Investigation of Death
Standard Operating Procedure

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<tr>
<th>Owning Department</th>
<th>SCD – Major Crime</th>
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<tbody>
<tr>
<td>Version Number</td>
<td>4.00</td>
</tr>
<tr>
<td>Date Published</td>
<td>12/12/2018</td>
</tr>
</tbody>
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Compliance Record

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<tr>
<th>Compliance Description</th>
<th>Status</th>
<th>Date</th>
</tr>
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<tr>
<td>Equality and Human Rights Impact Assessment (EqHRIA): Date Completed / Reviewed:</td>
<td>12/12/2018</td>
<td></td>
</tr>
<tr>
<td>Information Management Compliant:</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health and Safety Compliant:</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Publication Scheme Compliant:</td>
<td>No</td>
<td></td>
</tr>
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Version Control Table

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<tr>
<th>Version</th>
<th>History of Amendments</th>
<th>Approval Date</th>
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<tr>
<td>1.00</td>
<td>Initial Approved Version</td>
<td>27/08/2013</td>
</tr>
<tr>
<td>1.01</td>
<td>Correction to typing error in Appendix List, amendment to Appendix ‘E’</td>
<td>16/09/2013</td>
</tr>
<tr>
<td>1.02</td>
<td>Amendment to email address within Appendix ‘D’</td>
<td>12/02/2014</td>
</tr>
<tr>
<td>2.00</td>
<td>Full review, document has been re-written in its entirety.</td>
<td>25/02/2016</td>
</tr>
<tr>
<td>3.00</td>
<td>Under the direction of DCC Johnny Gywnne the amendments noted in this SOP are in relation to grammatical changes only from the wording 'police office' to 'police station'.</td>
<td>19/07/2017</td>
</tr>
<tr>
<td>4.00</td>
<td>Procedures Around Preparatory Work Updated as per Memo PS 156-18</td>
<td>23/11/2018</td>
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1. **Purpose**

1.1 This Standard Operating Procedure (SOP) supports the Police Service of Scotland (hereafter referred to as Police Scotland) policies;
- Crime Investigation,
- Criminal Justice,
- Equality, Diversity and Dignity

1.2 Deaths occur in society on a very regular basis, they can occur in hospital settings and within the community. Police Scotland will be called upon to support families and assist HCP (HCPs) in the management and on occasions the investigation of some of those deaths. This SOP aims to provide officers and staff with guidance on the critical role and responsibility of Police Scotland and our partners when attending incidents of death to ensure our actions are sympathetic, proportionate and appropriate to the situation and the needs of all those involved.

1.3 The investigation of death is a critical area of daily business for Police Scotland, which in all circumstances requires thorough investigation and the utmost professionalism by all staff involved.

1.4 When dealing with any form of death it is imperative that officers and staff consider the impact the death may have on the Next of Kin (NOK) and other persons involved. It is of the utmost importance that all parties are treated with dignity, compassion and respect throughout.

1.5 Officers liaising with NOK should be sincere in their approach and provide only accurate and appropriate information surrounding the circumstances of the death. Each individual incident and the information suitable for disclosure may change therefore clear instruction must be given to staff by the Officer in Charge (OIC).

2. **Health and Safety Considerations**

2.1 Deaths can occur anywhere and in any circumstances, therefore certain circumstances may present particular risk and the potential for harm. Supervisors must ensure that all officers are aware of any specific risk assessments applicable to the incident in question and that all recommended safety measures and practices are deployed.

2.2 Dynamic risk assessment will be an ongoing process throughout the duration of an incident. Suitable control measures will be put in place to remove or mitigate the effects of hazards identified through the process.
2.3 The following Generic Risk Assessments (GRAs) should be adopted and adapted depending on the type of incident faced by officers and staff during a death investigation;

- Body Handling and Recovery,
- Chemical Fatality and Self Harm Incidents,
- Confined Spaces,
- Hazardous Substances,
- Major Incidents,
- Officer Traveling Offshore and
- Railways.

2.4 The list above is not exhaustive, if appropriate use should be made of additional GRAs available from the Health, Safety and Wellbeing intranet pages.

2.5 Given the very nature of sudden deaths, there will be occasions where individuals are exposed to traumatic incidents. These traumatic incidents are events with the potential of having a particularly distressing impact on individuals. Supervisors and Managers should consult the Trauma Risk Management SOP and consider referring staff who are involved in such incidents to Occupational Health. Appropriate welfare support should also be provided. Advice can also be sought from local employee assistance programmes if appropriate.

