A Comparative Analysis of Policing Practice: Established Investigative Standards v Operation Talla Policing

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Executive Summary

This report examines a question of fundamental importance to the administration of justice:

What is the proper response of the State where allegations arise that criminal conduct in a healthcare context may have caused death or serious harm?

Two recently published frameworks:

- *Police Practice Advice: Medical Investigation of Suspected Homicide (2025)*

and

- *Guidance on Investigating Healthcare Incidents Involving Potential Criminality (2024)*

set out a clear and structured model.

That model requires:

- early engagement,

- evidential preservation,
- coordinated investigation,
- and proper entry into the criminal justice system.

This report contrasts that model with:

- the Metropolitan Police Service handling of CRN 6029679/21,
- the Speirs Directive (25 January 2022), and
- NPCC disclosure evidence indicating a “to not record” approach.

The contrast is direct and material.

1. The Established Investigative Model

The two documents provided establish a consistent framework for dealing with suspected criminality in healthcare settings.

1.1 Early Recognition of Criminal Suspicion

Where there is reasonable suspicion that conduct may have contributed to:

- death, or
- serious life-changing harm

the matter is to be treated as potentially criminal.

There is no provision for dismissal at the point of approach.

1.2 Entry Into Formal Investigation

The model requires:

The emphasis is clear: The system must open, not close.

1.3 Evidence Preservation

Both documents stress:

- immediate securing of evidence,
- acquisition of medical records,
- coordination with pathology and coronial processes.

The rationale is explicit: Failure at the initial stage risks loss of investigative integrity.

1.4 Multi-Agency Coordination

The 2024 guidance provides for:

- coordinated response across police, CPS, regulators and healthcare bodies,
- structured information-sharing,
- collective oversight of serious cases.

1.5 System-Level Consideration

The frameworks recognise that:

- causation may be complex,
- responsibility may extend beyond individuals,
- and wider systems may require examination.

2. Operation Talla: Documented Approach

The Operation Talla material presents a different model.

2.1 The Speirs Directive

The directive states that where individuals request police assistance in relation to relevant allegations:

- *"these requests should be rejected."*

It further provides for:

- intelligence submissions,
- routing through Operation Talla channels.

2.2 NPCC Disclosure Evidence

Internal correspondence records:

- *"the guidance to not record has been a success."*

This indicates:

- a defined operational approach,
- measured outcomes,
- and an emphasis on non-recording.

3. Case Study: CRN 6029679/21

The handling of this matter provides a practical illustration.

3.1 Material Submitted

- extensive witness and expert evidence,

- allegations of serious harm,
- formal reporting to police.

3.2 Initial Position

- crime reference number issued,
- clear indications of investigative activity.

3.3 Subsequent Position

- no witnesses contacted,
- no proper, full investigative steps undertaken,
- position asserted by MPS that no investigation took place.

4. Points of Contrast

The contrast between the two models may be stated succinctly.

4.1 Entry v Rejection

Established Model:

- Allegations enter the system and trigger investigation.

Operation Talla Model:

- Requests for assistance are rejected at the point of approach.

4.2 Recording v Non-Recording

Established Model:

- Incidents are formally recorded to preserve evidential integrity.

Operation Talla Model:

- Non-recording is identified as a successful outcome.

4.3 Evidence Preservation v Evidential Absence

Established Model:

- Immediate steps are taken to secure and preserve evidence.

CRN 6029679/21:

- No evidential steps were taken despite substantial material being available.

4.4 Investigation v Administrative Routing

Established Model:

- Police-led investigation with structured oversight.

Operation Talla Model:

- Routing through intelligence and coordination channels without investigation.

4.5 System Examination v System Exclusion

Established Model:

- Recognition that systemic issues may require scrutiny.

Operation Talla Model:

- No investigative pathway through which such scrutiny could occur.

5. Observational Analysis

The distinction between the two approaches is not procedural detail. It is foundational.

The established frameworks are designed to ensure that:

- serious allegations are examined,
- evidence is preserved,
- and justice processes are engaged.

The Operation Talla material, in contrast, indicates a model in which:

- allegations may not be recorded,
- assistance requests may be rejected,
- and investigative processes may not commence.

6. Conclusion

This report makes no finding as to the merits of any individual allegation.

It addresses only process.

The comparison demonstrates that:

- the State's own guidance requires entry into investigation where serious harm is alleged;

- the Operation Talla approach, as disclosed, appears to have operated at the point of exclusion;
- and the handling of CRN 6029679/21 is consistent with that exclusionary position.

Final Observation

Where a system facilitates investigation, the law is applied.

Where a system prevents entry into investigation, the law does not engage at all, but is blocked/denied application.

The distinction is decisive.

Home Office

The Medical Investigation of Suspected Homicide

Police Practice Advice

June 2025

Version 3

This publication is available at www.gov.uk/government/publications/sudden-unexpected-death-medical-investigation

Any enquiries regarding this publication should be sent to us at: pathology@homeoffice.gov.uk.

Version 3

Contents

Introduction

This guidance provides advice on dealing with the pathology aspects of an investigation into a sudden and unexpected death. Separate guidance provides advice on the initial actions at the scene before instigating a homicide investigation (see: death investigation diagram below).

Together, they replace Chapter 11 (Pathology) of the Association of Chief Police Officers (ACPO) 2006 Murder Investigation Manual and have been approved by the National Police Chiefs' Council (which superseded ACPO), the Chief Coroner, the Coroners' Society of England and Wales and the British Association in Forensic Medicine (BAFM).

This advice relates to the investigation of the death of adults. Separate practice advice can be found for the investigation into the death of children in the College of Policing library.

Where relevant, references to senior investigation officers (SIO) relate also to senior identification managers (SIM) in a mass fatality context.

Dealing with death

Dealing with the death of a human being is one of the most fundamental roles within policing, and one that has, over the years, brought much criticism to the police service in England and Wales.

The system of death investigation in England and Wales essentially fits into one of four pathways.

- Death which is anticipated due to naturally caused ill health and where a medical doctor can issue a Medical Certificate of the Cause of Death (commonly referred to as a MCCD).

- Death where a doctor is unable to issue a certificate because there is reason to suspect the death is violent or unnatural or they have not recently attended upon the deceased or the cause of death is unascertained. The case is then referred to a coroner for investigation. This will usually involve the police and/or the coroner's officer attending the scene of the death and completing an initial investigation on behalf of the coroner. If the outcome of that investigation is that the death is not suspicious, and there is no third-party involvement, the coroner will continue with the investigation. This is often assisted by the police, which may involve the appointment of a non-forensic hospital 'histopathologist' to conduct a post mortem examination to help determine the medical cause of death (Section 14 Coroners and Justice Act 2009).

- Non-suspicious, unnatural deaths that will need automatic referral to a coroner, for example, deaths from industrial disease, suicides, or drug-related deaths.

- Death where the outcome of the police investigation is that the case is suspicious, the police take on primacy in the investigation. In consultation with the police, the coroner will appoint a Home Office registered forensic pathologist to conduct the post mortem examination. The two processes of routine non-forensic post mortem examinations and forensic post mortem examinations are very different. Therefore, if the outcome of the initial police investigation is flawed, and the decision by the police is that the case is not suspicious, there will be no forensic examination of the body and a potential homicide could be missed.

Forensic pathology in England and Wales is overseen by the Home Office Pathology Delivery Board (PDB), which is responsible for the maintenance of the Home Office Register of Forensic Pathologists and matters connected with the medical investigation of death in police cases.

A report published by the Forensic Science Regulator on GOV.UK in December 2015 'A Study into Decision Making at the Initial Scene of Unexpected Death', highlights the

potential to 'miss' a homicide. To reduce the likelihood of such a 'miss', it is essential that the police service deals with death in a systematic and professional manner. Further research was carried out in this area leading to a PhD thesis, entitled, 'Fatal call – getting away with murder: a study into influences of decision making at the initial scene of unexpected death'; which can be viewed on the University of Portsmouth website.

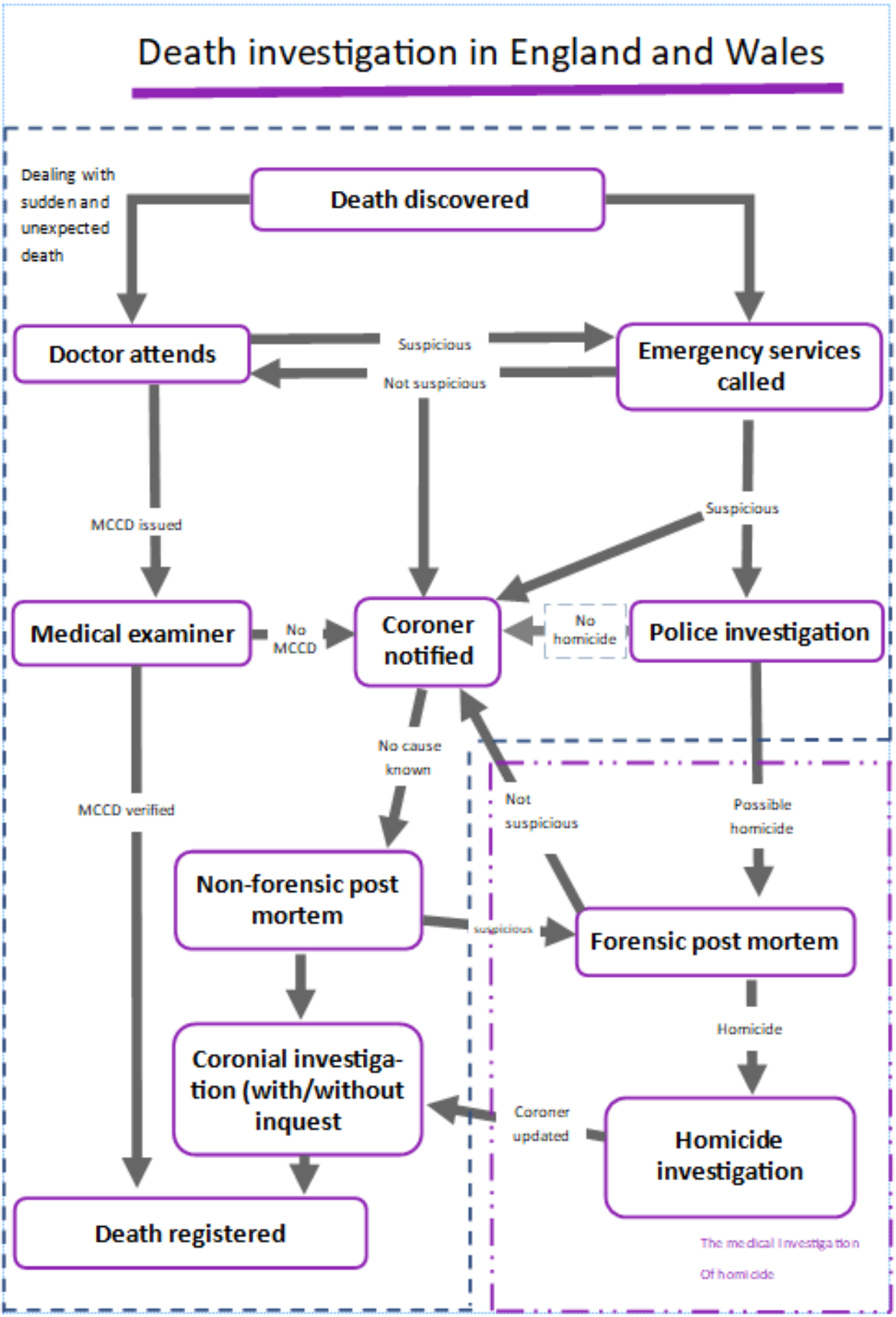
Forensic pathology is an essential element in most suspicious death and homicide investigations. Senior investigating officers (SIOs) must have a clear knowledge of how pathology can assist an investigation, and of the various issues that are associated with the discipline.

Home Office registered forensic pathologists are appointed in each suspicious death case by the senior coroner for the relevant district, and in consultation with the local chief officer of police. In such cases, the forensic pathologist receives a statutory fee from the coroner in accordance with The Coroners Allowances, Fees and Expenses Regulations 2013. The police also pay the forensic pathologist a case fee as an expert witness. This fee is reviewed annually and agreed by the National Police Chiefs' Council lead for forensic pathology and the British Association in Forensic Medicine.

Death investigation

The following diagram outlines the process of death investigation in England and Wales. It includes the boundaries between this guidance and the 'Dealing with sudden and unexpected death' guidance.

Figure 1 shows the process of a death investigation which now includes the Medical Examiners scrutiny of the MCCD.



The pathology strategy

Strategy content

There are several issues that must be addressed in relation to pathology:

- Identification of the deceased, if identification has not already been established.
- Notifying the coroner, who will, in consultation with the police, appoint a forensic pathologist to undertake the post mortem examination. This is in line with, The Coroners (Investigations) Regulations 2013 Part 3, Regulation 12, and Chief Coroner Guidance 32.
- Consideration of health and safety and staff welfare arrangements.
- Assessing the value of a forensic pathologist's attendance at the crime scene or access by remote visual means.
- Liaising with the forensic pathologist throughout the investigation.
- Removal of the body, including:
    - what actions must be performed before removal,
    - supervising the removal,
    - continuity of the body from the scene to the mortuary,
    - identifying the body to the forensic pathologist, prior to the post mortem examination (or establishment of continuity if identity is unknown).
- Deciding who should attend the post mortem examination and/or scene, including specialists.
- Providing the correct resources at the post mortem examination to deal with exhibits, samples and photography.
- Forensic post mortem examinations must take place in a mortuary which is licensed by the Human Tissue Authority, as stated in the Human Tissue Act 2004. This includes temporary mortuaries. The mortuary must be suitably equipped for conducting forensic post mortem examinations.
- Family liaison considerations presented by the post mortem examination.
- Potential for an additional examination of the body or relevant material, i.e., the second or 'defence post mortem examination' see: Chief Coroner's Guidance No. 32

Post-Mortem Examinations Including Second Post-Mortem Examinations[1] - Courts and Tribunals Judiciary.

- Consideration of the legal issues that may arise during the forensic medical examination of a foetus. A foetus which is born alive becomes a living person, independent from its mother. Where the foetus does not survive until birth or is stillborn, it has not lived and as a result, has not died (this seems a harsh statement, but is the state of the current law). This means that the coroner (in England and Wales) has no jurisdiction over a foetus or stillborn child. For further information, see: Chief Coroner Guidance 45. It also means that any medical or scientific examination of the remains does not amount to a post mortem examination. If an official post mortem examination is granted, then any examination should be carried out in the same circumstances and to the same standards as would apply to a deceased infant. The police powers to seize and examine, or order the examination of evidence, can be applied to a foetus or stillborn child. The position in Northern Ireland is different, where the coroner has jurisdiction.

- Timely release of the body.

- Issues surrounding seizure and retention of human tissue (see section: Retention of material after post mortem examination).

- Additional considerations in relation to child death investigations, available within the ACPO (2014) Practice Advice on Child Death Investigations.

These issues and any additional elements of the forensic strategy must be recorded in the SIO policy file and continuously reviewed.

Key roles

Pathology plays an essential role in forming the forensic strategy. The following professionals are key to this process.

Home Office registered forensic pathologist

Home Office registered forensic pathologists (England and Wales) /consultant forensic pathologists (Scotland) /state pathologists (Northern Ireland), sometimes require the assistance of paediatric pathologists in child death cases, and other organ specific pathology specialists (such as neuro, eye, and bone pathologists) to assist the forensic pathologists in their investigations in complex cases. The SIO may draw on the expert assistance of a forensic pathologist on a number of areas, including the following:

- Advising on the removal of the body to the mortuary.

- Assisting with the identification of the victim.

- Assessing the size, physique, and previous health of the victim.

- Determining the cause, mode and potential time of death where possible.
- Obtaining and recording evidence, including advising on detailed photographic evidence of external and internal injuries.
- Providing advice on the possible type and dimensions of any weapon.
- Setting the post mortem examination findings in context with the initial crime scene assessment.
- Assisting the SIO with early lines of enquiry.
- Contributing to the forensic strategy.
- Contributing to the decision-making process throughout the inquiry, as appropriate.
- Advising on the use of computerised tomography (CT) scanning of the body prior to the post mortem examination.

Strategies relating to crime scene management and the collection and analysis of evidence are inextricable from pathology. The SIO will need to take account of all the latter points when developing, reviewing, and managing the forensic strategy.

Forensic pathologists are on call 24 hours a day, 7 days a week to respond to requests to attend scenes, and conduct post mortem examinations in accordance with local force memorandum of understanding (MoU), or contractual agreements, and the Code of Practice and Performance Standards for Forensic Pathology in England, Wales and Northern Ireland. Forensic pathologists can advise on health and safety issues in conjunction with the crime scene manager (CSM) at the scene and within the post mortem examination room or mortuary. It is established good practice that forensic pathologists conduct post mortem examinations in all suspicious death cases. If a non-forensic pathologist conducts a post mortem examination of a suspicious death, they are expected to comply with the same performance standards.

Physical control over the body rests with the coroner, and after consultation with the chief officer of police, the coroner should appoint a ‘suitable practitioner’ (a forensic pathologist) (Regulation 11, of The Coroners (Investigations) Regulations 2013) to conduct a post mortem examination as soon as reasonably possible in cases where a homicide is suspected.

Where the police have notified the coroner that a homicide offence is suspected in connection with the death; the coroner must notify the police of the date, time and place at which the post mortem examination is to be made, and a police representative may attend the post mortem examination. Under Regulation 13, of the Regulations 2013, the police have a right to be present at the post mortem examination and to be represented by a medical practitioner (a forensic pathologist on the Home Office Register).

Post mortem examination using non-forensic pathologists

Using a non-forensic pathologist may lead to a homicide being missed or could lead to the loss of vital forensic trace or DNA evidence transferred to the deceased from the offender. This is discussed within the ACPO National Policing Homicide Working Group's Journal of Homicide and Major Incident Investigation, Volume 9, Issue 2 November 2014, page 58 - 72, available in the College of Policing library.

Maintaining contact with the forensic pathologist

The role of the forensic pathologist is not limited to the post mortem examination. There may be regular contact between the investigation team and the forensic pathologist throughout the investigation, including certain decision-making points with the Crown Prosecution Service (CPS). This is often the case when evidence relevant to the injuries or cause of death becomes available from witnesses, scientists or the offender as the investigation progresses.

It is essential there is effective and documented communication between the SIO, coroner, and forensic pathologist. As soon as the case has been referred to the CPS, details of the CPS lawyer should also be provided to the coroner.

Photographs of the scene and relevant scientific results from a post mortem examination such as toxicology results must be relayed to the forensic pathologist as soon as possible, along with any other issues relating to the injuries or cause of death that become apparent during the investigation.

Coroner's officer

It is essential that the enquiry team establish early liaison with the coroner through the coroner's officer, in order to get the necessary authority to conduct the post mortem examination and have a forensic pathologist appointed.

A designated coroner's officer, who works directly for the coroner only, should be responsible for producing the necessary file relating to identification and how the death occurred, which will allow the coroner's investigation to be conducted. This ensures that action is taken to satisfy the coroner that all examinations are completed before the body can be released. The SIO will liaise with the coroner to facilitate the release of the body when no further examination is required by the prosecution and defence.

Other expertise available

Other medical expertise

If the circumstances of the case require additional expertise to support the pathological examination, such as a paediatric or organ specific pathologist (e.g., a neuropathologist), it is the responsibility of the forensic pathologist to make appropriate recommendations to the SIO, CSM and coroner.

Injuries

In addition to medical experts, the SIO may also (in consultation with the forensic pathologist) consider contacting the National Crime Agency (NCA), Major Crime Investigative Support Forensic Medical Advice Team (FMAT) for advice and guidance on the instruction of appropriate experts and the provision of clear instructions. More information can be found on their website: Major Crime Investigative Support (National Crime Agency).

In all cases where additional experts are used for pathology related investigations, the original forensic pathologist should be consulted, and all necessary steps must be taken to ensure continuity. The forensic pathologist is responsible, in consultation with the coroner and the SIO, for advising on the need for additional examinations and/or investigations.

