

4.98 In self-inflicted death and other non-natural death investigations, the PPO will normally conduct an opening visit, and this must be facilitated by the prison. The opening visit will normally include viewing the cell or scene of the death, meeting the Governor, Head of Healthcare, IMB Chair and other staff as relevant. The PPO will want to speak to prisoners in adjoining cells or others as relevant. The PPO will also collect any evidence that cannot be provided electronically during this visit. The PPO investigator may wish to view CCTV or BWVC footage during the opening visit and must be informed of any property found in the prisoner's cell.

Interviews

4.99 The PPO will have access to establishments, headquarters and regional offices at reasonable times as specified by the PPO, for the purpose of conducting interviews, examining documents (including those held electronically), and for pursuing other relevant inquiries in connection with investigations. The PPO will normally arrange such visits in advance.

4.100 Staff are required to attend interviews with the PPO unless there are exceptional reasons as to why they are unavailable. Staff being interviewed may be accompanied if they wish by a work colleague or trade union representative.

4.101 The PPO will occasionally tape-record interviews, subject to the permission of the interviewee. If this is necessary arrangements will be made in advance for the PPO's equipment to be set up.

4.102 Interviews with prisoners must be within sight, but out of the hearing, of staff unless the prisoner, or the PPO, requests that it takes place within hearing. A room must be provided for this purpose. Subject to the agreement of the PPO, the prisoner may have a friend or adviser present so long as that person would normally be allowed to visit the prisoner.

4.103 If a member of the PPO's staff wishes to speak to a prisoner by telephone, s/he will telephone the establishment to make arrangements to speak to the prisoner. On receipt of such a request, prisoners must be given the opportunity to use an official telephone out of hearing of staff and at a time convenient for the regime.

4.104 The PPO will endeavour to arrange visits (or telephone calls) at a time that does not conflict with prisoners' work or education commitments but, in any event, prisoners must not lose pay as a result of an interview or telephone conversation which takes place at the request of the PPO.

Disclosure of sensitive information

4.105 Staff giving information to the PPO or checking draft reports must identify to the PPO any information that they consider must not be disclosed. Examples will include circumstances where disclosure would be:

- against the interests of national security
- likely to prejudice the security of the prison
- likely to put at risk a third-party source of information
- likely to be detrimental on medical or psychiatric grounds to the mental or physical health of a prisoner
- likely to prejudice the administration of justice, including legal proceedings
- of papers capable of attracting legal privilege.

4.106 In order to ensure that sensitive documents such as intelligence reports are securely managed, there is an agreement between HMPPS and the PPO to ensure that only relevant information, particularly from intelligence reports, is routinely provided. If they contain information belonging to a third party (e.g. police or other organisations), the written consent of the data owner will need to be obtained before disclosing it to the PPO. Any concerns by establishment staff about the release to the PPO of specific information will need to be discussed with the Head of Security or Operations and/or the Safer Custody Casework team. Where personnel records of staff are requested, the agreement of the staff member concerned is required.

4.107 When requests are made to security staff by those acting on behalf of the PPO for copies of intelligence reports, they must be provided by the establishment, but the source of the intelligence must be redacted. It should also not be possible to infer the source from reading the redacted text. If the intelligence is of a confidential nature, it can be sent via the Brent fax to the National Intelligence Unit (NIU) who in turn will arrange for it to be delivered to the PPO.

4.108 If a further request is received concerning the source of the intelligence, the Head of Operations or Security will consider the 'need to know' principle and if in agreement will indicate the nature of the source. If the Head of Security or Operations considers that the source should be withheld, the matter will be decided on by the Governing Governor.

4.109 If there is no satisfactory resolution, then the Governing Governor must refer the matter to the NIU for consideration by the Director of Operational Security Group and to the Ombudsman by his representative.

4.110 All third-party names, excluding the names of staff and third party professionals and any prisoners who are witnesses to events surrounding the death (e.g. other prisoners' names, or other sensitive information), must be redacted before disclosure.

4.111 If there are concerns about disclosure of the subject matter of the intelligence, the matter must be referred to the Head of Operations or Deputy Governor. Only in an exceptional case would the information requested not be disclosed. In such circumstances the Governing Governor must inform the PPO in writing giving the reasons for withholding the information. The NIU may be consulted for advice.

4.112 The National Security Framework (Function 4, Intelligence Systems) sets out the requirements for the sanitising and dissemination of intelligence reports.

Advance disclosure

4.113 Where an identified member or members of staff are criticised in the draft report, in line with the PPO's terms of reference they may disclose an advance draft of the report to the Governor (or Head of Healthcare for healthcare staff), in whole or part, so that it can be shared with the individuals concerned so they have the opportunity to make representations.

Initial report

4.114 Once the PPO investigation is concluded they will issue the initial report to HMPPS, the family and the coroner. There is then a consultation period during which HMPPS will consider the findings and check the report for factual accuracies and prepare the response to the PPO. The response will include a completed action plan setting out the actions that have been or will be taken in response to any recommendations.

4.115 The Governor, Head of Safety and PGD will receive the initial report from the Safer Custody Casework team, who will work with the prison's Safety team to identify any concerns regarding the report and produce the response to any recommendations made to the Governor. Once agreed, the Governor and PGD will clear the final version of the action plan.

4.116 The Safer Custody Casework team will coordinate the response to any national recommendations.

4.117 Governors must ensure that any staff named in the PPO's fatal incident report are given the opportunity to read the report at the initial stage and to respond within the consultation period.

4.118 The initial report is also likely to inform the coroner and family's understanding of events and influence what will be further explored at inquest.