2.6 Officers should also be mindful of the health and safety risks around Clinical Waste Procedures for the potential for Blood Borne Virus.

3. Categories of Death

3.1 Not all deaths are the same and some may present challenges for policing, however, throughout any incident of death, regardless of whether Police Scotland are the lead agency or not, officers and staff will provide support and assistance to families and our partners as required.

3.2 In general there are three broad categories of deaths; Medical Death, Unexplained Medical Death and Police Reportable Death.

3.3 Medical Death

3.3.1 Where death is expected or attributable to natural causes. The vast majority of deaths occur as a result of an obvious medical condition within a medical environment. HCP have a primary responsibility to fulfil their statutory obligations and provide a Medical Certificate of Cause of Death (MCCD) and to provide support and guidance to families.
3.3.2 There may be little or no knowledge or involvement of the Police or Crown Office Procurator Fiscal Service (COPFS) in such deaths. The continuing role of the Police in such circumstances is very limited and often unnecessary and inappropriate.

3.3.3 A MCCD may be issued if a medical practitioner is able to identify a cause of death to the best of their knowledge and belief. Certainty is not required.

3.4 Unexplained Medical Death

3.4.1 Where the death is sudden and unexplained. In circumstances listed in the COPFS Guidance on Reportable Deaths, a healthcare professional may require to report the fact of the death to COPFS. The Scottish Fatalities Investigation Unit (SFIU) is a specialist unit within COPFS with responsibility for receiving reports of deaths occurring in Scotland which are sudden, suspicious, accidental or unexplained and fall within the categories set out in the guidance.

3.4.2 Not all deaths which are reportable to COPFS require police involvement.

3.4.3 Appropriate HCP have their own processes and systems for reporting deaths to the SFIU. Medical uncertainty as to a cause of death is not in itself cause for suspicion. A healthcare professional may notify the police of a death in order to enable an initial police assessment of the whole circumstances. However, this need not necessarily lead to the police assuming responsibility for investigating or reporting the death, unless there are concerns supported with facts and circumstances over and above medical uncertainty, i.e. intelligence, signs of violence or criminality at the locus, etc.

3.4.4 In the absence of suspicion a death would be classified as a medical death. The continuing role of the Police in such circumstances would be very limited and often unnecessary and inappropriate.

3.5 Police Reportable Death

3.5.1 It is the responsibility of Police Scotland to investigate and report to COPFS all deaths which fall into the following categories:

- Suspicious death – any death where the circumstances are unknown and give cause for concern i.e. age of deceased, location, public place, circumstances, intelligence, lifestyle, etc.
- Drug misuse;
- Accidental deaths - including deaths resulting from falls and industrial accidents;
- Any death of a child or young person under 18 years of age which is unexplained;
- Incidents of suicide;
- Deaths occurring as a result of neglect or fault;
• Any death where the identity of the deceased is unknown and cannot be readily ascertained;
• Deaths in legal custody;
• Any death as directed by COPFS.

3.5.2 Initial Response

Often the initial information received by the police can be indicative of the nature of the death and therefore the response will be relatively obvious. In order to provide a consistent service to families and partners and ensure every death receives an appropriate assessment and response it is important to follow the stages below:

• **Stage 1** Preserve life – Unless death is undisputable, seek emergency medical assistance. Pronouncing Life Extinct (PLE) is a clinical decision which can only be determined by a competent healthcare professional.

• **Stage 2** Initial assessment – This is a police function, which must consider the body, the scene and known risks in order to understand the circumstances and inform decision making. HCP may offer opinion related to clinical matters, however, the police have the responsibility and capability to investigate the whole circumstances and determine the category of death.

• **Stage 3** Response – Having identified the category of death it will be possible to identify the most appropriate agency to lead the response.
  
  o Police Reportable Deaths – Police Scotland will assume responsibility, under the supervision and direction of an officer of at least the rank of Inspector, for the investigation of the death, including the seizure and transportation of the deceased and reporting the circumstances of the death to COPFS.
  
  o Medical Deaths – The National Health Service (NHS) will be the lead agency for managing the incident with police assistance (tracing relatives, death messages, etc.) if required. An appropriate medical practitioner will either issue a MCCD or report the matter directly to COPFS.