Radiological examinations and body scanning

While it is appreciated that scanning facilities may not be universally available, the use of radiological examination and/or CT and magnetic resonance imaging (MRI) scans must be considered in consultation with the forensic pathologist in:

- Cases of suspected non-accidental injury in children; and
- All deaths involving firearms or explosives.

It is encouraged that all suspicious death investigations should have a CT scan of the body prior to the post mortem process.

It can also greatly assist in the examination of badly burnt or decomposed bodies and may also be appropriate in other instances, for example sharp wounds where knives have impacted on the bone.

Skeletal surveys are considered mandatory for the investigation of unexpected child deaths. Where available, MRI scans should be reserved for children and not normally used in adults.

Advantages

Where facilities are available, scanning may assist an investigation for the following reasons:

- It captures external and internal features (within the limits of CT scanning) prior to any invasive procedures. This provides a permanent record that can be reviewed at any time in the future (so-called ‘virtual exhumation’) by properly interested persons. These features can be later used for the presentation of pathology matters within a court setting with the use of 2D and 3D images, as well as video representation.
- It permits the documentation of the presence of external and internal injuries that can be identified with CT scanning.

- It may identify some pre-existing natural disease. This would include the identification of infectious diseases such as tuberculosis prior to opening a body.
- It may identify the location of foreign bodies on and inside the body.
- It can assist in identifying a potential cause of death and permit some postulation upon a potential mechanism of death.
- It can potentially be used to assist in the estimation of post-mortem interval (time of death), although the current evidence base for this is at a basic level and should not be relied upon as sole evidence in this field of practice.
- It can assist in the identification of an individual.
- It can assist with the collection of biological samples by needle such as toxicology, microbiology and histology.

Limitations

The limitations of CT scanning are the following:

- It cannot be used to document the nature or location of bruises or abrasions on the surface of the body. An external examination is needed instead.
- It will not be able to demonstrate the path of (for example) a stab wound or projectile to the same level as an invasive examination.
- It can identify the location of a bruise in internal structures, although this is not currently at the same level as that of an examination by eye.
- While CT scanning may identify a potential cause of death, this may not be the actual cause of death.

Toxicology, microbiology and other such samples should be taken prior to when contrast injection (ink injected into the body) is used with CT scanning. Contrast injection does not affect subsequent DNA samples, including blood samples used for DNA identification.

Other specialists

Depending on the nature of the death, the SIO should also consider (in consultation with the forensic pathologist, CSM and coroner) inviting additional specialists to attend the post mortem examination. Examples of specialists who might be considered by the SIO include, but are not restricted to, the following:

- Odontologist
- Biologist
- Botanist

- Medical illustrator (decomposed bodies)
- Toxicologist
- Ballistics expert
- Entomologist
- Anthropologist
- Other pathology disciplines such as paediatricians and neuropathologists.

Initial response and actions to be taken before a post mortem examination

Reporting to the coroner

Once a body has been discovered and a violent or unnatural death is suspected, or the cause of the death is unknown, or the deceased died while in custody or otherwise in state detention, it must be reported to the senior coroner for that area as it is that coroner's duty to investigate all deaths of this nature. This is stated in the Coroners and Justice Act 2009, part 1, chapter 1.

The SIO is responsible for reporting to the coroner/coroner's officer immediately that an investigation is underway. A senior coroner may now direct a body to be removed to any suitable place (subject to certain restrictions) within the coroner's area or elsewhere for the purpose of conducting a post mortem examination under section 14 of the Coroners and Justice Act 2009. In many forces, the coroner's officer has an important role in this regard. The SIO should therefore consult with the coroner/coroner's officer if there is a need for a body to be removed to a particular mortuary for a specific purpose. The SIO/SIM/coroner should consider sending the bodies of victims to a separate mortuary to that of the perpetrators in cases of terrorist incidents and domestic homicides.

Initial SIO actions

In the initial stages of an investigation, the SIO must ensure the following:

- Details of all persons attending the scenes/victim are recorded (recording them in the Crime Scene Attendance Log).
- Separate medical practitioners should be used for suspected victim(s) and suspect(s) examinations in order to avoid cross-contamination issues.
- Details of all treatment and drugs administered to the victim are recorded and relayed to the forensic pathologist (before the post mortem examination, where possible).
- Details of any drugs (both prescription and non-prescription) or alcohol found at the crime scene(s) are recorded and relayed to the forensic pathologist.
- The victim's medical records are obtained and made available to the forensic pathologist before the post mortem examination (usually arranged by the coroner's officer).
- Any possibility of hazardous substances suspected to have caused the death are communicated to anyone else at risk.

- Wishes of the next of kin relating to organ transplantation, which may require careful consideration depending on the cause of death. See also paras 14-19 of the Chief Coroner Guidance 26 on Organ Donation.

  See: ACPO/NPIA Journal of Homicide and Major Incident Investigation Volume 6, Issue 1 Spring 2010.

Crime scene attendance

The forensic pathologist may be requested to attend a crime scene, along with any other relevant specialists under the following circumstances, or, for the following reasons:

- To gain a better understanding of the crime scene.
- In cases of multiple stabbings, mutilation or shootings involving multiple shots.
- Where the scene is regarded as complex, for example a buried body or the attempted destruction of a body by fire.
- Where there are multiple scenes and/or multiple deaths.
- Circumstances where samples need to be taken in situ, such as:
  - sexual offences,
  - weapons embedded in the body, and
  - entomological evidence exists (this is best performed by an entomologist).
- Where advanced decomposition has occurred.
- To advise on removal of the body.
- If it is not practicable for the personal attendance at the scene, still or video footage can be relayed to the forensic pathologist by secure means.

Briefing the forensic pathologist

Prior to attending a crime scene, the SIO, deputy SIO or delegated person, must fully brief the forensic pathologist. This should be done in writing where possible, as well as verbally to answer any questions either by the police or the pathologist, so the needs of the investigation are clearly communicated.

The following key areas should be included in the briefing:

- Identity of the deceased, if known.

- History of the deceased – including the deceased's medical history, drugs found at the scene and actions taken or developments since the discovery of the body.
- Timescales concerning the finding of the body, the last sighting and any other significant times which may impact upon the estimated time of death.
- Any additional information received from other experts if appropriate.
- Initial evidence from witnesses.
- Scope and priorities of the investigation.
- Any special evidential expectations and requirements of the scene examination and post mortem examination.
- Circumstances surrounding the scene and death, so that potential experts who may assist the forensic pathologist are able to discuss and assess these with the forensic pathologist.

It must be noted that the expert opinion of the forensic pathologist as to the cause of death is often contextually based upon other circumstances and other evidence.

At the briefing, the pathologist (in liaison with the SIO, CSM and other experts) will evaluate the available information and identify:

- Health and safety issues and relevant risk assessments at the crime scene;
- Evidential issues raised by the circumstances of death and how these issues are best approached;
- Risk of contamination posed by the circumstances of the case, and the measures that are required to prevent such contamination;
- How the examination of the scene and body should be approached;
- The best location for the post mortem examination and, if possible, an approximate time of arrival at that location;
- Whether the post mortem examination should be conducted under 'high risk' conditions (for instance if the body could be contaminated); and
- Welfare considerations throughout the course of the Investigation.

Forensic pathologists should make a detailed, dated, and timed record of the briefing. Forensic pathologists must record full details of the scene and the body, and document both their own actions and the actions of others that may be significant to their examination.

If for whatever reason, the coroner restricts the police briefing of the pathologist, the Code of Practice and Performance Standards for Forensic Pathologists advises as follows:

'The briefing of the pathologist must be comprehensive. If the coroner is not content with a complete briefing the pathologist should consider whether it is appropriate to (a) decline the instruction or (b) decline to act for both the police and coroner in the case'.

Accordingly, if the coroner issues instructions to restrict the briefing, the SIO should consider challenging this decision of the coroner, (and declining to pay for the forensic examination), and in extreme cases, may consider appointing another forensic pathologist who is fully briefed, to observe the forensic examination and advise the police accordingly.

In the rare instances where this happens, advice can be sought from the Forensic Pathology Unit of the Home Office at pathology@homeoffice.gov.uk.

Taking samples

Lawful seizure at the scene

It is essential that no samples are taken from the body until there has been consultation between the forensic pathologist, SIO, CSM and other forensic experts. Samples at the scene should normally be taken under section 19 of the Police and Criminal Evidence Act (PACE) 1984.

If the body is not in 'premises' as defined by section 23 of PACE, consideration should be given to taking the samples under common law.

Legal advice regarding powers of seizure from the body must be sought. The proper lawful authority for taking and retaining human tissue material in a post mortem examination is contained in the GOV.UK document written by Paul Ozin of 23 Essex Street Chambers, London. Again, common law powers should be used if PACE does not apply. If any material from the body is to be retained and/or preserved, the coroner must be informed in writing by the pathologist.

Where there is a concern that trace evidence may be shed or contaminated by manipulation of the body into the body bag, it may be advisable to remove some or all of the clothing at the scene. All specimens should be taken using only equipment supplied or approved by the crime scene investigator (CSI). If clothing needs to be cut, only instruments supplied by the CSI should be used. This process should be included in any specific strategy relating to body removal.

Samples

Samples from the following areas should be considered:

- Tapings or adhesive tape lifts from exposed body surfaces, uppermost surfaces of clothing, and known or suspected contact areas.

- Combings of head, facial and pubic hair.
- Plucked hairs from the above areas (additional hair samples may be needed if there is objective evidence of chronic drug use).
- Swabs from the mouth, teeth, genitalia, and any injured or moist surface areas of the body, specifically bite marks.
- Tapings from the hands where any foreign material is recognised.
- Scrapings from underneath the fingernails of each hand, or fingernail cuttings.
- Washing of nasal passages for pollen deposits (in consultation with a forensic botanist).
- Any other samples appropriate to the circumstances of the case.

Where the death may be related to firearms or explosives, samples must be taken from hair and hands using only the appropriate, specific sampling kits approved by the relevant forensic service provider.

If the forensic pathologist cannot attend or is delayed and it is agreed that removal of the body is essential (for example, because of the location or adverse weather conditions), the SIO should consult with the CSM to determine the most appropriate course of action. Where a forensic pathologist has not attended a scene, photographs, video recordings and other imaging techniques will be useful in the forensic pathologist's subsequent briefing.

In all cases where the victim is not dead at the scene and taken to hospital, consented pre-transfusion blood should be taken for analysis of alcohol/drugs (police powers do not provide for the taking of blood). Drug/alcohol traces in the blood will degrade over time, therefore it is important that blood is obtained at the earliest opportunity. If the victim subsequently dies, post mortem samples are likely to be less evidentially valuable. Pre-transfusion blood should also be obtained from any suspects taken to hospital. Reliance on hospital analysis of blood should be avoided unless absolutely necessary, due to the following reasons:

- Hospital laboratories tend to test for a 'panel' of drugs which are relevant for the medical treatment of the 'patient'. That panel will not necessarily include the drugs potentially relevant to a criminal investigation.
- Most hospital laboratories do not adhere to the processes and standards required by the criminal justice system.

Removal of the body

Once the scene has been assessed and the removal of the body is approved by the SIO and authorised by the coroner, the CSM (with assistance from the forensic pathologist if

appropriate), will usually supervise the removal. If trace evidence has not been collected at the scene, bags may be placed over the deceased's hands before the body is removed. If the head is bagged, it is important to remember that any open wound is likely to shed blood into the bag during transit. This may obscure details such as the direction of dried bloodstains and make it difficult to collect trace evidence. Therefore, it is advisable to examine the head for such material at the scene where possible, and to photograph it before bagging. Care must be taken to secure the bags, so that additional marks are not made which may mistakenly indicate the use of ligatures.

The CSM has the delegated responsibility of the SIO for ensuring continuity of the body. The CSM must designate an officer to accompany the body from the crime scene to the mortuary, and to identify the body to the forensic pathologist.

On arrival at the mortuary, the body should remain undisturbed. It should remain in its wrapping or body bag until the forensic pathologist arrives to undertake the examination. This is to maintain the integrity and continuity of the body. It is also important that the body is not placed in a refrigerator if the body temperature needs to be taken to assist with the estimation of the time since death (post mortem interval).

Victim identification

Visual identification

The identity of the victim is usually known and can be positively confirmed by a relative or friend at an arranged time. Identification should usually be made by two people, independently, to provide corroboration. Viewing before a post mortem examination should be considered by the SIO on a case-by-case basis but should normally be avoided unless there is an important investigative need. This reduces the possibility of contamination or destruction of trace evidence and assists the timeliness of the post mortem examination. Viewing the body is facilitated by the family liaison officer (FLO) in consultation with the coroner's officer.

Where the identity of a victim is unknown, it is vitally important to discover this as soon as possible. On some occasions, the body may be mutilated or have been concealed for such a time that post mortem changes make visual identification impossible. The detailed examination of the body for evidence of identity is a specialised task for the forensic pathologist and other experts (e.g., odontologists, entomologists, anthropologists).

It is worthwhile considering four key principles, which Lord Justice Clarke (Marchioness Disaster) believed should be kept in mind throughout the identification process:

- The provision of honest and as far as possible accurate information at all times, at every stage;
- Respect for the deceased and the bereaved;
- A sympathetic and caring approach throughout; and
- The avoidance of mistaken identity.

Primary methods

The following primary methods may assist in identifying the victim where the body is decomposed, dismembered or otherwise unsuitable for visual identification:

- Odontology;
- Fingerprints; and
- DNA.

Secondary methods

In addition, secondary identification methods can be used:

- Unique medical identifier – serial number of an implant;
- Marks;
- Scars;
- Tattoos;
- Medical records;
- Medical images, such as X-ray, CT scan;
- Unique identifiable jewellery;
- Personal effects;
- Distinctive or unique clothing; and
- Physical disease, amputations, etc.

Assistance only methods

These include:

- Jewellery;
- Clothing;
- Location;
- Description;
- Visual appearance of the deceased; and
- Items found on the body (such as driving licence and credit cards etc.).

For further advice, see the College of Policing website for Civil Contingencies Disaster Victim Identification within the Authorised Professional Practice (APP) 'Recovering and identifying the deceased and human remains'.

Databases

There are several databases which may be used to help identify a body:

- the National DNA Database ® (NDNAD);
- National fingerprint database (Ident1);
- Vulnerable persons database (VRS); and,
- Missing person DNA database (MPDD).

Mass fatalities

In cases of unidentified bodies and mass fatalities, the SIO should ensure the pink Interpol Disaster Victim Identification form is completed in consultation with the designated force SIM. The designated force SIM should also use the Interpol processes for circulating details of unidentified bodies, if applicable.

See Civil Contingencies Disaster Victim Identification (Authorised Professional Practice) for advice on the recovery of multiple bodies and body parts from scenes, including, if deployed, the role of the SIM.

Bodies/body parts washed up on beaches

For investigations relating to bodies or body parts washed up along the coastline, consideration should be given to the possibility that such remains may have come from one of several sea burial grounds, sited on the UK's coastal areas (currently there are three: off the Needles at the Isle of Wight, Coast of Sussex and Northumbrian Coast), although only the Isle of Wight site is currently active. In these cases, it is recommended that early contact is made with the National Crime Agency's (NCA) Missing Persons Unit (MPU). The Marine Management Organisation (MMO) issues licences for sea burials and may be able to provide assistance. From October 2023, all sea burials off the Needles (Isle of Wight) require a DNA sample being loaded on the National Missing Persons database which can facilitate early identification of body parts washed ashore. This provision does not currently apply to other sea burial sites, but if in the future, body parts are washed up on shores in other burial sites, such instances should be reported to the National Missing Persons Unit and the Home Office Forensic Pathology Unit.

Forensic anthropology

When skeletal remains are found, information can usually be provided concerning:

- Whether the remains are bones;
- Whether the bones are human;
- Sex;

- Age;
- Height of the person; and
- Ethnic origin.

Family liaison

In all instances the SIO should ensure the victim's family is kept informed of developments in the investigation, including the outcomes of the pathology investigation, and given appropriate support. It is also important to ensure that the FLO updates the coroner's officer particularly at a point where FLO involvement may cease and continued contact with a family will be via a coroner's officer.

In general terms, it is important to ensure that FLO's and other officers engaged in an investigation remain in contact with the relevant coroner's office on the matters discussed below.

Family Liaison Officers undergo specialist training through the College of Policing Learning Standards, but the Independent Review of Forensic Pathology has recommended some amendments following interviews with Hillsborough families and families of the Manchester Arena bombing. Authorised professional practice on Family liaison is available on the College of Policing website. This is underpinned by a professional profile for the Family Liaison Officer and Family Liaison Coordinator

The Independent Review of Forensic Pathology following the Hillsborough disaster can be viewed at https://www.gov.uk/government/publications/independent-review-of-forensic-pathology.

Information the family should be informed about

A particular issue raised by some of the Hillsborough families was the definition of 'family' in terms of engagement. Family can sometimes be a complicated mix of present and past relationships and including some people as 'family' can cause inter-familial disputes. Other than the normal definition of 'family', the SIO/SIM and FLO should consider the individual circumstances within families as part of their engagement strategy. Decision making and engagement should be based upon the unique circumstances in each case.

The Human Tissue Authority (HTA) has published guidance on the 'hierarchy' of family members as follows:

1. Spouse or partner (including civil or same sex partner);
2. Parent or child (in this context a 'child' can be any age);
3. Brother or sister;
4. Grandparent or grandchild;
5. Niece or nephew;
6. Stepfather or stepmother;

7. Half-brother or half-sister; and
8. Friend of long standing.

(see https://www.hta.gov.uk/guidance-professionals/guidance-sector/post-mortem/qualifying-relationships).

Guidance in the Family Liaison APP describes the family as follows:

> 'family' includes partners, parents, siblings, children, guardians and others who may not be related, but who have a direct and close relationship with the victim (can include step relatives).
>
> The SIO and FLO should also consider deployment to any person who had regular and/or intimate contact with the deceased and who can provide the most recent and relevant information to assist the investigation.

This definition is useful; however, the SIO/SIM/FLO should be sensitive to particular issues within families, and it will be a matter for considered judgment to decide who else should be considered as 'family' according to the individual circumstances of each case, which may mean a wider consideration than the HTA hierarchy above.

If the FLO determines a person to be a family member, this should be communicated to the coroner's officer in order to consider whether that person is an 'Interested Person' for the purpose of an inquest.

Section 47 (2) Coroners and Justice Act 2009 lists the people who may qualify as 'Interested Persons' for the purpose of a coronial investigation.

One of the issues raised by some families of the Hillsborough disaster and the Manchester Arena bombing was that they stated they were not informed of the fact there would be a post mortem examination of their loved ones, the reason why a post mortem examination was necessary, and also their right to have representation at the examination (Section 13 of the Coroners (Investigations) Regulations 2013).

Some families of both Hillsborough and Manchester only discovered the answer to these questions years after the event. Therefore, SIOs (and in the case of mass fatality events, the SIM) should ensure that FLOs are briefed to include this information in the early stages of engagement with families. The briefing of families by the FLO should also briefly explain the basics of what will happen at the post mortem if they are asked, and only at an appropriate time, bearing in mind that the death of a loved one will be raw and they may not fully take in what is being explained to them. However, this will need to be carefully balanced alongside the need for the post mortem examination to take place as soon as possible in line with the SIO/SIM requirements.

It is also important for families to be informed about what will happen to their loved one after the post mortem examination has taken place.

The FLO might be asked by the family about registration of the death, The Coroners Officer will be better placed to do this as registration in a homicide case or where there will be an inquest will be done by the coroner's office. Guidance on registering a death can be found at the GOV.UK website at: What to do after someone dies: Register the death - GOV.UK.

The FLO should explain, at an appropriate time that dependent upon the findings at a post mortem examination and other evidence gathered, the police may consider the criminal investigation will not proceed and the case will revert to being solely a coronial investigation. At all times, it will be for the FLO in discussion with the SIO/SIM to make a judgement as to the appropriate time to communicate this information to the family.

If the family member is asked to identify the deceased, this should be done in a respectful manner whereby the preservation of scientific or medical evidence is paramount, but if these issues are not relevant, they are allowed to do the following:

- Bring to the deceased any item or clothing they which they perceive their loved one would have wished them to bring.
- Be allowed to have physical contact with their loved one if this will not compromise evidential opportunities.

