Ministry of JUSTICE
National Offender Management Service

MAY 2011 ISSUE 7

National Safer Custody Managers & Learning Team
Offender Safety, Rights & Responsibilities Group

Who Needs To See This Bulletin?

Please ensure that this bulletin is circulated to ALL STAFF.

Please print out copies of this bulletin for distribution around your establishment. You may also wish to distribute it to Managers at your morning meeting.

Quick-Time Learning Bulletin Retention of Documents for Investigations following a Death in Custody and Inquests

This quick time learning bulletin is the seventh in a series from Offender Safety, Rights and Responsibilities Group (OSRRG). Its aim is to remind staff of the importance of retaining all documentation following a death in custody.

Following a death in custody prisons will have to provide a number of documents to the police (who act on behalf of the coroner) and the Prisons and Probation Ombudsman (PPO) in order to assist their investigations.

The coroner is also likely to request further documents in preparation for the inquest. However, 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 crucial therefore that prisons retain all documentation relating to the death in custody.

Staff should co-operate fully with requests by the police, the PPO and the coroner for documents. Any queries about disclosure and possible redaction of documents should be directed to OSRRG.

KEY LEARNING POINTS:

- Prisons should have in place local contingency plans for the actions required following a death in custody, including the collation of documents for investigations by the police and PPO and the coroner's inquest.
- Prisons are required to have a nominated member of staff to liaise with the police, and PPO and the coroner and to be a point of contact.
- As soon as possible after the death, all documentation should be gathered together and securely stored in a locked cabinet with signed access only until after the inquest. This will include:

- Copies, or originals if not removed by the coroner, of the F2050
- ACCT documentation
- Observation books
- Staff details
- Clinical records (to include all the health records such as Care Plans and dental records).

- Local policies and protocols in operation at the time of the death should be retained, in particular policies on suicide prevention, IEP and segregation.
- Any evidential CCTV footage should be retained.
- All documentation handed over, should be signed for, and copies kept by the prison.
- A copy of all documentation provided to the coroner should also be sent to the Treasury Solicitor.

Prompts for action

All deaths in custody.

Good practice

The use of a checklist detailing the documentation to be retained, and to whom and when, it is handed over. A checklist template is attached to this bulletin but an electronic version can also be obtained from any of the contacts points below.

NB The retention of all documentation also applies after incidents of serious self-harm and serious assault for potential Article 2 of the European Convention of Human Rights investigations.

Contacts points at OSRRG

Jenny Rees: 0300 0 475681 / Jenny.Rees@noms.gsi.gov.uk
Jacqueline Townley: 0300 0 475678 / Jacqueline.Townley@noms.gsi.gov.uk
Tony Sperry: 0300 0 475682 / Tony.Sperry@noms.gsi.gov.uk