3.5.3 The following overriding principles will be observed:

• The overriding priority is to preserve life.

• A police incident must be created on receipt of every report relating to a potential death, regardless of how the report is received, either to a contact centre or directly to an officer or member of staff. ACR response to this is key in ensuring that all of the reporter’s information is recorded accurately, additional emergency services contacted and that the correct police action is taken.
• Assume life and request the attendance of emergency medical care, unless a competent health care professional is in attendance and has Pronounced Life Extinct or it is evident from the information available that death is indisputable i.e. decapitation, significant mutilation or burning or advanced decomposition.

• Officers and staff must at all times ensure that the deceased and any family or friends are treated with respect, dignity and compassion.

• Immediately notify the appropriate area Inspector who will maintain oversight and responsibility for the initial incident response.

• Notify the appropriate area Sergeant, or nominated representative where attendance of a Sergeant is not possible. They will attend the locus and be responsible for the initial assessment and operational response.

• The circumstances of each death will be subject to a thorough initial investigation by the Police to establish the category of death, this may include information from attending HCP but may also include a physical examination of the deceased and scene and checks of police systems to establish potential sources of threat, risk and harm to the deceased.

• Without prejudicing the duty to preserve life, officers must remain forensically aware, in the absence of any evident cause of death, officers should consider the circumstances to be suspicious and a possible Crime Scene. Some interference with a scene is inevitable in order to discharge the duty to preserve life and conduct a meaningful initial assessment, however, this must be minimised and the details of any interference noted.

• The identification of the deceased and notification to the NOK should be regarded as a priority, provided that this poses no investigative conflict.

• At any point following the confirmation of death where the circumstances indicate the potential that the death may be a police reportable death, first responders must withdraw from and protect the scene, update the incident and the area Inspector with oversight of the incident.

• Where it is established that the circumstances do not meet any of the Police Reportable Death criteria, it will be the responsibility of the NHS to assume responsibility for the management of the incident. Officers will provide ongoing assistance as necessary, however, ongoing Police involvement is very limited and often inappropriate.

• It should be recognised that some families may have difficulties accepting the circumstances of the death. Cultural or religious values can play a part in this reluctance, particularly if it involved suicide. Advice from diversity units or Local Lay Advisers must be a consideration in incidences where cultural or religious values are a factor.
4. **Do Not Attempt Cardiopulmonary Resuscitation Notice**

4.1 A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Notice is a statement completed and signed by a clinician, usually a medical consultant or a General Practitioner, following close consultation with a patient and / or their relatives or carers which declares that in the event of the patient suffering cardiac arrest any attempt to resuscitate them would be inappropriate. DNACPR are predominantly in place for elderly people and others with chronic illness and medical conditions, however, officers must be aware this does not preclude any other necessary medical treatment.

4.2 If on arrival at a locus medical personnel in attendance intimate that a DNACPR Notice is in place then no further medical intervention, in relation to CPR should take place if medical personnel believe that carrying out CPR would not realistically have a medically successful outcome.

4.3 In these circumstances families have expected and planned for the event, ongoing police involvement is often inappropriate in the absence of grounds for concern then this should be treated as a medical death and the NHS and families be allowed to manage the incident.

5. **Incident Management and Scene Attendance**

5.1 A Police Inspector on duty with responsibility for the area in which the death occurs must be notified of the incident immediately. They must review the circumstances and ensure the response is and remains appropriate, maintaining oversight and responsibility for a successful outcome to the incident.

5.2 Over and above police first responders the attendance of a supervisor appropriate to the circumstances is required to attend every death. The minimum attendance criterion is for a Sergeant to attend the locus.

5.3 It is recognised that in certain remote locations within Scotland the attendance of a Sergeant at every death may be challenging. In such circumstances the non-attendance of a Sergeant should only be decided upon by the Police Inspector with oversight of the death. Depending on the circumstances and the seriousness of the incident it may be appropriate for the Police Inspector with oversight of the death, to attend at the locus and assume the role of Police Incident Officer (PIO), particularly in cases of suspected homicide, Major Incident or potential Critical Incidents.