Nothing should be said to the family member which states or implies that the body is the 'property of the coroner' or is a 'crime scene'. If it is necessary to restrict access to the body for investigative reasons, this should be explained to family members, but that they can have access to the body when investigative processes have been completed.

After the post mortem examination has concluded, and after consultation with the SIO/SIM and HM Coroner, the family should be notified of:

- the outcome of the post mortem examination (if this will not compromise the investigation),
- the result of the post mortem examination (if this will not compromise the investigation), and,
- what will happen to the body after the post mortem, and the possible arrangements of a second or defence post mortem examination by the defence (see Chief Coroner's Guidance number 32).

This might be the appropriate time for the FLO to speak with the family concerning their wishes in relation to retained human tissue from the post mortem examination.

Retention of human tissue

All police forces in England and Wales have accepted a national policy for dealing with human tissue. The national template for this policy can be found at https://www.gov.uk/government/publications/proposed-human-tissue-policy-for-police-forces.

Families should, at an appropriate time, be told that human tissue samples will probably be taken from their loved one during post mortem. The reasons for this should be explained sensitively. Families should also be told options are available when forensic examination has concluded, and the tissue samples are no longer required for a criminal justice purpose.

Family members should only be asked to consider issues about retention of human tissue once they have had an opportunity to fully understand what is expected of them. The experience of Hillsborough and some Manchester families was that conversations about retention of human tissue were not dealt with well. Although Hillsborough was before current policies were developed, some Manchester Arena families were upset because they were asked for their wishes about human tissue disposal before they were able to take in the information and make an informed decision. Some said that they were asked for their view at the same time they were informed about their loved one's death. This was wholly inappropriate, and they could not give the question proper consideration.

FLO's should ensure that the coroner's office is aware that these conversations have taken place.

Images taken at the post mortem examination

Families should be informed that it may be necessary for photographic imagery, including CT or MRI scanning to be taken. The reasons should be explained which include:

- Making a permanent record of what was found during the post mortem examination;
- Recording injuries and marks on the body for evidential purposes;
- Presenting evidence of injuries and marks to any subsequent criminal, civil, coronial or public inquiry purpose; and
- Allowing the defence, or any other relevant person or body to re-examine the evidence in the case should that be required.

Occasionally family members may ask to see post mortem images of the deceased, either at the scene of the death, or of the post mortem examination. This happened with some of the Hillsborough families who were offered this opportunity after all prosecutions were concluded.

Such requests should be dealt with very sensitively and carefully. Images may be traumatic for the family to view, and once seen, can never be ‘un-seen’. The welfare of the family member should be central in any decision to allow viewing.

There should be a clear process for the FLO or inquiry team when dealing with such requests.

- The police should never pro-actively ask if family members wish to see the images, even though family members should be told that images of the scene and the post mortem examination exist.
- If a family member does ask to see the images, they should be fully prepared for what they may see and warned about the potential distress this may cause. This may be the last image they see of their loved one. A description of what each image depicts should be provided to family members.
- If the family member(s) insist that they would still like to see the images, accepting the warning and information provided; a cooling off period, for example, 48-hours is recommended. They should be encouraged to speak to family and friends to discuss whether viewing would be appropriate, and the potential impact viewing may have.
- If the family member(s) still wants to view the images, they should be offered the opportunity to have the images redacted with the most distressing parts of the images pixelated or otherwise obscured.
- It is suggested only one family member is initially shown the images. That family member can then advise other family members about what they have seen and potentially limit the negative impact on other family members.
- If the family member(s) still wish to view either the redacted or un-redacted images, they should sign a disclaimer which confirms that they have been fully informed of the content of such imagery, but that they nevertheless do want to view the images. SIOs should consider what support is required to the family member in such circumstances.
- The coroner’s officer should also be informed that family members have viewed the imagery in case there is a subsequent inquest.

Identification and viewing of the deceased

Making arrangements for the family to view or identify the deceased should be carefully planned with respect and sensitivity. The experience of Hillsborough families is that this process can have a significant positive or negative impact on the families.

The Hillsborough families were distressed to be asked to identify bodies in the gymnasium at Hillsborough football ground, after first viewing photographic images displayed on a display board. Bodies were then presented to the families on trollies, and their faces revealed from body bags. Family members were not permitted to approach or touch their

loved ones and told that the body was the 'property of the coroner'. This is not acceptable and must never happen again. The distress this caused to the Hillsborough families has lived long within their memories.

Although the FLO will be constrained by the facilities available and mortuary policies, they should as far as possible, work with the mortuary staff to ensure that the viewing is carried out sensitively and with dignity for the deceased and their family. For example, where possible, consider whether the deceased can be moved to a private space either within a temporary mortuary or a local mortuary to avoid the viewing taking place where other bodies may be present, or where support mechanisms are available. In some circumstances, this may be unavoidable, but the FLO should always consider the best place for the family to view the body. At the Manchester Arena bombing, bodies were transferred to local mortuaries for this purpose.

There may be forensic reasons why is necessary to limit physical contact with the deceased, for example, contamination and potential destruction of evidence. In these cases, the reason for refusing physical contact should be fully explained and an undertaking offered to allow such contact when evidence has been retrieved. The FLO, in consultation with mortuary staff should facilitate contact and provide the family the opportunity to spend time with the deceased wherever possible.

Any person who views a deceased should be suitably warned if there are injuries to the neck and head, which may have been caused either at the post mortem examination or during life.

Issues of contamination in mass fatality incidents may be less relevant, but the SIO in consultation with the crime scene manager and forensic pathologist should make a decision based on the individual circumstances of each case.

Non-suspicious death cases reverting to the coroner

Historically, about two thirds of suspected suspicious deaths which are subject to a forensic post mortem examination transpire not to be a homicide. These cases are returned to the jurisdiction of the coroner for further investigation. The FLO should be able to explain to the family why the police will take no further role in the death investigation.

Conclusion of the post mortem examination

At the conclusion of the post mortem examination, and when the forensic pathologist is able to give a view on the cause of death, the family should be briefed after consultation with the coroner's office. This should include the following:

- What was done during the post mortem examination.
- The outcome of the post mortem examination.

- The potential for a second or defence post mortem examination, and what this will involve (either a desk top review or a full second post mortem process).

- In appropriate cases where the family so request (particularly in mass fatality incidents), consideration should be given to facilitate a meeting (either virtually or in person) between the family and the forensic pathologist, who will be in a position to explain any aspects the family wishes to discuss or to answer any questions the FLO was unable to answer. A meeting should be arranged in consultation with and supported by the SIO. All forensic pathologists interviewed as part of the Independent Hillsborough Pathology Review expressed a willingness to take part in such a process. A record of what was discussed should be prepared for disclosure purposes if criminal proceedings subsequently take place, Although the coroner does not have to be consulted in this process, the coroner should be appraised that this has taken place, and details of what was discussed communicated to the coroner in case this becomes relevant in any subsequent inquest.

- If the family member does not wish to meet with the forensic pathologist but want help with complex medical terminology in the forensic pathologist's report, they can seek advice from another medical expert, such as their GP, or the coroner's office.

The FLO in consultation with the coroner's officer, should explain the arrangements for the repatriation of the body to the family once the coroner has authorised this. The Chief Coroner's guidance number 32 advises this should be done within 28 days of the death. However, the family should be warned that this may not always be possible due to other evidential reasons, or the requirement for a second or defence post mortem examination.

Time and cause of death

Evidence of the time of death based on factual evidence, such as when the victim was last seen or when they were found dead, tends to be more accurate than that based on the condition of the body and the immediate environment. However, temperature readings may be more reliable for estimating time since death in the early post-mortem interval stage. There should be a clear requirement for attending officers to take and record ambient temperature in circumstances where they find a body indoors and consider the room to seem excessively hot or cold (hypothermia can be very difficult to establish on post mortem examination). Further guidance can be found under the title 'The Use of Time of Death Estimates Based on Heat Loss From the Body'.

It is important that the SIO obtains from the forensic pathologist, an indication of the time period in which the death occurred. A forensic pathologist is more likely to provide a range of estimated times. Even an approximate time of death can be invaluable in narrowing the investigation and evaluation parameters or informing suspect and witness interview strategies.

Uncollected mail and newspapers may assist in estimating the time and date of death. The condition of the environment, the presence of food and dirty dishes, as well as cell site information and data communications from mobile phones, computers and other devices (such as CCTV recording used to establish prior movements) can also be useful indicators. Consideration should be given to developing and using timelines to assist in determination.

Forensic analysis of alcohol levels, which can be provided by the police force's forensic provider, may also be useful. Blood alcohol levels may assist either solely or in combination with other methods in providing a time of death estimate in the early post mortem interval phase. Alcohol back-calculations in road traffic collision cases are well established and based on sound data. Similar conclusions about the time that has elapsed since drinking can be drawn in fatal cases, but certain factors need to be considered that could affect the alcohol levels seen, e.g., if the victim had diabetes, or died of hypothermia or is in the process of decomposition.

Where the contents of a last meal are unusual or have distinctive ingredients which may tie in with a known meal, this can assist in establishing a time of death by confirming sightings from potential witnesses. However, the physiological behaviour of the digestion system varies, and estimating the time of death using stomach contents emptying must be assessed with great caution due to the many variables that could affect the rate of emptying. Stress, as well as a head injury, can slow down or stop the digestion process. Should the SIO require a forensic expert to establish time since death, this should be discussed with the forensic pathologist initially (Swift, B. (2010) Methods of Time Since

Death Estimation within the Early Post-mortem Interval). The Journal of Homicide and Major Incident Investigation, Volume 6, Issue 1 page 97.

The cause and/or manner of death may be a pivotal factor in a homicide investigation. It is, therefore, essential that the SIO fully understands the cause of death identified by the forensic pathologist, and the reasons for coming to this conclusion. The SIO must be prepared to draw on material generated by the investigative team to assist or challenge the forensic pathologist's conclusions.

The cause of death should be included in the forensic pathologist's report and explained in both plain English and in medical terms.

The post mortem examination

The purpose of the post mortem examination is to establish the identity of the body; the cause of death; the extent and nature of the victim's injuries and the presence of any natural disease; to collect evidence and to make a factual record of the findings relevant to the circumstances of the death. Furthermore, the forensic pathologist may offer an opinion concerning what may have happened at the scene, and when and how death might have occurred.

The mortuary used for a forensic post mortem examination will be determined by the coroner who authorises the post mortem examination and must be licensed by the Human Tissue Authority. The forensic pathologist must record full details of the post mortem examination and document the processes they have adopted. These records are disclosable to another forensic pathologist who may be appointed by the coroner to conduct a second or defence post mortem examination.

Religious and other considerations

There may be a natural resistance from some communities regarding a post mortem examination. This could be based on cultural or religious beliefs that the body should be left intact following death. The SIO should respond sensitively to these matters and bring them to the attention of the coroner. Further information on this is available from the Equality and Human Rights Commission.

Attendance at post mortem examinations

Regulation 13 of The Coroners (Investigations) Regulations, 2013 also provides for the police to attend the post mortem examination. In addition to the professional resources outlined in the 'Key roles' section, the SIO and the coroner will also need to consider if any additional persons should attend. However, it should be noted that this is for the coroner to authorise under Regulation 13.

The coroner has the discretion to allow others to attend under Regulation 13. It should also be noted that a suitably qualified medical practitioner may be nominated by the deceased's next of kin, or personal representative to represent them at the post mortem examination, also under Regulation 13.

There may be occasions when the coroner, in accordance with the provisions of Regulation 13 (3) and (4), consents to persons other than those involved in the police investigation to be 'represented' at the post mortem examination by a medical practitioner, or if the person is a medical practitioner, to attend the post mortem examination in person.

Although there is no definition of what 'represented' means, in practical terms, it is suggested that on most occasions, it would be sufficient for the representative to view proceedings from a suitable viewing gallery or area within the post mortem room. This will allow the forensic pathologist, the assisting police staff, and other specialists to conduct the post mortem examination in a non-crowded environment. Likewise, this will help minimise health and safety and biohazard risks inherently associated with being present at a post mortem examination and prevent any potential compromise to the police investigation.

In situations where it is known that 'representatives', other than those involved in the police examination, will be attending the post mortem examination, it may be useful to discuss with the forensic pathologist and coroner beforehand the reason for their attendance, and where they are expected to view the proceedings. The 'representative' can then be suitably briefed on this before the post mortem examination commences.

Although the personnel attending a post mortem examination will vary depending on the nature of the case being investigated, they will typically consist of:

- The forensic pathologist;
- SIO or deputy;
- Anatomical pathology technologist/technician (APT);
- CSM;
- Crime scene investigation personnel;
- Police photographer;
- Exhibits officer; and
- Other forensic experts.

The SIO should consider whether or not they ought to attend the post mortem examination in person but should always appoint a senior member of the management team to attend if they are unable to attend or decide not to. This will ensure that the SIO is always directly involved if there are interpretational issues or findings that could significantly alter the course of the investigation.

In some cases, the SIO may wish to send their deputy, who must be comprehensively briefed regarding their role and the evidential issues. The SIO or their nominee should attend at the start and the end of the post mortem examination in order to be briefed by the forensic pathologist.

An exhibits officer will be required to record details of all exhibits retained, including human tissue.

Health and safety

There may be occasions when a deceased person being examined is known or suspected to be infected with disease, which would represent a serious risk to the health and safety of those present at the examination. The Health and Safety Executive provides information on Managing infection risks when handling the deceased. Such infections include the viral haemorrhagic fevers (e.g., Ebola, Lassa fever) and also smallpox. A detailed list of dangerous pathogens and other agents is provided by the Health and Safety Executive.

In such cases, the SIO should be guided by the forensic pathologist regarding any special precautions that should be taken. However, as a general rule, it is recommended that post mortem examinations where serious infections (e.g., viral haemorrhagic fevers) are present should not take place unless a) it is essential and b) the risk of infection or contamination can be appropriately controlled.

Lawful seizure at a post mortem examination

In the police investigation of suspicious death cases, as with all criminal investigations, it is essential that the appropriate lawful power of seizure is used. This is to enable continued lawful retention of evidence by the police and to bring it under the purview of such legislation as the Criminal Procedure and Investigations Act 1996 (CPIA) for disclosure purposes.

The main sources of law relating to powers of seizure at a post mortem examination by police are provided under section 19 of PACE, or less frequently used common law powers, used to seize evidence relative to the investigation of crime. In rare cases it may be necessary to use a section 8 PACE warrant (see 'Samples' under 'The post mortem examination').

As section 19 of PACE can only be used when a constable is lawfully on premises, seizure of items when not on premises can be made using common law powers. Consequently, a 'constable' must be present at the post mortem for Section 19 PACE powers to exist.

Material taken by the forensic pathologist at a post mortem examination on behalf of the coroner (although there are no clear coronial powers stated in legislation, the Ministry of Justice view is that coroners' powers of seizure at post-mortem are 'inferred') may subsequently be seized under police powers if required and the conditions set by PACE are met.

Human tissue seized under police powers can be lawfully retained under section 22 of PACE or common law and will automatically engage police obligations of retention and disclosure to the CPIA (see 'Retention of material after post mortem examination').

In summary, it is imperative that PACE is used to seize all exhibits from the deceased at the scene (if on premises) and at the post mortem examination. If the deceased is not in

premises, common law police powers should be used (see 'Samples' under 'The post mortem examination').

The coroner must be kept informed in writing when material is taken from the body during a post mortem examination as there will often be sensitive discussions between families and coroner's officers on this subject.

For further information on the powers of seizure and retention of material at post mortem examinations see Forensic Science Regulator's (archived document) guidance – 'Legal Issues in Forensic Pathology and Tissue Retention'.

Samples

Based on the initial crime scene assessment and available information, and following discussion with the forensic pathologist and CSM, the SIO determines the exact sampling requirements for the investigation. Samples may include:

- Anal, vaginal, oral, penile, and in special circumstances, nasal swabs;
- Fingernail cuttings;
- Head and pubic hair (toxicology/trace evidence);
- Blood and urine (toxicology);
- Stomach contents (toxicology/time of death);
- Sample of blood taken at the time of admission to hospital;
- Swabbing of exposed fractures for foreign debris, e.g., head fractures;
- Tissue sections for histology;
- Bile (in special circumstances);
- Ocular fluid (toxicology, and in special circumstances, time of death); and
- Liver, lung, brain, fat tissue (in special circumstances).

Recording retained material

A single list of all material retained at the post mortem examination, regardless of under which authority it is taken (i.e., police or coronial), should be produced and provided to the SIO, forensic pathologist and the coroner. This list must be updated if material is returned to the body or next of kin, sent for further examination or returned to the coroner. The list must form a comprehensive history of the material, which is auditable and from which the origin of the material can be ascertained. This includes material taken at any subsequent post mortem examinations.

If the forensic pathologist indicates that an organ is missing from the body, they should consider the possibility that the deceased could have been trafficked for the purpose of organ donation which may have been a contributory factor to the death. Offences of human trafficking or illegal removal from the body contrary to Sections 32 and 33 of the Human Tissue Act 2004 should also be considered.

Recording the post mortem examination

The forensic pathologist, in consultation with the SIO and other experts, must make a record of all injuries and assess their significance. A trained photographer should be used at the direction of the forensic pathologist, SIO and CSM.

Visual images, including video (especially of a specific process) can be useful in facilitating the review of a post mortem examination. In particular, they can:

- Create as near a complete record of the processes as possible;
- Provide a visual record of the body in its original state;
- Assist the process of a second post mortem examination;
- Assist the SIO and the investigation team in understanding crucial elements of the post mortem examination in specific cases; and
- Record the removal of ligatures and other devices from the body, where possible. Such a visual recording might also assist in a virtual reconstruction, where deemed appropriate.

The body should be photographed while fully clothed and particular attention should be paid to injuries and damage to the clothing. Care must be taken when removing clothing from the victim, as valuable evidence may be altered or destroyed. Undressing the body should only take place in the presence of the forensic pathologist. All clothing should be fully searched, and any items found should be photographed and properly exhibited.

When visual images are taken, it is essential to obtain detailed images of external and internal injuries with and without a scale, in a logical order with a covering index.

The following general principles apply to post mortem photography:

- Photographs at the post mortem examination should be taken under the direction of the forensic pathologist, SIO and CSM.
- All individual/groups of injuries should be photographed with and without a scale.
- Where possible, photographs should be taken at an angle of 90 degrees (directly above) to the injury or group of injuries.

- In addition to directed photos, the SIO may request more specific photographs.
- Where the identity of the victim is unknown, photograph the victim's clothing, tattoos, marks, and unusual scars. Care must be taken when photographing clothing in the mortuary because of the dangers of contamination. Clothing can always be described in detail at the post mortem examination and photographed after the conclusion.
- Copies of any photographs taken should be made available to the coroner.

External examination of the body may reveal surface fragments of material, such as flakes of paint, glass fragments, fibre, blood, semen, other bodily fluids or hairs embedded in wounds. Foreign material may also be present under the fingernails and may include hairs, fibres, skin fragments and blood from the possible suspect. It is essential that these items are correctly photographed, recorded, seized, packaged, labelled, and retained.

Body maps may be used to record the position of injuries, marks, scars, and any other distinguishing features. It is important that only one set of contemporaneous notes (with or without diagrams) is taken and produced by the forensic pathologist.

Consideration should also be given to using specialist photography and alternative high intensity light sources to enhance specific injuries (seek advice from the CSM or CSI). If there are a number of bruises or other injuries, it is good practice that the forensic pathologist gives each of these an identifying number when photographed for ease of reference. All photographs, notes and diagrams (such as body maps) made at the post mortem examination, including any photographs taken by the forensic pathologist, may be disclosable under the CPIA 1996 and the Criminal Procedure Rules, Part 19.

Exhibits

Where a weapon is found impaled in the body, the SIO, forensic pathologist and CSM will need to assess the risks involved in removing the weapon at the scene before the body is transferred to the mortuary or leaving it in situ for removal during the post mortem examination. The SIO should consider the potential risks of taking recovered weapon exhibits to the mortuary to avoid contamination issues.