Challenges and factual inaccuracies

4.119 Most inaccuracies identified will be straightforward, such as wrong spelling of names or roles. More complex issues must be discussed immediately with the case manager in the Safer Custody Casework team, as they will require discussion with the PPO. SCCT will liaise with the investigator on behalf of the prison, and where necessary the Assistant Ombudsman, to seek resolution. Challenges need to be backed up with evidence and must be supported by Governor and PGD.

Final report

4.120 Once HMPPS and the family have responded to the initial report the PPO will issue the final report. This is not the same as the version published on the PPO's website following the inquest, from which the names of third parties (such as staff and other prisoners) are removed, and which does not include any of the annexes other than the action plan provided by the prison.

4.121 The final report, including the response to any recommendations, is shared by the PPO with the coroner. A robust and detailed action plan that sets out clear, defined action is extremely useful at the inquest stage as it provides the starting point for addressing the coroner's concerns that may result in a Report to Prevent Future Deaths ('PFD' or 'Regulation 28'), giving an understanding of what progress has been made since the death.

Serious case review (deaths of young people under 18)

4.122 Following the death of a young person in custody the establishment must have procedures in place for informing the Local Safeguarding Children Board, who will undertake a serious case review. Further guidance is available in PSI 08/2012.

Coroner's inquest

4.123 The purpose of an inquest is to find out by what means and in what circumstances an individual came to their death. An inquest is inquisitorial and not adversarial and cannot apportion blame to named individuals. The majority of inquests into non-natural deaths in custody will be held before a jury.

Legal representation

4.124 Government Legal Department (GLD) act as HMPPS's legal representatives for all deaths in custody. They are responsible for liaising with the coroner's office to ensure that HMPPS responds appropriately to all requests for disclosure and coroner's directions. The coroner is a judicial officer and has the powers of a court, so any disclosure request for disclosure or statements must be complied with in the same way as a court order. This can include staff investigations and disciplinaries.

4.125 We have a duty of candour that requires us to ensure that all Interested Persons, including the family and their representatives, have access to information and documents we hold if the coroner directs us to provide them. Missing information or documents is reputationally damaging and can have a negative impact on the running of the inquest.

4.126 All available documentation must be provided to GLD, who will share it with the coroner. All correspondence with the coroner, and disclosure relating to individual cases, must go through GLD. Some coroners may contact the prison direct requesting information - where this happens prisons will need to forward this on to GLD for response.

4.127 The coroner will usually share all disclosure, including relevant sections of CCTV and BWVC footage, with all Interested Persons, usually in pixelated form.

Staff representation

4.128 HMPPS provides representation through the GLD for all employees who are required to attend an inquest following a death in custody, provided there is no conflict of interest. For the majority of inquests, GLD and counsel will represent the interests of all staff required to give evidence, without the need for separate representation.

4.129 GLD is unable to act for healthcare or contracted prison staff but can act for controllers of contracted prisons.

4.130 All staff are required to give evidence at an inquest if requested by the coroner. Where there are extenuating circumstances, such as serious illness or significant mental health distress that may be caused by giving evidence, GLD can make representations to the coroner, but the decision as to whether a witness is required ultimately rests with the coroner. A witness summons from a coroner carries the same weight and potential contempt of court consequences as a summons to a criminal court.

4.131 In advance of the inquest, GLD will arrange a witness conference, where counsel acting for HMPPS will provide details of the inquest process and what staff can expect when

attending an inquest.

Conflict of interests

4.132 Where a conflict of interests arises and it is decided that the GLD and counsel are unable to represent the member of staff concerned, staff witnesses who want legal advice will need to seek separate representation. Decisions as to whether a conflict of interests exists will be made on a case-by-case basis. If a conflict of interests is identified, there will be a presumption that HMPPS will exercise its discretion to fund the costs of separate legal representation for the staff involved, unless certain circumstances exist.

4.133 GLD will refer any potential conflicts to SCCT, who are responsible for taking this forward and will work with the Head of Safety to manage this process.

Prisoner witnesses

4.134 The coroner may decide to call a prisoner as a witness to the inquest. Prisons are required to produce prisoners whose attendance has been requested or summonsed by the coroner.

4.135 In many cases the coroner will not have a secure court. If a secure court is required arrangements will need to be made by HMPPS with the coroner for the most appropriate way of hearing the prisoner's evidence, i.e., by use of a secure court or through a video link if possible.

4.136 If a Listener is called as a witness the Samaritans must be notified so that they can attend the inquest and support the Listener.

Report to Prevent Future Deaths (PFD) / Regulation 28

4.137 The Coroners and Justice Act 2009 imposes a duty on a coroner to issue a PFD report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action needs to be taken to prevent further deaths.

4.138 Where the coroner makes a PFD report to HMPPS, SCCT will work with the establishment and GLD to produce the response. Although the coroner may direct PFDs to a range of people, such as the Governor or Prisons Minister, all PFDs are responded to by the Director General Operations.

Costs for family attending inquests

4.139 The family may ask the prison to pay their costs associated with attending the inquest, including accommodation and subsistence. There is no requirement for the prison to pay these costs. Family members can be advised that the coroner may be able to help with costs if their circumstances mean that they will have difficulty participating in the inquest without it.

5. Constraints

5.1 This policy applies in the event of a death in prison custody. This does not include deaths on non-medical release on temporary licence, on early release on compassionate grounds or following discharge from custody. However, as explained at 4.7 above, the response to such deaths must follow the same principles.

6. Guidance

6.1 Guidance is available on the HMPPS intranet.