Exhibits must be properly packaged to avoid injury and contamination to those handling the exhibit and to ensure continuity, but should also, where possible, be clearly visible. A packaged knife must allow the width and length to be measured. A photograph taken of the weapon in situ (with and without scales) must be taken. This photograph should be available for viewing by the forensic pathologist before commencing any post mortem examination.

Other material may be of mutual interest to the forensic pathologist and the investigative team. It should, therefore, be preserved either at the crime scene or during the post mortem examination. Examples of such articles include:

- Ballistic projectiles;
- Extraneous items such as hairs, fibres, blood or semen on the body or clothing;
- Ligatures (do not cut or undo the knot); and
- Needles.

The SIO should ensure the following.

- All items/samples are seized using police powers and exhibited and reviewed after the post mortem examination.
- If items/samples are retained, the reasons must be clearly documented. They may be released to the coroner for the coronial investigation and then reviewed for disposal or seizure or retained for an unsolved criminal investigation and/or disposed of, taking into consideration the next of kin’s wishes. The family should be informed after the conclusion of the investigation or the end of the criminal process in accordance with the CPIA 1996 and force policy.

The post mortem examination report

Initial findings

The SIO, or deputy SIO, should discuss the findings with the forensic pathologist at the time of the post mortem examination. It is essential that the SIO ensures that the forensic pathologist is kept up to date with any investigative developments, even after the report has been provided to the coroner and agreement has been given for it to be supplied to the SIO. If information subsequently revealed by the investigation impacts on the conclusions contained in the post mortem examination report, the forensic pathologist should produce a supplementary report incorporating that information and any revised conclusions.

Content of the report

The post mortem examination report should include the following:

- The information the forensic pathologist received in advance of the post mortem examination.
- Those present during the post mortem examination.
- Confirmation that the data justifying the decisions and actions taken at the examination of the scene and the body have been retained.
- Details of all investigations made either personally or by submission to a laboratory or subspeciality expert for a report.
- Conclusions drawn and an explanation for them. Where unusual features are found but are concluded as irrelevant, the forensic pathologist must explain why the finding has been discounted.
- The reasoning for why a particular explanation is favoured where findings are open to alternative explanations.
- The reasoning that supports the conclusions, detailing all the material drawn on to support that reasoning, including reference to pertinent and current literature.
- All samples that have been retained by the forensic pathologist, whether or not these have been assigned police exhibit references.
- Any other information required under CPS guidance on expert witnesses obligations on disclosure and the Forensic Science Regulator's (archived) 'Expert Report Guidance FSR-G-200'.

Production of the report

When the post mortem examination is complete, the forensic pathologist will produce a written report for the coroner.

The forensic pathologist should be supplied with a record of all the exhibits taken and their relevant exhibit numbers at the completion of the post mortem examination so that an accurate reference can be made to them in the post mortem report.

The forensic pathologist's report shall not be supplied to anyone else, including the SIO, without authorisation from the coroner under Regulation 16 of The Coroners (Investigations) Regulations 2013, Part 3. Once the coroner has agreed, a section 9 Criminal Justice Act 1967 statement will be provided to the police. In practice however, coroners usually consent to the forensic pathologist providing the SIO with a copy of the report.

The report should be produced as soon as possible (subject to receipt of all supporting subspeciality pathology and other medical and scientific reports) within an agreed timescale. Some aspects of the post mortem examination that require further specialist pathological examination, such as examination of the brain/eyes/bones, may take a considerable time to complete and could delay the final report.

When the report is received, the coroner will provide copies to all those having a proper interest, including the SIO and any person who has been charged in connection with the death (and to their legal advisers), although this will be the responsibility of the police and the CPS in relation to disclosure obligations if criminal proceedings are instituted. Any photographs or video recordings taken at an examination will also be made available by the police. The deceased's next of kin should also be advised that the report is available unless the next of kin is thought to be a suspect in the death. See the Forensic Science Regulator's (archived) guidance (2012) Legal Issues in Forensic Pathology and Tissue Retention (NOTE: this document is archived since the Forensic Science Regulator ceased to hold responsibility for forensic pathology, but the principles within this document still apply) and Criminal Practice Directions and the Criminal Procedure Rules 2020.

Rapid interim accounts

In order to utilise the information revealed in other aspects of the post mortem examination, the SIO should ask the forensic pathologist to provide a rapid interim account in writing to the coroner within fourteen days of the post mortem examination, as stated in the 'Code of practice and performance standards for forensic pathology in England, Wales and Northern Ireland'.

The SIO should be aware that the results of any subsequent tests may significantly alter the findings within any interim or preliminary report, and that the conclusions of the final report could differ from earlier ones provided.

Delays

In complex cases, the forensic pathologist should provide the coroner and SIO with a provisional timetable for the production of the final report. When the post mortem examination report is expected to be delayed, the SIO should liaise with the coroner and forensic pathologist. Also, to assist the courts and the CPS with case management (in accordance with the Criminal Procedure Rules 2020), SIOs should ensure that the CPS is informed at the earliest possible opportunity, concerning any anticipated delays in respect of the forensic pathology evidence, using the appropriate MG form.

Interpreting post mortem examination results

The role of the forensic pathologist

The post mortem examination findings represent a vital component of the investigative process, so it is important for the SIO to consider the significance of the findings. The forensic pathologist can contribute to the interpretation of the post mortem examination results by:

- Attending conferences called by the police or the CPS to discuss the post mortem report and/or other issues involved in the case;
- Clearly explaining all the findings and their interpretation in the context of the case;
- Considering alternative explanations, testing alternative hypotheses, drawing conclusions and giving advice based on the facts of the case and established scientific principles;
- Stating what is required before additional conclusions can be drawn, and requesting those requirements are fulfilled before any further opinions are given;
- Identifying, clarifying, and summarising areas of agreement and disagreement; and
- Requesting feedback to determine whether those involved in the investigation understand the outcomes of the consultations.

Issues for consideration

The SIO may wish to explore the following issues:

- Cause of death:
    - Which injury was responsible for death?
    - If there are multiple injuries, which one was the fatal injury?
    - What is the significance of injuries?
    - What degree of force was used?
    - What medical intervention was involved, if any?
- Time of death:

  - This is useful for setting 'Relevant Time' enquiry parameters, e.g., to assist with a period of time to review CCTV footage and communications data etc.
  - It should be noted that the various methods suggested to estimate post mortem interval are vast, and therefore a testament to the inherent inaccuracy of the methodologies used in this area.
  - This data may inform the investigation but should not be used to make final decisions about who may have committed the offence.

- Toxicology:
  - Is there evidence of victim drug abuse?
  - Was the victim drugged or intoxicated?
  - Stomach contents may give evidence of lifestyle or sequence of events.

- Level of attack:
  - This is likely to give an indication of the mode of attack, the degree of force used and over what period.
  - Was the victim capable of 'fight, flight or freeze'?
  - What was the likelihood of the offender being injured?
  - Was there evidence of post mortem violence?

- Injury analysis:
  - What is the number and type of injuries?
  - How were the injuries caused?
  - Is there evidence of defence wounds?
  - What was the timing of injuries in relation to the time of death?
  - Is there evidence of gratuitous violence?
  - Were the injuries caused before or after death?
  - Are the injuries consistent with accounts of witnesses?
  - Is there evidence of bodily contact, e.g., bites and scratches?
  - Consideration should also be given to exploring the support and advice offered by the Forensic Medical Advice Team, accessed via the NCA Major Crime

Investigative Support team. More information can be found on their website: Major Crime Investigative Support - National Crime Agency.

- Body deposition site:
    - Is there evidence that the deposition site was not the murder site?
- Disguise cause:
    - Have attempts been made by the offender to disguise the cause of death?
- Sexual motivation:
    - Is there evidence of sexual interference, such as rape, oral sex, shaving of pubic hair, penile penetration, clothing removal and semen deposits?
    - However, the absence of such evidence does not exclude a sexual element.
- Weapon analysis:
    - What type of weapon was used?
    - How many weapons were used?
    - Is there any correlation with any potential weapons found at the scene?
- Victimology:
    - Are there hate crime considerations?
    - What was the general health of the victim?
    - Is there evidence of other recent assaults?
- Size and physique of the victim.
    - Is there evidence of the victim being restrained before death?
    - Is it likely that the victim could have posed a threat after being injured? The position of defence wounds may assist.
- Similar incidents:
    - Have there been any recent or historic instances?
    - Have intel and command/control checks been done for other similar local instances?

Defence and second post mortem examinations

Second post mortem examinations

The Chief Coroner issued guidance in 2019 (Chief Coroner's Guidance number 32) which superseded Home Office Circular (No.30/1999). Whilst there has been a general decrease in the number of second post mortem examinations carried out, there remains a wide regional variation. The guidance is intended to promote consistency in coronial practice.

While a coroner has legal control over the body of a deceased person, it is for the coroner to decide whether to commission a first or subsequent post mortem examination and it is for the coroner to decide whether to permit a second post mortem examination of the body on the instruction of an interested party. Despite there being a widespread misconception (particularly in homicide cases), there is no automatic right to a second post mortem examination and requests should be scrutinised rigorously by the coroner on a case-by-case basis.

Whenever a post mortem examination is requested on behalf of the defence, as Chief Coroner Guidance 32 sets out, it is a matter for the defence to justify to the coroner, the reasons for the request. This is to limit what used to be a standard acceptance that there would be a second or 'defence' post mortem examination in all cases. The process of a second post mortem examination can be distressing to families which is why the Chief Coroner introduced this guidance. If it is anticipated that there will be an application to the coroner for a second post mortem examination, it may be useful to visually record (by video) the initial post mortem examination if a second post mortem examination will not take place for whatever reason. One option is to perform a 'desk-top review' of a first forensic post mortem examination where it will be sufficient, instead of a second invasive post mortem examination.

If there is no suspect/person charged prior to the body being released, it is a matter for the SIO and coroner to discuss the merits of conducting a second post mortem examination for the defence of any future defendant in the case.

Use of a non-forensic pathologist

Second post mortem examinations may be conducted by a non-forensic pathologist. Such pathologists must adhere to the same standards as a forensic pathologist. Defence solicitors will need to establish, for example, the nature of the wounds and the cause of death. They may also need to examine the first post mortem examination report, photographs and any other relevant issues. Investigators should ensure that this documentation is available, subject to the coroner's prior approval.

Attendance at a second post mortem examination

The original forensic pathologist should, whenever possible, be present to discuss their findings from the first post mortem examination. The SIO (or a representative) and a photographer should also be in attendance.

Samples

On occasions, samples from the body are sent by the forensic pathologist to a forensic pathologist acting for the defence. The forensic pathologist should seek permission from the SIO to do this, and mechanisms should be put in place to ensure that such samples are returned to facilitate disposal in an appropriate manner. Forensic pathologists should also be mindful of the requirement in The Coroners (Investigations) Regulation 2013 Part 3, section 14 (1) to notify the coroner of the material that they preserve, and of provisions in the Human Tissue Act 2004.

There may be occasions when the forensic pathologist acting for the defence wishes to send human tissue for examination to an expert outside of the jurisdiction. However, it should be noted that the export of evidence can give rise to particular problems.

- The material will be outside the control of the police or coroner on whose authority it is held.
- The material is no longer under the control of the courts in this jurisdiction.
- It will be difficult to supervise the actions of those in possession of the material.
- The risk of the material being lost is increased.
- The maintenance of continuity will be more difficult.
- The material will be subject to the laws of the country to which it is exported, and this creates a risk of satellite litigation.

It is therefore recommended that human tissue is not exported outside of the UK jurisdiction of England and Wales, Scotland and Northern Ireland. All human tissue should be accounted for and capable of audit.

Post mortem examination report

Any report prepared for a solicitor acting for a defendant is likely to be a legally privileged document and not available to the police. However coronial practice does vary, and some coroners may choose to disclose the defence report to the police. This practice is to be encouraged, as a difference of opinion between the first and second forensic pathologist can be more speedily resolved, assisting the defence, prosecution, and the coronial inquiry.

The coroner may decide to provide the police with a copy of the report from any second post mortem examination that they request in the absence of any charged suspects, and coroners may request additional post mortem examinations if there are significant differences of opinion between the first and second post mortem examination. The coroner will retain the second report, and if an arrest in connection with the death is subsequently made, they will provide a copy of this to the defendant or their legal representatives.

There are mixed opinions amongst coroners on whether second and subsequent post mortem examination reports should be shared with the police or retained by the coroner and served only on the defence in cases where a defendant has been charged. However, it would seem reasonable that in the event of a conflict between the first post mortem examination and subsequent examinations, the coroner should consider ordering another post mortem examination in the interests of justice and to settle the true cause of death (Dorries, C. P. (2014). Coroners' Courts: a guide to law and practice (Third Edition). Oxford University Press).

Release of the body

Release of the body

Subject to the interests of the criminal justice system, it is the responsibility of all agencies to treat the early release of the body as a priority. Where this cannot be done within 28 days after discovery of the body, the coroner must notify the next of kin or personal representative of the deceased of the reason for the delay, as stated in The Coroners (Investigations) Regulations, Part 5, Regulation 20. It should also be a priority for the SIO and FLO to help the family to cope with their grief.

The SIO in consultation with the coroner should consider the following issues when contemplating the release of a body.

- Whether the identification of the victim is in dispute.
- The evidential value of retaining the body.
- The needs of the investigation.
- The need for a defence or second post mortem examination when the identity of the offender is unknown.

The coroner will not usually release the body unless all those having a proper interest confirm in writing that they have no objection to the body being released. The coroner will then notify their intention to release the body, in writing, to all such persons who have not yet confirmed their interest.

Where the coroner is initially informed that a person may be charged within 28 days of the discovery of the homicide and it subsequently appears unlikely that any person will be charged, the SIO should inform the coroner at the earliest opportunity.

Religious and other considerations

Consideration should be given to cultural and religious beliefs held in certain communities. Some faiths, for example, require that burial should occur within 24 hours and in any case as soon as practicable following death. However, the requirements of the criminal justice system must override family wishes.

Communication with the family

The SIO and the coroner should be proactive in pursuing an early resolution of all post mortem examinations and ensure that the conclusion of the body examination process has

been communicated effectively to the family via the coroner's officer and the FLO in order to allow the funeral to take place as soon as possible.

Families will want to know details of when the deceased will be released for the funeral and subsequent burial/cremation. The FLO should facilitate this request through the coroner's officer after consultation with the SIO. The coroner has lawful control of the body and the decision for release ultimately rests with them, therefore the SIO should ensure that the coroner is consulted and advised about the progress of enquiries.

Families should be asked if they wish to wait to receive the body complete (this could take an extended period of time), or if they would prefer the body (even if not complete) to be returned as soon as possible. However, they should be made aware that some material from the body may be preserved for further examination or evidential reasons for many months or years. For example, if examination of the brain is necessary, it may be more than six weeks before a report is available. In paediatric cases, delays may be even longer.

Retention of material after post mortem examination

Continuity

SIOs should be aware that material taken from the body and seized as part of a criminal investigation (under section 19 of PACE or under common law) is subject to the same level of continuity as any other police exhibit. Because such material may go to specialists and will be out of direct police control, the SIO must ensure that the specialists who handle the exhibit maintain its integrity and continuity.

Notification of preservation of material

The statutory duty to inform the relevant persons about what material has been preserved lies with the coroner as stated in Regulation 15 of The Coroners (Investigations) Regulations 2013. The coroner is also responsible for notifying the chief officer of police or prosecuting authority of any period for which the coroner requires material to be preserved or retained as stated in Regulation 14 of The Coroners (Investigations) Regulations 2013.

Human Tissue Act 2004

Although the Human Tissue Act 2004 does not apply to criminal justice samples (by virtue of section 39 of that Act), the Home Office and the Human Tissue Authority advises that the principles of the Act 2004 and relevant code of practice should be followed.

The SIO must be confident of:

- A lawful power to seize;
- A lawful purpose to examine;
- A clear policy for disposal; and
- The fact that the coroner has been informed in writing of all material preserved.

The SIO should consider whether an image or histological samples are sufficient when deciding whether to retain human tissue during the police investigation, subsequent trial or appeal. Material retained must be kept in secure storage and under suitable conditions. The location of material must be properly recorded, indexed and easily accessible, as stated in FSR-G-203, the Forensic Science Regulator's archived guidance entitled: 'Legal Issues in Forensic pathology and Tissue Retention'.

Criminal Procedure and Investigations Act 1996

The CPIA 1996 states that any material obtained in the course of a criminal investigation, which may be relevant to the investigation, should be retained until the end of criminal proceedings and the risk of any appeals has passed. In general terms, this may be interpreted as the release from detention of a person convicted of homicide. Retention may, however, be required for longer than the CPIA provisions, e.g., a requirement by the Criminal Cases Review Commission.

Human tissue audit

Between 2010 and 2012, the National Policing Improvement Agency (NPIA) oversaw a national audit of human tissue in England, Wales and Northern Ireland. The Report on the Police Human Tissue Audit 2010-2012, by ACPO and the NPIA, made a number of recommendations, which they, along with the Home Office, strongly advise are adopted by forces. These are as follows.

- A debrief should take place at the end of each suspicious death or homicide inquiry to decide on the question of tissue retention. This should involve (as appropriate) the police, coroner and the forensic pathologist and be documented in a recoverable form. This does not need to be a physical meeting, but clear decisions need to be made and recorded in consultation by whatever means concerning the retention and disposal of human tissue.

- In cases where it is determined following post mortem examination that the death is not suspicious and there is no further police investigation, a clear process should be followed between the police and the coroner to ensure material is suitably dealt with.

- It is often the case that where a death is initially considered suspicious, the post mortem examination reveals it is not. When a decision is made not to pursue a criminal investigation, a discussion will be held between the coroner and the SIO regarding the tissue already taken from the body using police powers. In such cases a clear policy needs to be agreed with the coroner on whether the seized material is required for coronial purposes, or whether the tissue can be returned to the body before burial or cremation.

- SIOs must review the retention of material, the samples seized and the continuity of exhibits periodically during the investigation of a suspicious death/homicide, specifically at the stage when the body of the deceased is being released to relatives and at the post-trial debrief. Material should not be disposed of without prior consultation with the coroner who may require material for the purpose of their duties at an inquest and, when appropriate, with the CPS.

- There needs to be close communication between the police, the coroner, the forensic pathologist and the CPS regarding the disposal of material. In consultation with the

coroner, the SIO should review the continued retention of material and samples seized periodically during the investigation and specifically at the post-trial debrief.

- Forces are advised to adopt a policy whereby there are periodical reviews of retained material, as reliance cannot be made on those originally investigating homicide cases due to turnover and retirements of staff. Force review teams should be tasked with implementing this recommendation.

- In relation to the retention and storage of post mortem imagery, it is important from the experience of some Hillsborough disaster families, that they perceived that police officers and staff had ready access to this material, caused much distress. It is important that such imagery is treated with the utmost respect and sensitivity. This imagery will depict deceased persons in a state of nudity, and in a state of evisceration which families will demand restricted access to. Therefore, such imagery should only be retained on secure systems with restricted access with an audit facility showing who and when access was gained to them. There must be a fully auditable system on which these images are retained. Hard copies of images should similarly be kept with restricted access, and a log kept and maintained to record access and the reasons for such access. Advice has been issued to forensic pathologists which may provide guidance to the police in how imagery should be dealt with (guidance not yet published but can be requested from the Forensic Pathology Unit of the Home Office).

- Mortuaries may have internal CCTV systems in operation, which may be operated by private companies. In the case of footballer Emiliano Sala who sadly died in an air crash in 2019, CCTV footage was released by employees of a private company engaged to monitor security in the mortuary at Bournemouth. Checks should be made to ensure that such footage does not cover the area where the post mortem examination is to take place.

- It may be that such imagery of the post mortem examination and scene are required by the coroner for the purposes of the inquest. Whilst outside the scope of this Practice Advice, coroner's officers should consider similar security measures to that described above.

Disposal of material held on the authority of the police

The police investigating homicide cases are sometimes required to retain evidence, including human tissue, for much longer periods than in coroner's cases. An approach must, therefore, be adopted that:

- Allows an effective means of dealing with retained evidence;
- Does not place an undue burden on police resources; and
- Respects, as far as practicable, the wishes of the family of the deceased.

Material may also be held for a considerable period and SIOs must be aware that it may be inappropriate to return the material to the family after such a period.

Following Recommendation 1 of the ACPO (2012) Report on the Police Human Tissue Audit, in order to avoid previous problems (where human tissue has been retained without proper authority or purpose), a formal and documented debrief should take place between the SIO, coroner, forensic pathologist and where relevant, the CPS. This debrief does not have to be a physical meeting but could be a conversation or correspondence in whatever form to ensure that all interested parties agree to the disposal or retention strategy. Decisions made at this debrief stage should be documented in a recoverable form.

It is good practice at the beginning of an investigation into a death to issue a major incident room (MIR) standard (or 'perennial') action to deal with seized tissue at the end of the inquiry. This stands as a reminder, as the tissue could be required for many months or even years.

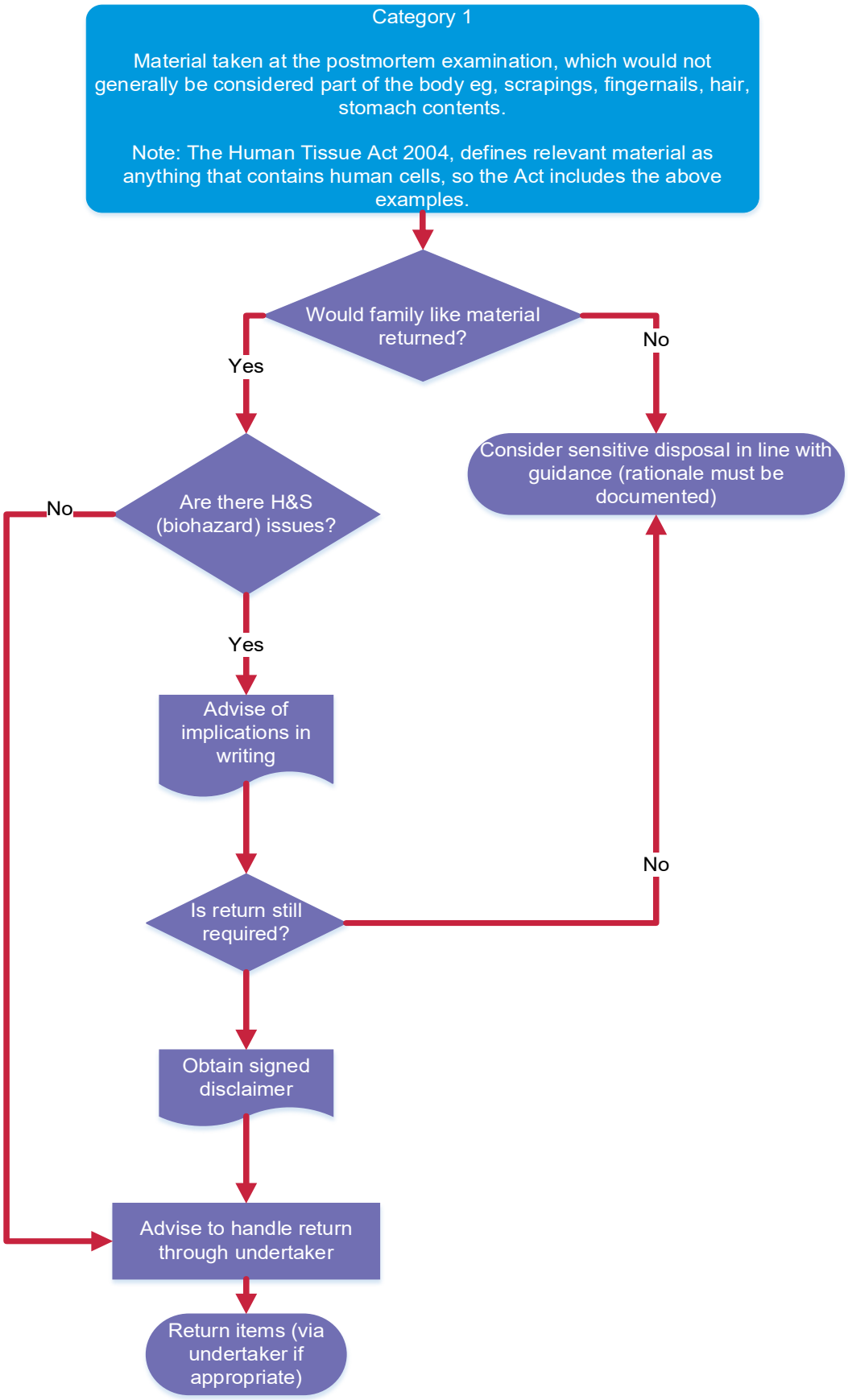
Regarding the disposal of pregnancy remains, which may have been retained in connection with a criminal inquiry, although the seizure will have been made under the relevant provisions of PACE, disposal in these extremely sensitive cases should be conducted following (where possible, and dependant on the circumstances of the case) the spirit of the Human Tissue Authority publication 'Guidance on the disposal of pregnancy remains following pregnancy loss or termination'.

Disposal of human tissue no longer required for a criminal justice purpose

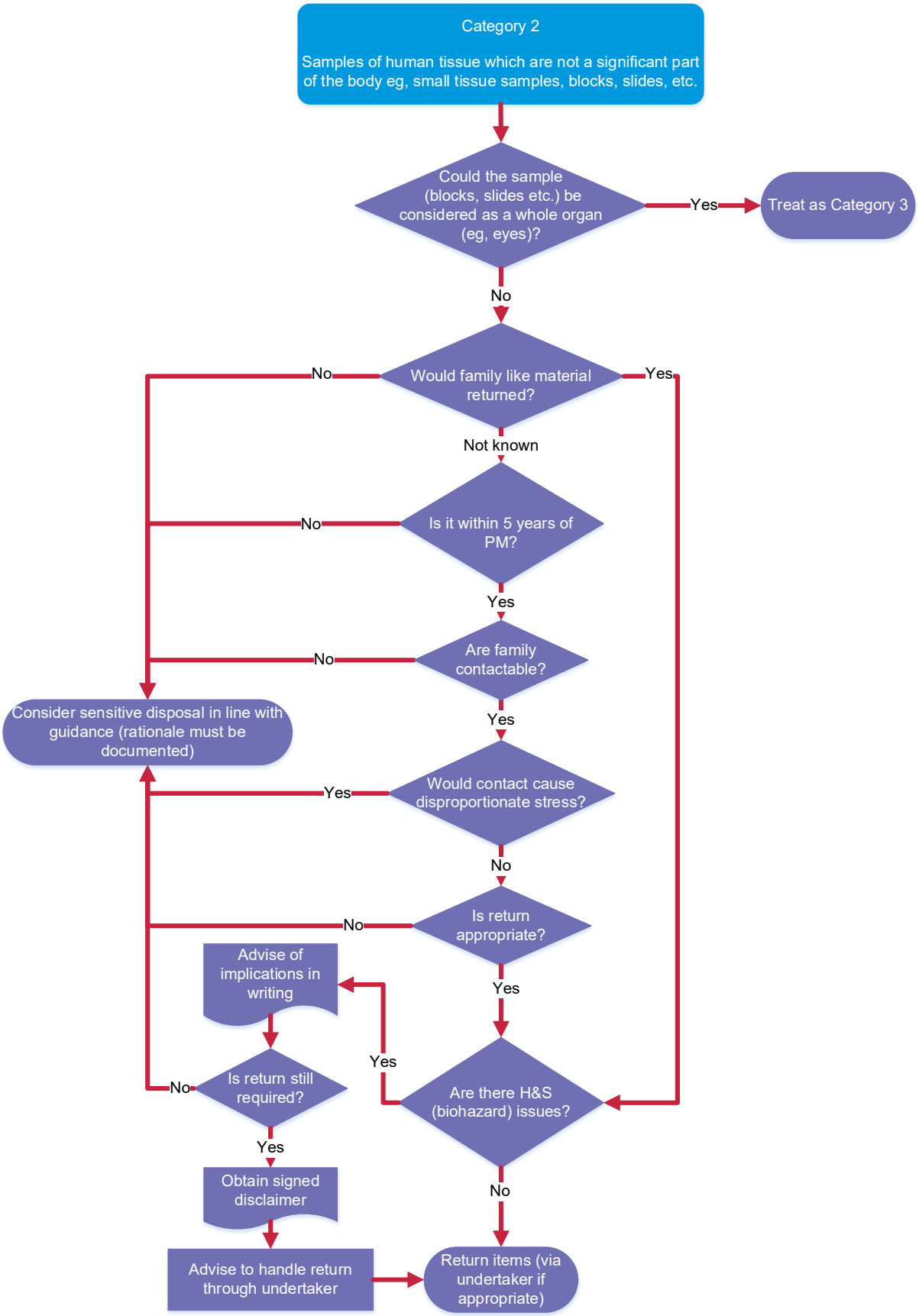
Material held by the police can be divided into three categories as per the aforementioned Forensic Science Regulator's (archived) 2014 guidance 'Legal Issues in Forensic Pathology and Tissue Retention'. How material is disposed of depends on which category it falls into. Each investigation should be considered on a case-by-case basis. The

following flowcharts will, in conjunction with the College of Policing APP National Decision Model, assist in the decision-making process.

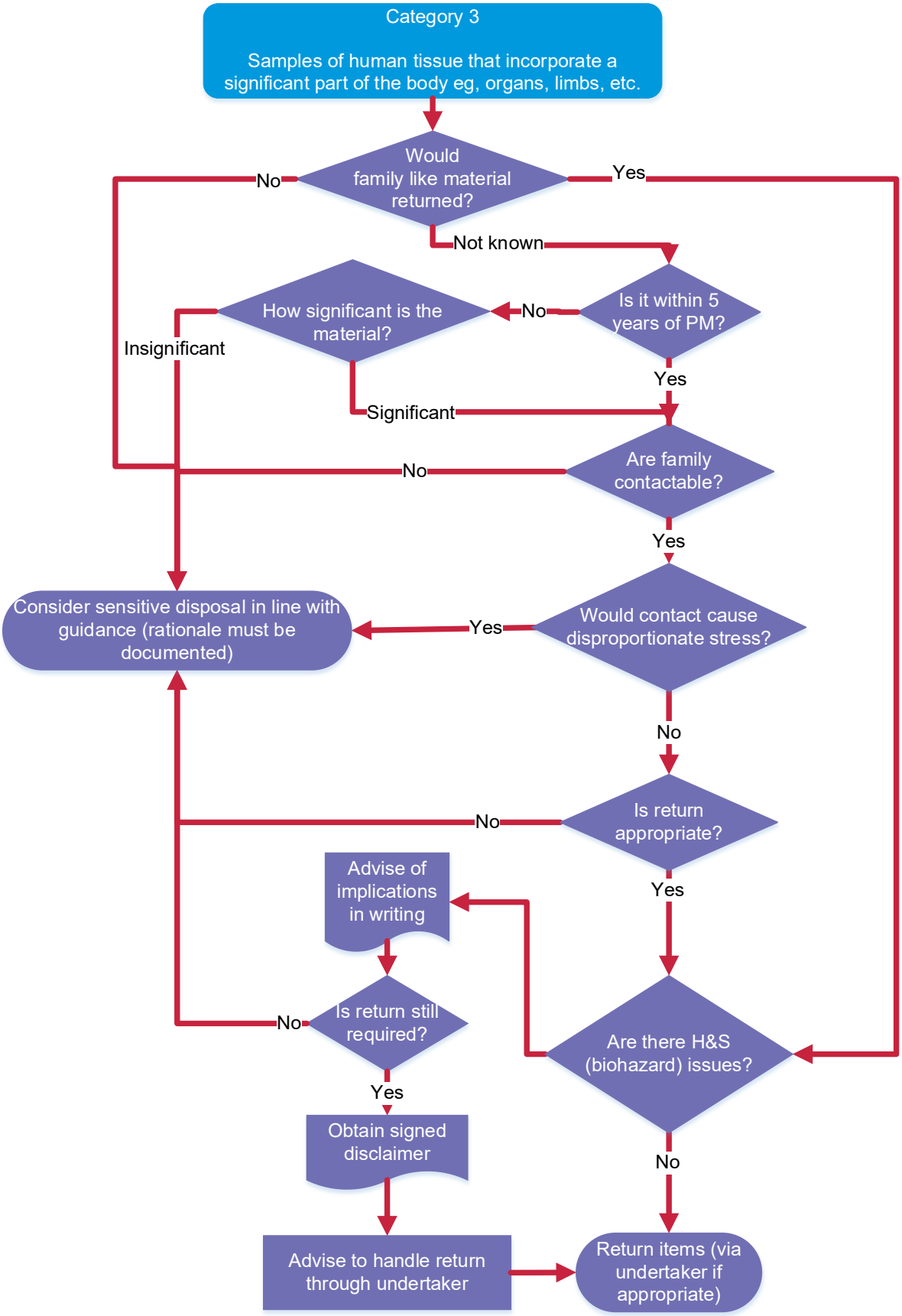
Category 1



Category 2


Category 2
Samples of human tissue which are not a significant part of the body eg, small tissue samples, blocks, slides, etc.
Could the sample (blocks, slides etc.) be considered as a whole organ (eg, eyes)?
Yes
Treat as Category 3
No
Would family like material returned?
No
Yes
Not known
Is it within 5 years of PM?
No
Yes
Are family contactable?
No
Yes
Consider sensitive disposal in line with guidance (rationale must be documented)
Would contact cause disproportionate stress?
Yes
No
Is return appropriate?
No
Yes
Advise of implications in writing
Is return still required?
No
Yes
Yes
Are there H&S (biohazard) issues?
No
Obtain signed disclaimer
Advise to handle return through undertaker
Return items (via undertaker if appropriate)

Category 3


Category 3
Samples of human tissue that incorporate a significant part of the body eg, organs, limbs, etc.
Would family like material returned?
No
Yes
Not known
Is it within 5 years of PM?
No
How significant is the material?
Insignificant
Significant
Yes
Are family contactable?
No
Yes
Would contact cause disproportionate stress?
Yes
Consider sensitive disposal in line with guidance (rationale must be documented)
No
Is return appropriate?
No
Yes
Advise of implications in writing
Are there H&S (biohazard) issues?
Is return still required?
No
Yes
Obtain signed disclaimer
No
Advise to handle return through undertaker
Return items (via undertaker if appropriate)

Sensitive disposal

Where material is to be disposed of, this must be done in a sensitive manner, either by incineration or cremation.

Incineration

Incineration facilities can be provided by the local hospital which will incinerate material in a dignified and appropriate manner. The coroner's officer or hospital trust will be able to advise on the process to be followed.

Cremation

Cremation can only take place when regulated by the Cremation (England and Wales) Regulations 2008. The cremation of body parts is only permitted following authorisation by a medical referee at a crematorium.

In order for a medical referee to authorise cremation, an application must have been made using the form Cremation 2, and evidence must be produced that the material was removed for a post mortem examination and is no longer required. Applications are usually made by the next of kin or executor to the deceased, but they can be made by any near relative over the age of 16. If it is not possible to contact the next of kin or any near relatives, the application can be made by any other person as long as the medical referee is satisfied that they are the correct person to make the application.

A funeral director will normally facilitate this process, but it may not be possible to pursue cremation if all the relevant information is not available or the medical referee is not satisfied that there is a suitable applicant.

In line with Forensic Science Regulator's (2014) (archived) guidance, 'Legal Issues in Forensic Pathology and Tissue Retention', paragraph 14.1.13, it is not envisaged that a religious ceremony would occur if the religion were not known, and an inappropriate ceremony would cause more offence than none.

The ashes should be given to the person who applied for the cremation (usually the next of kin, executor for the deceased or a near relative), but if the applicant does not want the ashes, or the cremation was applied for by someone other than the next of kin, the cremation authority can scatter the ashes in a garden of remembrance at the crematorium, in line with Regulation 30, of Cremation (England and Wales) Regulations 2008.

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END OF DOCUMENT

Version Control

This police practice advice is managed by the Home Office Forensic Pathology Unit within the Home Office Science Directorate.

Any suggestions for improvements or comments should be directed to the team at: pathology@homeoffice.gov.uk.

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Version history

Version history

Version number	Date published	Published by	Brief description
Version 3	May 2025	Home Office	Amended in the light of the independent review of Forensic Pathology following the Hillsborough Disaster (2024)
Version 2	February 2024	Home Office	Amended in the light of feedback from the Coroner's Society.
Version 1	03 May 2019	College of Policing	Amendments made from Chapter 11 Pathology in ACPO (2006) Murder Investigation Manual.
Version 3 (draft)	November 2024	Home Office	Draft for consultation

Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm

A Memorandum of Understanding between regulatory, investigatory and prosecutorial bodies

(England)

Date: 17 December 2024

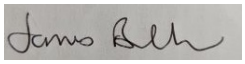
Contents

1. Signatories

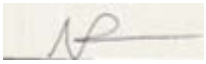
1.1 This Memorandum of Understanding has been agreed and signed by the following organisations:

- Care Quality Commission
- Crown Prosecution Service
- Health and Safety Executive
- National Police Chiefs' Council
- NHS England
- General Medical Council
- Nursing and Midwifery Council
- General Dental Council
- Health and Care Professions Council
- General Pharmaceutical Council
- General Optical Council
- General Chiropractic Council
- General Osteopathic Council

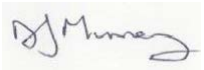
1.2 The roles and responsibilities of each signatory, as well as links to strategic aims, can be found at Annex A.



James Bullion
Interim Chief Executive
Care Quality Commission



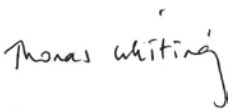
Nick Price
Head of Crime and Counter Terrorism Division
Crown Prosecution Service



David Murray
Director, Planning, Finance & Procurement
Health and Safety Executive

Kate Meynell
Chief Constable
National Police Chiefs' Council

Nick Jones
Chief Executive and Registrar
General Chiropractic Council



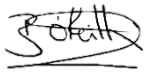
Tom Whiting
Chief Executive and Registrar
General Dental Council

Charlie Massey
Chief Executive and Registrar
General Medical Council

Leonie Milliner
Chief Executive and Registrar
General Optical Council

Matthew Redford
Chief Executive and Registrar
General Osteopathic Council

Duncan Rudkin
Chief Executive and Registrar
General Pharmaceutical Council



Bernie O'Reilly
Chief Executive and Registrar
Health and Care Professions Council

Helen Herniman
Acting Chief Executive and Registrar
Nursing and Midwifery Council

Aidan Fowler
National Director of Patient Safety
NHS England

2. Introduction and background

2.1 This document has been produced to help deliver early, co-ordinated and effective action following incidents where there is **reasonable suspicion** that a patient/service user's death or **serious life-changing harm** occurred as a result of an incident where there is suspected criminal activity in the course of healthcare delivery. Terms appearing in **bold** on their first use/mention are defined in Annex B. This document will assist those responsible for carrying out any safety, regulatory or criminal investigation, provide clarity for all involved on their responsibilities and liabilities and help to ensure that such investigations are handled correctly. As a result, the document should help to protect the public and facilitate both justice and learning.

2.2 The document has been developed in consultation with the signatories named in section 1, together with the Department of Health and Social Care (DHSC), and is based on an earlier protocol first published in 2006.[1]

2.3 Professor Sir Norman Williams' review into **gross negligence manslaughter (GNM)** in healthcare settings, published in June 2018[2] recommended that a new Memorandum of Understanding (MoU) be agreed between relevant bodies to replace the 2006 protocol. It recommended that, as a minimum, the MoU should establish a common understanding of the respective roles and responsibilities of the organisations involved, support effective liaison and communications, and cover what is expected of **expert witnesses**, in particular that they should consider the **wider system** as a whole in which the actions of an individual took place. This includes examining aspects of the organisation's culture, work patterns and leadership as well as a consideration of job workload, procedures and the working environment.

2.4 This document will be disseminated by signatories to promote a greater understanding of legal issues among healthcare professionals and of healthcare issues among non-healthcare signatories. It has been drafted with a view to supporting the development of a '**just culture**' in healthcare, which recognises the need to consider the wider context and circumstances in which any incident involving a breach of a duty of care occurs. This includes considering the wider systems in place at the time of the incident, to support a fair and consistent evaluation of the actions of individuals.

[1] https://webarchive.nationalarchives.gov.uk/20080728191742/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4129918

[2] https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare

3. Aims and purpose

3.1 This MoU sets out how healthcare organisations, regulatory bodies, investigatory bodies and prosecutorial bodies in England will work together in cases where there is suspected criminal activity on the part of an individual in relation to the provision of clinical care or care decision making. It covers any such incidents occurring in the course of healthcare delivery where suspected criminal activity on the part of an individual is believed to have **led to or significantly contributed** to the death or serious life-changing harm (whether of a physical or psychological nature) of a patient or service user.

3.2 An outcome from the use of this MoU is to help support the development of a 'just culture' in healthcare which recognises the impact of wider systems on the provision of clinical care or care decision making, as set out in recommendation 3.5 of the Williams' review into gross negligence manslaughter in healthcare.

3.3 The signatory organisations are independent from each other and have different legal remits and obligations for safety, regulatory and criminal investigations and patient safety learning responses. Those which have a remit for such investigations and learning responses should, wherever possible (i.e. insofar as their legal and investigatory policies allow), co-ordinate activities and share information where it is appropriate, lawful and reasonable to do so. Information should not be shared where doing so conflicts with statutory obligations; the duty to comply with statutory obligations must take precedence.

3.4 This MoU aims to:

- facilitate efficient and effective co-ordination of appropriate approaches, patient safety learning responses and investigations, while taking steps to avoid prejudicing regulatory or criminal investigations or criminal proceedings;
- ensure relevant information and **confidential information** is quickly, lawfully and efficiently shared between the relevant signatories where necessary to progress learning responses, investigations and proceedings.
- ensure evidence is quickly identified, secured and handled in accordance with best practice;
- allow steps to be taken quickly to manage ongoing risk and as far as possible protect the public and service users.

4. When the Memorandum of Understanding applies

4.1 The MoU applies when more than one of the signatories needs to investigate, in parallel, any incident where there is a reasonable suspicion that:

- a criminal offence has or may have been committed by an individual
- **providing healthcare services** in a health or care setting that
- leads to or significantly contributes to the death or serious life-changing harm of a patient or service user.

The MoU therefore only covers the most serious cases: acts of deliberate harm or circumstances where the act(s) or omission(s) of a member of healthcare staff amount to a breach of duty of care which results in death or life-changing harm, and are so reprehensible and fall so far below the standards to be expected (taking into account relevant qualifications, experience and responsibilities), that it amounts to a crime.

4.2 The MoU has been signed by NHS England on behalf of the wider NHS in England. It should therefore be used when incidents as described in paragraph 4.1 occur in the delivery of NHS-funded healthcare and in the delivery of privately funded or Local Authority funded healthcare that occurs on NHS premises. While no organisation is appropriately placed to sign this MoU on behalf of private healthcare organisations, the DHSC has consulted with the Independent Healthcare Providers Network[3] (IHPN) on its drafting and it is expected that the principles contained within it should also apply when incidents requiring investigation as described in paragraph 4.1 occur in the delivery of privately funded healthcare outside of NHS premises or as part of NHS service provision.

4.3 The MoU applies to such incidents occurring in England only.

4.4 The processes outlined in this MoU should be put in place as soon as is practical to ensure that all parties to the response are properly co-ordinated; that evidence is properly secured; that investigations and patient safety learning responses take place effectively and efficiently; and so that affected patients/service users, families, carers and loved ones are kept well-informed and supported, and are also provided with the opportunity to be actively involved throughout the investigative process.

[3] While the IHPN is the only membership organisation for the independent healthcare sector, it is not the case that all independent healthcare providers are members.

4.5 It may not be immediately clear following the incident that a criminal offence may have been committed. The types of incident that may prompt an NHS organisation to involve the police are those that display one or more of the following characteristics:

- reasonable suspicion that the actions leading to harm were intended to cause harm;
- reasonable suspicion of **gross negligence** and/or **recklessness**

Where a local concern, review or investigation identifies reasonable suspicion of a criminal offence, the procedures set out in the MoU should be instigated. The police should consult the CPS where they consider it necessary to do so, when parties need to determine whether the decision/act/omission under investigation amounts to a criminal offence[4]. Such consultation will assist the investigation and in cases where the CPS advise that the incident does not meet the threshold for a criminal offence, will allow it to be concluded early.

4.6 The MoU covers incidents that are concerning the individual (in)actions/(in)decisions of those providing healthcare or care services. Deaths requiring investigation that occur in healthcare environments and that are not related to individual clinical care or individual care decision making are covered by *Work-Related Deaths: A Protocol for Liaison (WRDP),* [5] which sets out a step-by-step approach to the joint investigation of fatalities arising out of – or occurring in connection with – work. Where both definitions apply, this MoU and the WRDP should be used in conjunction.

4.7 All patient safety incidents involving NHS provided or funded care should be considered as set out in the Patient Safety Incident Response Framework (PSIRF)[6]. The vast majority of patient safety incidents in the NHS can and should be dealt with under the PSIRF without any need for this MoU to be invoked. Where the NHS is conducting a learning response under the PSIRF and this MoU has been invoked, then the NHS bodies should follow the advice of the Incident Co-ordination Group (ICG) in how they manage that learning response to ensure any other response – particularly any criminal investigation – is not adversely affected.

4.8 Where signatories to the MoU have independent working arrangements or agreements (e.g. under the MoU held between HSE and CQC[7]), this MoU should not affect their operation, but should be used in conjunction with them.

[4] In normal circumstances it will be the Senior Investigating Officer (SIO) appointed by the police who will contact the CPS for such advice.
[5] http://www.hse.gov.uk/pubns/wrdp1.pdf
[6] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
[7] https://www.hse.gov.uk/agency-agreements-memoranda-of-understanding-concordats/assets/docs/mou-cqc-hse-la.pdf

4.9 The NHS in England may apply the principles and processes of this MoU to other incidents of suspected criminality connected to a patient safety incident[8] on a case-by-case basis at the discretion of the relevant signatories on consideration of, for example, the seriousness and impact of the offending.

[8] The Patient Safety Incident Response Framework ('PSIRF') defines patient safety incidents as 'unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients'.

5. Memorandum of Understanding – Incident Co-ordination Group

5.1 Where one or more parties to the MoU identifies a reasonable suspicion of a criminal offence of the nature outlined in paragraph 4.1, an initial meeting of the Incident Co-ordination Group[9] (ICG), either in person or virtually, will be held as soon as is practical[10]. This also includes cases where the complaint has been made directly to the police.

Setting up the ICG

5.2 The party who first establishes the reasonable suspicion outlined in 4.1 will, by default, convene, chair and minute that meeting. To ensure co-ordination and investigatory direction, and prevent any duplication of any undertakings, the ICG should agree a lead. This will not prevent urgent action being taken in advance of the ICG meeting. The MoU will take effect from the convening of the ICG. Advice on items to be discussed at ICG meetings can be found in Annex D. Future meetings may be either in person or virtually and will be chaired by the agreed lead.

5.3 The ICG will be instigated when the party first to have reasonable suspicion contacts the relevant (one or more) other signatory bodies, found in Annex C. That party will make its suspicion known and request attendance by a representative from each of the signatory bodies it considers relevant (note the initial assessment of relevance of signatory bodies by the first party can be updated as understanding of the events increases). The lead for each signatory body should provide contact details for its nominated representative and its availability for the first ICG meeting. Routine patient safety event recording via the Learn From Patient Safety Event service, Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card or other system does not constitute instigation of the ICG.

5.4 Engagement of the signatory bodies should be informed by a clear understanding of legal responsibilities and accountabilities. The ICG will usually include any NHS provider(s) in which the events took place (unless deemed inappropriate as per paragraph 5.24). As set out in the NHS Patient Safety Incident Response Framework (PSIRF), management of the learning response to any patient safety incident in the NHS should be led as close as possible to the events in question while maintaining appropriate objectivity and independence. From a patient safety

[9] The ICG is a group including the relevant signatories of this MoU. It is likely to include representatives from the relevant healthcare organisations, regulatory bodies, investigatory bodies and prosecuting bodies. NHS England has signed this MoU on behalf of the wider NHS. In practice it is likely that individual NHS provider organisations will sit on individual ICGs, and that representatives from NHS England will only sit on the ICG in cases where it is appropriate. The Crown Prosecution Service will provide legal advice on a potential criminal offence; it will not act as an investigatory body.

[10] Under the National Quality Board's (NQB) Risk Response and Escalation Guidance, this is the equivalent of a Rapid Quality Review meeting. This guidance is used to manage quality risks, concerns and issues arising in providers, systems and more widely. The principles of the NQB guidance and this MoU are the same, and what framework is used does not matter if the same principles are adopted.

perspective, the NHS focus is on learning and improvement and any NHS patient safety investigation must be managed entirely separately from any employment investigation, fitness to practise assessment, claims liability or other purpose, whilst ensuring there is no prejudice to a potential police/HSE/CQC investigation, especially during the collection of evidence. The work of the NHS provider to manage that learning response should be co-ordinated with the work of any parallel criminal or other investigation, via the ICG. It may be that reasonable suspicion of criminal activity only arises part way through an NHS-led learning response. Co-ordination of parallel responses should begin via the ICG once that reasonable suspicion is identified.

5.5 The NHS provider(s) involved should inform their Integrated Care Board (ICB) and NHS England regional team that an ICG has been established. Whether it is appropriate for the ICB or NHS England Regional Team to sit on the ICG as well will depend on the nature of the events. It is more likely to be appropriate where the events are high profile with significant media or political interest, are complex and/or require co-ordination across multiple NHS providers or systems.

5.6 The CQC, or relevant regulator (where the healthcare setting is not regulated by the CQC), should be informed so that it can consider whether to carry out a parallel, but separate, monitoring, assessment and/or investigation of the healthcare provider to determine the impact of wider systems at the time of the incident.

5.7 The CQC or relevant regulator should make available the latest inspection reports of the quality of care provided by a particular organisation. The inspection reports along with any previously notified deaths should be considered when the CQC or relevant regulator decide whether to carry out a parallel investigation or inspection to identify the impact of wider systems.

5.8 The CQC should be invited to each ICG meeting but will have discretion over its attendance. The CQC will most likely attend the ICGs where the possibility of wider systems failures, including those that might give rise to provider level failure to provide safe care are under consideration. In cases where the CQC declines to send a representative, minutes from the first and any subsequent ICG meetings should be sent to the CQC contact detailed at Annex C within 14 days of the ICG. In cases where, after the first ICG meeting or during subsequent investigation, a signatory body identifies the possibility of wider systems failures, including those that might give rise to provider level failure to provide safe care, the CQC should be notified by that body (using the CQC contact detailed at Annex C) within 14 days of identifying that possibility. Where the CQC does not oversee the care provider, the relevant regulatory body should be invited to the ICG meeting, but will have discretion over its attendance, taking into account its investigation policies.

5.9 Where a concern is raised about the fitness to practise of a professional in one of the regulated professions, the appropriate signatory regulator should be invited to join the ICG.

5.10 Where relevant (i.e. when the incident involves early neonatal deaths, intrapartum stillbirths, severe brain injury in babies born at term following labour or maternal

deaths), the Maternity and Newborn Safety Investigations (MNSI) programme, should also be informed so it can ensure it is able to discharge its functions.

5.11 In instances of suspicious death, the ICG should ask the coroner if it wishes to send a representative to the meeting in addition to the police. In instances of the unexpected death of a child where an investigation under child protection procedures might be appropriate, the ICG may decide to ask children's social services if it wishes to send a representative to the meeting. In instances of the unexpected death of a vulnerable adult, the ICG may decide to ask adult social services if it wishes to send a representative to the meeting.

5.12 The ICG should consider whether other investigation bodies such as the Medicines and Healthcare products Regulatory Agency should be informed or involved, for example where there is evidence of use of counterfeit medicines or medical devices. Similarly, it may be considered appropriate to refer the events to the Health Services Safety Investigation Body (HSSIB). Where these other bodies become involved, they should be invited to join the ICG.

5.13 If additional organisations are required to join the ICG, the following stages should be followed:

- proposing the addition of a new member;
- convening to discuss the expertise and potential role of the new member, and the impact of their joining the group;
- before introduction, to approve the new member by majority vote;
- the new member must be sighted on the MoU and agree to its terms by signature.

5.14 Each signatory body nominating a representative to the ICG meetings should ensure that its own nominated representatives have sufficient seniority to take decisions on behalf of its organisation, understand the wider implications of the incident and has the appropriate skills, training (including on equality and diversity) and expertise to deal with any immediate concerns.

5.15 The ICG should consider, and take steps wherever possible to address, its own diversity, particularly with reference to the protected characteristics under the Equality Act 2010.

5.16 Once the police are alerted to a suspected criminal offence, they will appoint a senior investigating officer (SIO). The SIO will usually be responsible for seeking advice from the CPS and the views of an expert witness.

5.17 While recognising the importance of adhering to the procedures set out in this MoU, it may not always be appropriate for the police to attend meetings and/or share information when there is an ongoing police investigation and the police reasonably consider that such attendance/sharing of information may compromise the wider interests of justice. Such decisions should be reviewed on a regular basis and attendance/sharing of information should take place as soon as practicable.

5.18 The expert witness is accountable to the police. The terms of reference for the expert witness should be drawn up by the police and the CPS, according to CPS' Legal Guidance[11]. The terms of reference should include an explanation of the law relating to gross negligence manslaughter (if that is the crime under suspicion) and of the legal requirement to provide an objective and unbiased opinion. Expert witnesses should consider the effects of the wider systems in place during the incident.

5.19 Where the police refer a case to the CPS, the police must inform the Care Quality Commission (CQC) within seven working days so that CQC can consider whether to undertake monitoring, inspection and/or civil enforcement functions regarding any ongoing risk of harm to patients/service users; and whether to carry out a parallel, but separate, investigation of the healthcare provider to determine if it has breached any relevant regulations, including failure to meet regulations 12, 13, 14 or 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (see Annex A).

5.20 Where a healthcare setting is not regulated by the CQC the relevant regulator must be informed by the police within seven working days of a police referral to the CPS so that it can consider, taking into account its investigation policies, whether to carry out a parallel, but separate, investigation of the healthcare provider to determine if it has breached any relevant regulations, and to identify any action that may be required in line with its functions.

5.21 Where there is a police investigation and the CQC decide to carry out a parallel investigation, the latest MoU between the CQC and the police should be followed[12]. The CQC (in conjunction, where relevant, with MNSI) should consider evidence regarding wider systems. This should be promptly shared with the police so that it can be considered by expert witnesses and prosecutorial authorities when making decisions about charges and continuance of proceedings.

5.22 The CQC, or relevant regulator, where it has decided to investigate, should consider the findings of its investigation in deciding whether to undertake any follow up action (such as monitoring, or civil/criminal enforcement) if it has not done so already in relation to the provider and/or any wider review of system issues.

5.23 Throughout the investigation consideration of the wider systems at play during the incident should be made by all parties, including members of the ICG, expert witnesses and those tasked with securing and gathering evidence.

ICG Tasks

5.24 The ICG will:

- confirm that the incident is one for which use of this MoU is appropriate (see paragraph 4.1);

[11] www.cps.gov.uk/legal-guidance/expert-evidence

[12] www.cqc.org.uk/sites/default/files/20191017_%20mou_cqc_npcc.pdf

- identify the appropriate lead for co-ordination of the response and if at any stage primacy for the investigation changes, co-ordinate a handover;
- confirm the appropriate signatories to attend future ICG meetings related to the response;
- consider how organisations can work together to ensure a co-ordinated approach that allows the effective discharge of legal and regulatory duties whilst ensuring the rights of those potentially subject to a criminal investigation or prosecution to:
    - have a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law;
    - be presumed innocent until proved guilty according to law;
    - are informed promptly, in a language which they understand and in detail, of the nature and cause of the accusation against them;
    - have adequate time and facilities for the preparation of their defence;
    - may defend themselves in person or through legal assistance of their own choosing or, if they have not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;
    - examine or have examined witnesses against them and to obtain the attendance and examination of witnesses on their behalf under the same conditions as witnesses against them;
    - have the free assistance of an interpreter if they cannot understand or speak the language used in court.
- ensure that members of the ICG follow their own existing guidelines in providing support to any individual who is suspected of criminal activity in the incident.
- comply with the guidelines on data sharing in Annex E as per each individual case;
- ensure that any evidence is secured and preserved as soon as possible, with receipts obtained when any items are passed to other agencies;
- ensure that further necessary learning responses, including investigations, by the NHS, or relevant regulatory authorities, can be conducted in such a way as to avoid the danger of prejudicing the police and/or HSE and/or CQC investigations, for example, by obtaining information from members of staff who may subsequently give evidence at court;
- identify ways of working and engagement that are proportionate and effective as investigations progress;
- establish arrangements for co-ordinating safety learning responses by healthcare organisations alongside any regulatory/criminal investigation;
- co-ordinate liaison with the patient/service user or family members, loved ones, carers or advocates throughout the patient safety learning responses and investigations in a managed and reasonable manner, ensuring that they are involved and supported from the outset and throughout, and kept informed of the progress and outcome, potentially through a single point of contact;
- agree a communications strategy for dealing with the media;
- convene at appropriate intervals throughout the regulatory/criminal investigation to share findings, reflect on ways of working and address issues; and

- ensure that an official written record of each meeting of the ICG is contemporaneously made (ideally by the lead ICG member), detailing matters discussed, decisions reached, and any agreed actions and the names of those responsible for them. A completed action plan setting out what is to be done, by whom and by when should be circulated to all participants shortly after the meeting.

5.25 It may sometimes be necessary for the police and/or HSE and/or CQC to interview NHS staff. All efforts should be made following an incident in scope of this MoU to support NHS staff to make statements as requested by the relevant authorities. Where necessary, NHS staff should be given access to legal representation for this purpose following the guidelines in paragraph 5.24.

5.26 If at any point during the regulatory/criminal investigation a health or care provider becomes a potential defendant in criminal proceedings (for example, if there is suspicion of provider-level failure or organisational abuse), representatives from the provider should be removed from the ICG. The remaining members of the ICG should then consider whether this has any impact on their own investigations and form a decision as to whether they will need to exclude the existing input from the provider or should nominate a suitable alternative to represent healthcare such as an ICB or NHS England regional team.

5.27 The organisations will progress their own patient safety learning responses, investigations and actions in parallel, without – as far as is possible – infringing on the work of other organisations. The ICG should consider any potential impacts the individual processes of any party may have on the work of others.

5.28 Decision-making throughout the process should:

- operate in line with relevant law and best practice (e.g. in the sphere of information sharing);
- be prompt and efficient;
- consider the issues and concerns of affected patients/service users, their families or carers in shaping the patient safety learning responses and investigations, within the bounds of the investigations' remit underway, and involve these people wherever appropriate;
- be informed by the best available evidence;
- take the public interest into account; and
- be communicated promptly to relevant healthcare professionals, witnesses, patients/service users and families or carers as appropriate.

5.29 Outcomes of relevant investigations should be reported to the board of the relevant healthcare provider and shared with relevant regulatory, statutory, advisory and professional bodies.

5.30 The ICG has no role in directing the patient safety learning responses and investigations of the NHS, CQC, police, regulators and/or HSE.

5.31 Should the police and HSE decide they have no further role in the matter, it may be decided that the other bodies should investigate further and, if more evidence comes to light, convene another meeting of the ICG to discuss its findings. The police or HSE can then decide if they need to conduct their own investigation or if some other course of action is appropriate.

5.32 At the conclusion of any investigation, the ICG should meet to consider what went well and what could be improved to help inform future investigations.

5.33 This MoU should be reviewed every three years at a minimum (and more frequently if necessary) to assess its efficacy in meeting its objectives and to make amendments and improvements as required. DHSC will be responsible for commencing each three-yearly review.

Annex A – Roles and responsibilities of signatories

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Its purpose is to make sure healthcare services provide people with safe, effective, compassionate, high-quality care and to encourage them to improve. CQC does this by registering, monitoring, assessing, inspecting, and regulating hospitals, adult social care services, dental and general practices and other care services in England, to make sure they meet fundamental standards of quality and safety.

Where appropriate, CQC will pursue civil and/or criminal enforcement action against registered persons (registered providers and/or registered managers) who provide health and social care services for breaches of health and social care law. CQC can:

- use *requirement notices* or *warning notices* to set out improvements a care provider must make and by when;
- make changes to a care provider's registration to limit or require what they may do, for example by imposing positive or negative conditions for a given time, suspending registration or cancelling registration;
- place a provider in *special measures*, where CQC closely supervises the quality of care while working with other organisations to help them improve within set timescales;
- hold a care provider to account for their failings by:
    - issuing simple cautions
    - issuing fines
    - prosecuting registered persons (registered providers and/or registered managers) for offences set out in the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('RAR 2014') and the Care Quality Commission (Registration) Regulations 2009 ('RR 2009').
- in particular investigate and prosecute registered persons under Regulation 22(2) ("RAR" 2014)[13]. These provisions empower CQC to prosecute a registered provider and/or a registered manager for failure to comply with regulations 12(1) (safe care and treatment), 13(1) to (4) (safeguarding service users from abuse and improper treatment) or 14 (nutritional and hydration needs) and that failure results in avoidable harm to a service user(/s) or in a service user being exposed to a significant risk of exposure to avoidable harm. All harm is considered '*avoidable harm'* as defined at Regulation 20 (5B(b)) of the Health and Social Care Act 2008 unless the person providing the care cannot reasonably avoid it, whether because it is an inherent part or risk of a regulated activity or for another reason. For instance, because of the natural course of the service user's illness or because of the service user's underlying health condition.

[13] https://www.legislation.gov.uk/uksi/2014/2936/contents

- Where a relevant offence is proved to have been committed by a registered provider that is a body corporate or unincorporated association, CQC also has the power where it is appropriate to do so to investigate and prosecute individual real or purported directors, managers or secretaries, officers or members (relevant to English NHS bodies or local authorities), in circumstances where the registered person offence was committed by, or with that individual's consent or connivance or attributable neglect. CQC does not have the power under Regulation 22(1) or (2) RAR 2014 to prosecute individuals for failures in their individual clinical care or care decision making.

The Crown Prosecution Service (CPS) prosecutes criminal cases that have been investigated by the police and other investigating organisations in England and Wales. The CPS is independent and makes decisions independently of the police and government. The CPS:

- decides which cases should be prosecuted;
- determines the appropriate charges in more serious or complex cases, and advises the police during the early stages of investigations;
- prepares cases and presents them at court; and
- provides information, assistance and support to victims and prosecution witnesses.

The CPS has signed this MoU on the understanding that it will only be involved in cases where legal advice on a potential criminal offence is needed.

The Health and Safety Executive (HSE) aims to prevent workplace death, injury or ill health by helping people manage risks at work. It does this by:

- providing advice, information and guidance;
- raising awareness in workplaces;
- by influencing and engaging;
- operating, permissioning and licensing activities in major hazard industries;
- carrying out targeted inspections and investigations;
- taking enforcement action to prevent harm and hold those who break the law to account.

In England, the Care Quality Commission (CQC) is the lead inspection and enforcement body for safety and quality of treatment in care matters involving patients and service users in receipt of a health or adult social care service from a registered provider.

HSE or Local Authorities (LAs) are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of a health or care service from providers not registered with CQC. HSE will only be involved in cases where a serious incident occurs that resulted in significant harm or death in an unregistered care facility.

HSE or LAs are the lead inspection and enforcement bodies for health and safety matters involving workers, visitors and contractors, irrespective of registration.

The Health and Safety Executive provided a limited amount of support to DHSC in producing this guidance.

Healthcare professional regulators – There are nine healthcare regulators for different healthcare professional groups in England (although the majority also operate on a UK-wide basis). They are the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the General Dental Council (GDC), the Health and Care Professions Council (HCPC), the General Pharmaceutical Council (GPhC), the General Optical Council (GOC), the General Chiropractic Council (GCC), the General Osteopathic Council (GOsC), and Social Work England (SWE) which is not a signatory as the focus of this MoU is healthcare settings not social care). Their functions include:

- Setting standards of competence and conduct that healthcare professionals must meet in order to be registered and practise. Some regulators also register and set standards for businesses and premises.
- Checking the quality of education and training courses to make sure they give students the skills and knowledge to practise safely and competently.
- Maintaining a register that everyone can search.
- Investigating concerns about healthcare professionals on their register and deciding if they should be allowed to continue to practise (with or without restriction) or should be struck off the register – either because of problems with their conduct or their competence.

The National Police Chiefs' Council (NPCC) – The NPCC brings police forces in the UK together to help policing co-ordinate operations, reform, improve and provide value for money.

NHS England – NHS England aims to support the NHS and help improve care for patients. It leads the NHS in England and supports NHS foundation trusts and NHS trusts to provide patients with consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NHS England has signed this MoU on behalf of the wider NHS in England. In practice it is likely that individual NHS provider organisations will sit on individual ICGs, and that representatives from NHS England will only sit on the ICG in cases where it is appropriate.

Note: As stated in paragraph 4.8, where the above signatories have independent working arrangements or agreements (e.g. under the MoU held between HSE and CQC), this MoU should not affect their operation, but should be used in conjunction with them.

Annex B – Definition of terms

Confidential Information means all information (however recorded or preserved) relating to the aims and purpose of this MoU (as set out in Section 3) (excluding this memorandum) that is disclosed or made available whether before or after the date of this MoU (in any form or medium), whether true or false and whether or not marked 'confidential' directly or indirectly, by a Provider to a Recipient. This is likely to include (but is not limited to):

- written documents shared (at meetings of the ICG or otherwise);
- electronic communications between the parties in connection with the aims and purpose of the MoU including but not limited to the contents of electronic mail including attachments;
- details of verbal discussions between the parties relating to the aims and purpose of the MoU, unless all parties agree in writing that specific documents or details of verbal discussions are not confidential.
- personal information relating to individuals (which the parties agree must not be shared except in compliance with the Data Protection Act 2018 and the UK General Data Protection Regulations 2016/679) shared in connection with the aims and purpose of the MoU;
- the terms of this agreement; and
- any analysis or documents created from the Confidential Information.

Expert witnesses are defined as individuals instructed (usually) by and reporting to the police, often on the advice of the CPS, who have experience and knowledge of the area under investigation and are able to provide an objective and unbiased opinion on the matters being investigated.

Gross negligence is defined as a negligent act or omission that involves a gross breach of a duty of care to an individual that is so reprehensible and falls so far below the standards to be expected of the healthcare staff member (taking into account their qualifications, experience and responsibilities) that it is 'truly exceptionally bad' and amounts to a crime.

Gross negligence manslaughter (GNM) is defined as a negligent act or omission that (i) involves a gross breach of a duty of care to an individual and (ii) causes (i.e. made a more than minimal contribution to) the death of that individual. Note that there is a high bar for prosecution for GNM: CPS guidance summarises legal principles setting out that where it is reasonably foreseeable that there is a serious and obvious risk of death, the act or omission of an individual, that leads to the breach of the duty of care and which results in death, must be so reprehensible and fall so far below the standards to be expected of a person in the individual's position (taking into account their qualifications, experience and responsibilities) that it is 'truly exceptionally bad' and amounts to a crime. Visit Gross Negligence Manslaughter | The Crown Prosecution Service (cps.gov.uk) for further guidance. All CPS decisions are made in accordance with the Code for Crown Prosecutors.

A **Just Culture**[14] considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. A just culture is one where inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.

Led to or significantly contributed to. An act or omission will be taken to lead to or significantly contribute to death or serious life-changing harm, if in this context, it is related directly to the death or serious life-changing harm and the death or serious life-changing harm is not related to the natural course of the service user's illness or underlying condition.

Provider (in template agreement wording within Annex E: Information Sharing and Data Handling and Annex F: Confidentiality Agreement) means any party to this agreement which discloses or makes available directly or indirectly Confidential Information to one or more parties to this agreement.

Providing healthcare services in this context means individual clinical care or individual care decision making. Note that relevant acts of omission are included within the remit of this MoU.

Reasonable suspicion. A person is taken to have a clear and reasonable suspicion in this context if they have clear, objective, specific facts, observations or evidence that justify that suspicion. The grounds for suspicion are taken to be objective if a reasonable person given the same information would form the same suspicion.

Recipient (in template agreement wording within Annex E: Information Sharing and Data Handling and Annex F: Confidentiality Agreement) means any party to this agreement which receives or obtains directly or indirectly Confidential Information from another party to this agreement.

Recklessness[15] is unjustified risk taking. Someone acts recklessly with respect to:

(i) a circumstance when they are aware of a risk that it exists or will exist;

(ii) a result when they are aware of a risk that it will occur; and

it is in the circumstances known to them unreasonable to take the risk. Failure to consider a risk – however obvious it might be – does not give rise to recklessness; but closing one's mind to a risk requires first realising that there is one and this is equivalent to awareness.

Serious life-changing harm includes any serious injury that leads to a lessening of bodily, sensory, motor, physiologic, cognitive or emotional function that changes an individual's life permanently, leading to long-term medical problems, or reduced life-expectancy.[16]

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[14] Definition of just culture is taken from the Williams review into gross negligence manslaughter in healthcare - https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare

[15] Definition taken from www.LexisNexis.co.uk/legal/glossary/recklessness on 12/08/2024

[16] This is similar to 'catastrophic injury'. Please also see 'severe harm' as defined in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No. 2936.

The wider system is defined as the work system in which events of interest took place. Taking a systems-based approach means considering the event in the context of the wider system:

- identifying the different components of the sociotechnical work system and how they interact
- looking beyond the immediate events, to organisational/management decisions, policy and regulations that influenced the events of interest.

Consideration of the wider system shifts the focus from looking at an incident in isolation to understanding the complex inter-connected relationships between components of the system. Those components of the system can include:

- organisational factors such as staffing levels, shift patterns and education and training provision;
- task factors such as the complexity of medical interventions, processes and procedures;
- technological and tools-related factors such as the availability of health information systems, equipment, medication and diagnostics, the design of tools and equipment and how they are used;
- environmental factors such as the physical estate, its layout and maintenance, and how factors such as lights and sound can influence performance;
- person-related factors including fatigue, familiarity, clinical knowledge and experience;
- external factors including demand, financial pressures and regulatory interventions.

Annex C – Signatory contact information

Note: only relevant signatories should be contacted when instigating an ICG. The National Police Chiefs' Council and NHS England should only be contacted where appropriate. In many cases it will be more appropriate to contact the relevant police constabulary, or NHS Trust. The Crown Prosecution Service will only be involved in cases where legal advice on a potential criminal offence is needed and will not be involved as an investigatory body.

Signatory body		Named signatory	Department contact	Contact details
Care Quality Commission		James Bullion, Interim Chief Executive	Deputy Director of Enforcement Director of MNSI (for enquiries specifically relating to MNSI)	Strategicenforcementqueries@cqc.org.uk Enquiries@mnsi.org.uk (for enquiries specifically relating to MNSI)
Crown Prosecution Service		Nick Price, Head of Special Crime and Counter Terrorism Division	Special Crime Division	DLS.Team@cps.gov.uk
Health and Safety Executive		David Murray Director, Planning, Finance & Procurement	Health and Social Care Services Sector	Public.Services-Sector@hse.gov.uk
Healthcare professional	General Dental Council	Tom Whiting, Chief Executive and Registrar	Chief Executive and Registrar	FitnessToPractise@gdc-uk.org
	General Chiropractic Council	Nick Jones, Chief Executive and Registrar	Investigation	Investigation@gcc-uk.org
	General Medical Council	Charlie Massey, Chief	Fitness to practise	practise@gmc-uk.org

		Executive and Registrar		
	General Optical Council	Leonie Milliner, Chief Executive and Registrar	Case Progression	ftp@optical.org
	General Osteopathic Council	Matthew Redford, Chief Executive and Registrar	Regulation Team	regulation@osteopathy.org.uk
	General Pharmaceutical Council	Duncan Rudkin, Chief Executive and Registrar	Concerns	concerns@pharmacyregulation.org
	Health and Care Professions Council	Bernie O'Reilly, Chief Executive and Registrar	Fitness to Practise	ftp@hcpc-uk.org
	Nursing and Midwifery Council	Helen Herniman, Acting Chief Executive and Registrar	Chief Executive's Office	CEOffice@nmc-uk.org
National Police Chiefs' Council		Kate Meynell, Chief Constable	NPCC Chair of the Homicide Working Group	info@npcc.police.uk
NHS England[17]		Aidan Fowler, NHS National Director of Patient Safety	The NHS National Patient Safety Team	patientsafety.enquiries@nhs.net

[17] NHSE has signed this MoU on behalf of the wider NHS and general queries about NHS policy in relation to this MoU can be directed to the National Patient Safety Team, however any operational queries regarding specific incidents and their management, including involvement of NHS Providers, ICBs or NHS Regional Teams need to be directed to the relevant NHS bodies who are or should be involved in the ICG in question and not to the National Patient Safety Team.

Annex D – ICG meetings – suggested items for discussion

What should be discussed	What to consider
Nature of the incident(s)	• What has happened, when and how? • Who is involved?
Reasons for meeting, including an explanation from the organisation responsible for calling the meeting.	• Why has the meeting been called? • Are other parties involved e.g. relatives, the coroner?
Consider make-up of the Incident Co-ordination Group.	• Who will lead? • Which signatories will attend future ICG meetings? • Are those attending are senior enough? • Is the ICG diverse enough with regard to the protected characteristics under the Equality Act 2010? • Are diverse viewpoints represented and if not do new group members need to be added?
Needs of and support to patients, relatives and NHS staff (revisit this question at the beginning and end of every ICG meeting).	• What are these, how are these to be met and by whom?
NHS actions to date, including the outcome of any learning responses or improvement work	• What has the NHS done to date? • What is the organisation's Patient Safety Incident Response Plan? • How was a decision about the response to the incident made? • Are written reports available? • Have themes from the incident had improvement work?

Public safety concerns	• Does this matter raise such concerns? • If so, what are they? • Does any immediate action need to be taken to ensure public protection?
Safety of NHS systems and the need for continuity of patient care.	• Is there a need for remedial action, risk management, patient safety learning response and/or other processes/further investigation by the NHS? • Does the matter need to be reported to another body e.g. MHRA/ professional body?
The extent of further, immediate NHS patient safety learning responses or other investigations and how these may need to be constrained in subject matter or format by the needs and requirements of the police and/or CQC/HSE	• Is patient safety at risk? • If so, what has to be done to minimise this risk?
Ensure a consideration of the impact of wider systems is made	• Are wider systems being considered in all aspects of the investigation(s)? • How will it be ensured that expert witnesses consider wider systems? • Who will ensure the CQC or other relevant body is informed where necessary as soon as any signatory identifies the possibility of wider systems failures (within 14 days).
Collection of evidence	• What evidence needs to be collected and how will it be secured, preserved and transferred?
Determine which body is responsible for regulating the healthcare setting.	• Is the healthcare setting regulated by the CQC? If so who will inform the CQC? • If not regulated by the CQC, determine who the relevant regulator is and who will inform them? • Can relevant inspection reports be obtained? • Who will ensure the relevant body receives minutes of the meetings if they choose not to attend?

Consider whether other safety bodies should be involved.	• Should the MHRA be involved? • If the incident is maternity related, should Maternity and Newborn Safety Investigations programme (MNSI) be informed?
Consider the rights of those potentially subject to a criminal investigation or prosecution.	• What steps will be taken to ensure the investigation considers the rights of those under potential investigation?
Role and responsibilities of the NHS, police and/or CQC/HSE and next steps to be taken (except where this would jeopardise any investigation or subsequent legal proceedings)	• Each organisation should describe what it needs to do next and how it will fit – or conflict – with what others propose to do
If the police refer the case to the CPS, ensure relevant healthcare setting regulator is informed.	• Who will ensure the CQC, or other relevant regulator is informed within seven days of a police referral to the CPS?
Other statutory responsibilities	• Do the organisations have other statutory responsibilities they should consider e.g. are there any safeguarding considerations in respect of a child or a vulnerable adult? • Should social services be informed?
Need to inform professional regulatory bodies e.g. General Medical Council, General Dental Council, Nursing and Midwifery Council	• Does this individual(s) need to be referred? • Who should do this? • At what stage should this referral be made?
Securing and preserving evidence	• Has this been done and by whom? • What has been preserved and where located?
Sharing information	• What information is available? • When is the information required? • What may be shared and what is the legal basis for sharing that information – is consent required? • Consult with Caldicott Guardian
Information to other interested parties e.g. the coroner	• Who else needs to know? • What can they be told?
Handling communications/media	• Is the incident likely to attract the attention of the media?

	• What will be said in response? • Who will say it and in what circumstances? • Has a joint media strategy been agreed?
Future handling and co-ordination, including the appointment of a liaison officer from each organisation	• Who from each organisation is to act as single point of contact and lead (SPOC)?
Freedom of information/Disclosure	• Agree protocol for material ownership, retention and return

Annex E – Information Sharing and Data Handling

This annex:

- is not intended as a Data Sharing Agreement;
- is intended as a useful resource for signatories considering their data sharing requirements; and
- provides some template wording for an agreement; and
- provides a table to help consider the legal basis for data that needs to be shared and the lawful basis for sharing.

Signatories should consider independently whether a separate stand-alone Data Sharing Agreement is required following their own legal advice.

DHSC is the co-ordinator of this Memorandum of Understanding and will not be involved in handling or sharing any data.

Scope

'Parties' explicitly refers to the organisations within the ICG who will be involved in handling and sharing data. This may include:

- NHS bodies such as Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England
- National Police Chiefs' Council
- Care Quality Commission
- Crown Prosecution Service
- Health and Safety Executive
- General Medical Council
- Nursing and Midwifery Council
- General Dental Council
- Health and Care Professions Council
- General Pharmaceutical Council
- General Optical Council
- General Chiropractic Council
- General Osteopathic Council

The agreement will apply for the entire duration of the investigatory and/or prosecutorial process for any individual case.

This agreement is not intended to conflict with parties' statutory obligations. Where such a conflict occurs, statutory obligations take precedence.

The data and obligations referred to in this agreement relates only to data shared in connection with the work of the ICG, the terms of reference for which are set out at section 3 of the MoU (Aims and purpose). This may include, but is not limited to, the following purposes:

- to fulfil a request for information from an ICG party in relation to a case under investigation;
- to proactively assist another ICG party in determining whether there is an incident which may require a criminal investigation and/or prosecution; and
- to help another ICG party carry out its functions as set out in this MoU to ensure investigations are handled correctly.

Information Sharing and Data Handling

The parties formally acknowledge their explicit commitment to maintaining the confidentiality, safety, security and integrity of all Confidential and Personal Data which may be shared in connection to the work of the ICG.

The parties are aware of their statutory obligations regarding information sharing, obtaining, handling and usage, and understand and follow provisions within the common law on confidentiality, Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR). If parties decide that a more comprehensive data sharing agreement is needed, one may be drawn up and utilised as parties see fit. However, no additional data sharing agreement should be followed in any event where doing so prevents any party from discharging its statutory duties.

The parties will ensure the timely sharing and usage of information – in line with sharing obligations - throughout the duration of the investigatory process subject to avoiding prejudice to any investigation, and subject to the legal obligations on any member under the UK GDPR, Data Protection Act 2018, European Convention on Human Rights Article 8, the common law on confidentiality and any other rule of law governing information sharing.

The parties are committed to the fair, lawful and transparent handling of data. Only those personnel that need access to and use of the personal data in order to carry out their assigned duties correctly, will be permitted access to the data held. All personnel handling data should be made fully aware of their individual responsibilities and should be appropriately trained to handle such data.

The parties must comply with the following when processing personal data:

- personal data must be stored on a secure system or in a secured place with appropriate authority and access controls;
- personal data must always be handled with care and must not be shared with any colleague or any third party without authorisation;
- personal data must not be transferred to any device personally belonging to an employee or transferred or uploaded to any personal file sharing, storage, communication, or equivalent service (such as a personal cloud service);

- personal data may only be transferred to devices belonging to agents, contractors, or other parties working on behalf of the parties where the party in question has agreed to comply fully with the letter and spirit of the law (which may include demonstrating that all suitable technical and organisational measures have been taken, or by entering into a data processor contract);
- all personal data stored electronically shall be backed-up regularly and securely; and
- in addition to the obligations set out above, all personnel involved in processing personal data are required to read and adhere to the parties' information security policies.

The parties shall each implement appropriate technical and organisational measures to ensure the confidentiality, integrity, availability, and resilience of personal data. Such measures shall be proportionate to the risks associated with the processing activities in question, and shall include (without limitation):

- encryption and pseudonymisation of personal data where appropriate;
- policies relating to information security, including the secure processing of data;
- information security awareness training, including the secure handling of personal data;
- business continuity and disaster recovery capabilities to ensure the ongoing availability of and access to personal data; and
- upon reasonable requests demonstrate evidence of processes for regularly testing the technical and organisational measures implemented to ensure the security of the processing.

If a data incident, data breach or near miss occurs involving personal data, the designated contacts of all parties involved in investigating the incident must be notified without delay, and in any event, within 24 hours of any party becoming aware of it.

Once assessment of any data incident, data breach or near miss has been completed by all parties, the next course of escalation shall be mutually agreed prior to informing the Information Commissioner's Office (ICO), the regulatory authority for such matters. The data protection officer for the party or parties responsible for the breach should follow their established breach processes, including making the decision of whether to report to the ICO, and inform the relevant parties of the outcome. If responsibility for the breach has not been established, is unclear or is disputed between parties then the party that discovered the breach will be responsible for informing the ICO.

If an identified data breach is likely to result in a risk to the rights and freedoms of data subjects, the appropriate data protection authority must be notified of the breach without delay, and in any event, within 72 hours of any party becoming aware of it.

Further, in the event that a personal data breach is likely to result in a high risk to the rights and freedoms of data subjects, all affected data subjects are to be informed of the breach directly and without undue delay. Paragraph 2, Schedule 2 of the Data Protection Act 2018 provides an exemption from the obligation to notify data subjects of a high risk breach involving data processed for the prevention or detection of crime, or the prosecution of

offenders where doing so would be likely to prejudice those matters. The party responsible for notification of the breach should consult as appropriate with relevant parties (in particular, the originator of the data and the lead authority for any anticipated prosecution) in determining whether notification to data subjects would be likely to cause such a prejudice.

The parties will not retain any personal data for longer than is necessary. Thereafter, they will be securely destroyed in a manner that ensures that they can no longer be used or accessed and in compliance with the parties' corporate information retention and disposal policy.

The parties are subject to the Freedom of Information Act 2000, the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR). If one organisation receives a request for information that originated from another, the receiving organisation will discuss the request with the other before responding. The ultimate decision on the release of information, however, will remain with the organisation that has been requested to release it. Freedom of Information Policies for each organisation should remain available upon request.

Nature and Purpose of data processing

The nature and purpose of data processing, in line with the scope of the MoU, are satisfied when more than one of the parties needs to investigate, in parallel, any incident (occurring in England only) where there is a reasonable suspicion that:

- a criminal offence has been committed by an individual
- providing healthcare services in a health or care setting that
- led to or significantly contributed to the death or serious life-changing harm of a patient or service user.

Parties are independent controllers of any personal data shared under this MoU.

The following table indicates the lawful grounds for sharing the data for each party.

Party Name	**Lawful grounds/basis for sharing the data**
NHS bodies England	Lawful basis of the Provider is likely to be as follows: <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the NHS to provide a safe and effective health service. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The

	relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of NHS bodies to enable them to provide a safe and effective health service, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. Confidentiality Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU. Lawful basis of the Recipient(s) Data protection Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the NHS to provide a safe and effective health service. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of NHS bodies to enable them to provide a safe and effective health service, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. Confidentiality Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU.
National Police Chiefs' Council	Lawful basis of the Provider is likely to be as follows: Data Protection Act 2018, Schedule 1, paragraph 10 Lawful basis of the Recipient(s) Data Protection Act 2018 Schedule 2, paragraph 2(1)(a) and (b), and paragraph 5(2) as applicable.
Care Quality Commission	Lawful basis of the Provider is likely to be as follows: Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority

	vested in the controller by virtue of its statutory functions, recognising in particular that the CQC's primary objective in performance of its functions under section 3 of the Health and Social Care Act 2008 ('HSCA 2008') is to protect and promote the health, safety and welfare of people who use health and social care services; and also recognising that in relation to CQC's general powers and duties under Schedule 1, paragraph 2 HSCA 2008 CQC may do anything which appears to it to be necessary or expedient for the purposes of or in connection to the exercise of Its functions. Section 79 HSCA 2008 also sets out permitted disclosures that CQC can make. In relation to special category data, CQC can rely upon Article 9(2)(g) (substantial public interest on the basis of UK law), (h) (management of health and social care systems) and (i) (public health / ensuring high standards of quality and safety of health care). The offence for disclosure of Confidential Patient Information section 76 HSCA 2008 (subject to defences under section 77 HSCA 2008) provides the required safeguards for data subjects' rights. Lawful basis of the Recipient(s) Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions, recognising in particular that the CQC's primary objective in performance of its functions under section 3 of the Health and Social Care Act 2008 ('HSCA 2008') is to protect and promote the health, safety and welfare of people who use health and social care services; and also recognising that in relation to CQC's general powers and duties under Schedule 1, paragraph 2 HSCA 2008 CQC may do anything which appears to it to be necessary or expedient for the purposes of or in connection to the exercise of Its functions. Section 79 HSCA 2008 also sets out permitted disclosures that CQC can make. In relation to special category data, CQC can rely upon Article 9(2)(g) (substantial public interest on the basis of UK law), (h) (management of health and social care systems) and (i) (public health / ensuring high standards of quality and safety of health care). The offence for disclosure of Confidential Patient Information section 76 HSCA 2008 (subject to defences under section 77 HSCA 2008) provides the required safeguards for data subjects' rights.

Crown Prosecution Service	Lawful basis of the Provider is likely to be as follows: Data Protection Act 2018 (DPA) Schedule 1, Para 6 and / or 7. Lawful basis of the Recipient(s) DPA Schedule 1 Para 2, Para 3, Para 7 or Para 11 depending on the relevant circumstances. Special Conditions of Processing In rare occasions the CPS may commission a report which proves relevant to be shared – where this is the case the CPS would rely on the processing conditions cited already under the DPA for law enforcement, or under UK GDPR: Article 6(1)(e) and 9(2)(g) for special category data – sharing would have to be in the public interest and a case specific assessment would be made to determine whether disclosure is lawful / appropriate.
Health and Safety Executive	Lawful basis of the Provider is likely to be as follows: UK GDPR Article 6(1)(e): the processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. functions set out in the Health and Safety At Work etc. Act 1974, any Agency agreement or similar, and/or as set out in this MoU to prevent workplace death, injury or ill health by helping people manage risks at work. Where special category data is processed, HSE rely on Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of HSE. OR Data Protection Act 2018, S35(2)(b) processing is necessary for the performance of a task by a competent authority. Where sensitive processing is undertaken, Schedule 8, Condition 1 (statutory purpose), and/or Condition 4 (safeguarding of children or individuals at risk), will be met, as appropriate. Lawful basis of the Recipient(s)

	UK GDPR Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions. For special category data, Article 9(2)(g): processing is necessary for reasons of substantial public interest, supported by Schedule 1, Condition 6 (statutory functions). OR Data Protection Act 2018 Schedule 2, paragraph 2(1)(a) and (b), and paragraph 5(2) as applicable.
General Medical Council	Lawful basis of the Provider is likely to be as follows: <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the GMC to regulate the medical profession. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 11, (Protecting the public against dishonesty etc) where the processing is necessary for the exercise of a protective function. A protective function means a function which is intended to protect members of the public against: (a) dishonesty, malpractice or other seriously improper conduct, (b) unfitness or incompetence, (c) mismanagement in the administration of a body or association, or (d) failures in services provided by a body or association and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. <u>Confidentiality</u> <u>Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU.</u> Lawful basis of the Recipient(s) <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the

	purposes set out in section 3 of this MoU and to enable the NHS to provide a safe and effective health service. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of NHS bodies to enable them to provide a safe and effective health service, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. <u>Confidentiality</u> <u>Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU.</u>
Nursing and Midwifery Council	Lawful basis of the Provider is likely to be as follows: <u>Data protection</u> Article 6 (1)(c): processing is necessary for compliance with a legal obligation; and Article 6(1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions. Where information includes special category data, the NMC's legal basis is Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of NHS bodies to enable them to provide a safe and effective health service, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. The NMC is also required to co-operate with the signatories of this MoU in exercise of its functions in pursuance of public protection (the overarching objective under Article 3(4) of the Nursing and Midwifery Order 2001.

	Confidentiality Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU. Lawful basis of the Recipient(s) Data protection Article 6 (1)(c): processing is necessary for compliance with a legal obligation; and Article 6(1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions. Where information includes special category data, the NMC's legal basis is Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of NHS bodies to enable them to provide a safe and effective health service, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. The NMC is also required to co-operate with the signatories of this MoU in exercise of its functions in pursuance of public protection (the overarching objective under Article 3(4) of the Nursing and Midwifery Order 2001. Confidentiality Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU.
General Dental Council	Lawful basis of the Provider is likely to be as follows: Personal data Article 6(1)(e): the processing is necessary to perform a task in the public interest or for your official functions, to meet the GDC's overarching objective to protect, promote and maintain the health, safety

	and well-being of the public (Section 1(1ZA) and 1(1ZB) of the Dentist Act 1984. Special category data Article 9(2)(g): the processing is necessary for reasons of substantial public interest, to meet the GDC's overarching objective to protect, promote and maintain the health, safety and well-being of the public (Section 1(1ZA) and 1(1ZB) of the Dentist Act 1984. Criminal data Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the GDC's overarching duty to protect the public and the objective to protect, promote and maintain the health, safety and well-being of the public (sections 1(1ZA) and 1(1ZB) of the Dentists Act 1984) and the GDC's duty to co-operate including with public bodies that carry out activities in connection with national health services (section 2A of the Dentists Act). As in the above text, the necessity comes from the purposes set out in section 3 of the MoU. Lawful basis of the Recipient(s) Personal data Article 6(1)(e): the processing is necessary to perform a task in the public interest or for your official functions, to meet the GDC's overarching objective to protect, promote and maintain the health, safety and well-being of the public (Section 1(1ZA) and 1(1ZB) of the Dentist Act 1984. *Special category data* Article 9(2)(g): the processing is necessary for reasons of substantial public interest, to meet the GDC's overarching objective to protect, promote and maintain the health, safety and well-being of the public (Section 1(1ZA) and 1(1ZB) of the Dentist Act 1984. Criminal data Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the GDC's overarching duty to protect the public and the objective to protect, promote and maintain the health, safety and well-being of the public (sections

	1(1ZA) and 1(1ZB) of the Dentists Act 1984) and the GDC's duty to co-operate including with public bodies that carry out activities in connection with national health services (section 2A of the Dentists Act). As in the above text, the necessity comes from the purposes set out in section 3 of the MoU.
Health and Care Professions Council	Lawful basis of the Provider is likely to be as follows: Article 6(1)(e) – processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. The HCPC is exercising official authority in the performance of its functions under articles 3, 5 and 21 of the Health Professions Order 2001. Lawful basis of the Recipient(s) Article 6(1)(e) – processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. Special Conditions of Processing Article 9(2)(g) - processing is necessary for reasons of substantial public interest, on the basis of domestic law which shall be proportionate to the aim pursued and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject. The substantial public interest includes statutory and government purposes and the protection of the public.
General Pharmaceutical Council	Lawful basis of the Provider is likely to be as follows: Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its overarching objective set out in the Pharmacy Order 2010 to protect, promote and maintain the health, safety and well-being of users of pharmacy services and for the purposes set out in section 3 of this MoU. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to achieve the overarching objective set out in the Pharmacy Order 2010 to protect, promote and maintain the health, safety and well-being of users of pharmacy services and for the purposes set out in section 3 of this MoU.

	Lawful basis of the Recipient(s) Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of the GPhC's statutory functions and overarching objective under the Pharmacy Order 2010 to protect, promote and maintain the health, safety and well-being of users of pharmacy services and for the purposes set out in section 3 of this MoU. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge public functions set out in the Pharmacy Order 2010 and its overarching objective to protect, promote and maintain the health, safety and well-being of users of pharmacy services and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. In addition, the GPhC has enforcement powers and duties under the Poisons Act 1972, the Medicines Act 1968, the Humans Medicines Regulations 2012 and the Veterinary Medicines Regulations. <u>Confidentiality</u> <u>Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU.</u>
General Optical Council	Lawful basis of the Provider is likely to be as follows: Under section 13C(3) of the Opticians Act, the GOC *"may disclose to any person any information"* relating to registrants' fitness to practise, fitness to carry on business and/or fitness to undertake training, which it considers to be in the public interest to disclose. Lawful basis of the Recipient(s) Section 13B(1) of the Opticians Act 1989 empowers the GOC to *"require a registrant or any other person to supply any information or produce any document"* which it considers relevant to its functions re registrants' fitness to practise, fitness to carry on business and/or fitness to undertake training. Under section 13B(4) of the Opticians Act, it is to be assumed for the purposes of the Data Protection Act 2018 that such disclosure is covered by the exemption for disclosures required by law. Special Conditions of Processing

	Section 13B(3) of the Opticians Act: that the information is put into a form that is not capable of identifying the individual(s).
General Chiropractic Council	Lawful basis of the Provider is likely to be as follows: <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the GCC to provide a safe and effective health service. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of GCC to enable it to protect the public, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. <u>Confidentiality</u> <u>Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU.</u> Lawful basis of the Recipient(s) <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the GCC to protect the public. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of the GCC to enable it to protect the public, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU.

General Osteopathic Council	Lawful basis of the Provider is likely to be as follows: <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the GOsC to provide a safe and effective health service. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of GOsC to enable it to protect the public, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU. <u>Confidentiality</u> Sharing would not breach any obligations of confidentiality owed on the basis that it would be in the public interest for the purposes set out in section 3 of this MoU. Lawful basis of the Recipient(s) <u>Data protection</u> Article 6 (1)(e): processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller by virtue of its statutory functions i.e. for the purposes set out in section 3 of this MoU and to enable the GOsC to protect the public. Article 9(2)(g): processing is necessary for reasons of substantial public interest. Under section 10(3) of the Data Protection Act 2018 (DPA), this requires a condition in Part 2 of Schedule 1 of the DPA to be met. The relevant condition is paragraph 6 (statutory purpose), as the processing is necessary for the exercise of a function conferred on a person by an enactment or rule of law. Processing is necessary to discharge the functions of the GOsC to enable it to protect the public, and is necessary for reasons of substantial public interest, for the purposes set out at section 3 of this MoU.

The information to be shared will be based on a determination of necessity to be made on a case-by-case basis based on parties' guidance or other appropriate guidance at local

police force level. Systematic sharing of personal data is not proposed as part of this agreement, however, should such sharing become necessary in the future, a Data Protection Impact Assessment would need to be conducted before any systematic sharing took place.

Each party is responsible for effectively managing its responsibilities for the review, retention and secure disposal of personal data, shared under this MoU, in accordance with the requirements of the Data Protection Act 2018 and other current data protection legislation.

The table below provides a useful starting point for parties considering their data sharing requirements.

Organisation name	
Description	**Details**
Examples of categories of Data Subject (This list is non-exhaustive and will depend on the nature of the incident being investigated.)	The following categories of Data Subjects will be disclosed to the Recipient(s): [*insert details e.g. patients*].
Examples of type of Data (including Personal Data and Special Categories of Personal Data which will all be Pseudonymised, not contain identifiers and will be linked via the pseudonymous unique serial number identifier. This list is non-exhaustive and will depend on the nature of the incident being investigated.)	The following types of Personal Data will be disclosed to the Recipient(s): [*insert details*].
Data Transfer/ Permitted transfer	[*Insert details of any permitted data transfers by the Recipient(s) to other Recipients.]*
Consent process	*[insert details of consent process and specify where the consent is recorded.]*
File type	*[insert details of electronic file type]*
Frequency of Transfer	[Insert details of frequency e.g. ad-hoc, on-going]
Transfer mechanism	[*Insert data security details including: (i) method of sharing (e.g. specify encrypted site to be used for*

	*sharing); and (ii) any minimum expectations on technical and organisational measures to be us*ed].
Data Processors /Sub-Processors	*[insert details of the relevant persons responsible including names and job title]*
Data Storage Location	
Duration of Processing	*[insert details with reference to the principle set out in Article 5(1)(e) of UK GDPR]*
Plan for return or destruction of Personal Data upon termination of the Agreement	[*Insert procedure that Recipient(s) must follow for deletion of Shared Personal Data*]

Annex F – Confidentiality Agreement

This annex is intended as a useful resource for signatories considering issues around Confidential Information and provides some template wording.

Background

All members of the ICG, with the exception of the DHSC, may acquire or have access to Confidential Information (as defined below) and must consider the terms below in respect of such information.

This agreement is not intended to conflict with statutory obligations. Where such a conflict occurs, statutory obligations take precedence. In relation specifically to the Care Quality Commission, where information is shared under this MoU with CQC and that information identifies a known risk to a service user and/or information relevant to the discharge of its regulatory functions, the exercise of CQC's statutory functions will take precedence over this MoU and that information will be capable of informing the exercise of CQC's regulatory and/or enforcement processes.

In some cases, as to be decided by the ICG, it may be appropriate to set out in an additional written agreement:

- what information will be shared;
- when and how information will be shared;
- when and how information may be returned or destroyed; and
- the legal basis for all of the above.

Agreed terms on disclosure

1. The parties to this agreement wish to exchange information with each other in connection with the work of the ICG, the terms of reference for which are set out at section 3 of the MoU (Aims and purpose).

2. In consideration of a **Provider** agreeing to disclose Confidential Information to one or more **Recipients**, each Recipient undertakes to that Provider that it shall:

    i. keep the Confidential Information secret and confidential;
    ii. store the Confidential Information securely and take all reasonable steps to prevent access to it by unauthorised individuals;
    iii. not copy the Confidential Information save as for bringing the terms of this agreement into effect; and
    iv. not use or exploit the Confidential Information or any part or extract in any way, except for or in connection with the Section 3 of the MoU (Aims and purpose); and
    v. only make disclosure of the Confidential Information in accordance with clause 3 and clause 4 below.

vi. Any other disclosure can only be made with the Provider's prior written consent.

3. Each party may disclose the Confidential Information to any of its officers, employees, legal advisers and insurers that need to know the relevant Confidential Information for the Purpose only, provided that it procures that each such person to whom the Confidential Information is disclosed complies with the obligations set out in this agreement on terms that preserve confidentiality.

4. Each party may disclose the Confidential Information to the minimum extent required by:
   i. any order of any court of competent jurisdiction or any regulatory, judicial, governmental or similar body or taxation authority of competent jurisdiction; or
   ii. the laws or regulations of any country to which its affairs are subject.

Annex G – Other useful links

Information about health and safety and HSE's guidance is available here: www.hse.gov.uk

The *Work-related Deaths: A protocol for liaison* is available here Work-related Deaths: A protocol for liaison (England and Wales) - WRDP1 (hse.gov.uk)

Crown Prosecution Service (CPS) publications are available via the CPS website here: http://www.cps.gov.uk/publications/

The latest statement of law on gross negligence manslaughter is available here: https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter

National Police Chiefs' Council (NPCC) publications are available here: https://www.npcc.police.uk/

The *Patient Safety Incident Response Framework (PSIRF)* is published by NHS England. It details the requirements for NHS funded organisations in relation to their response, review and investigation of patient safety incidents. Information can be found here: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

Care Quality Commission publications are available here: www.cqc.org.uk

Medicines and Healthcare products Regulatory Authority publications are available here: www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/services-information

This publication is also available on our website at www.gov.uk/government/publications

For any enquiries regarding this publication contact DHSC Department of Health and Social Care - GOV.UK