6. **Stage 1 – Preserving of Life**

6.1 An officer’s first priority when responding to a report of a death in the community or any incident where they are at the scene of a death should be to preserve life. Only a Medical Practitioner, specifically trained nurses in certain circumstances and Paramedics can PLE.
Upon encountering an unresponsive casualty, police officers should never presume death and must request emergency medical attention immediately. Unless death is indisputable i.e. decapitation, significant mutilation or advanced decomposition. The deceased may be cold, however, this on its own is not confirmation that death has occurred.

Deaths require a partnership response therefore the use of language and terminology is very important and reinforcing any bias must be avoided. A reporter or NOK may use the term “dead” or first responders may think the person is dead, however, as neither are qualified to draw such a conclusion we must avoid influencing others and providing information which has not been verified.

The Scottish Ambulance Service (SAS) is our primary partner during stage 1 and should be provided with factual information to allow them to respond appropriately. The attending healthcare professional will retain primacy in respect of the health of the person concerned and must be afforded every assistance to do whatever they consider necessary to save the person’s life. Preserving life should not be compromised in an effort to preserve evidence.

If lifesaving is unsuccessful SAS Paramedics will formally PLE.

Obvious Death - The only circumstances where Police Officers may presume death is where there is decapitation, decomposition and decay, total incineration or significant mutilation as to make death indisputable and totally inconsistent with life, or following consultation with SAS.

Where death is obvious as described in 6.6 above there is no requirement to request emergency medical care or for a healthcare professional to PLE, in such cases the officers attending must note the “Time Found”.

Any interference with the deceased, their clothing or the locus as a result of life saving efforts must be noted by the officers present. Officers must be mindful to pay attention to the condition of the deceased, their state of dress or any disruption to a scene at the time of arrival and subsequently. This is extremely important in order to prevent misinterpretation by investigators at a later stage.

Stage 2 – Initial Assessment

Having had the fact of death confirmed by a competent healthcare professional all attention must now focus on assessing the situation with a view to identifying the category of the death. This will enable the appropriate lead agency to be appointed with ownership and responsibility for successfully concluding the incident.
7.2 Where it is clear that a death is evidently a Police Reportable Death no further assessment should be undertaken by initial responders. There should be no further interference with the body at this time and officers should move to Stage 3 (see Section 8 – Stage 3 - Response)

7.3 In all other cases where the category of death remains unclear, a thorough police assessment of the circumstances must be carried out. It is the responsibility of the Police Inspector with oversight of the incident to determine the level of assessment required and based on the information gained determine the category of death. Consultation and involvement of divisional CID and other specialist resources should be considered depending on the circumstances. All deaths are different and present unique challenges, therefore, it is not possible to provide a standard checklist of enquiries, however, officers should refer to paragraph 7.6 (Initial Actions) for suggested initial actions. The initial assessment is not a formal search or crime scene examination, its purpose is to identify the deceased and find any causes of concern, uncover potential criminality and determine the appropriate level of response required.

7.4 Scene Protection and Counter Contamination

7.4.1 Initial entry, and therefore scene contamination, is unavoidable in order to preserve life, however, disturbance must be minimised and precautions taken to prevent any cross contamination and potential for misinterpretation. As DNA analytical techniques become more advanced and sensitivity increases so also does the potential to detect contamination. Officers must be aware of the basic principles of DNA evidence and importantly the measures that must be taking to avoid secondary transfer. The implications for secondary transfer are extremely serious when dealing with DNA evidence as it could potentially result in DNA from a person being inadvertently transferred to an item they never actually touched or were in contact with. It is therefore imperative that robust counter contamination methods are employed when searching for or recovering items that may be subject to DNA examination. Further Guidance can be found within DNA Counter Contamination Guidance.

7.4.2 The following general principles should be applied to every scene:

- Prevent further access to the area in question;
- Remember Locard’s Principle, “every contact leaves a trace”;
- The minimum standard for DNA counter contamination is to wear a face mask and two pairs of disposable gloves;
- Replace outer gloves frequently, when contaminated, when moving between areas, when in contact with different persons or bodies or when touching any potentially significant item. Retain used gloves for consideration by forensic examiners / Crime Scene Managers (CSM);
- Handling items must be kept to a minimum, and any disturbance recorded;
- Do not move items unless unavoidable and never place significant items temporarily on another surface within a scene;
• Record counter contamination measures in your notebook, scene entry log and any subsequent statement and
• Enforce counter contamination standards in others at the scene.

7.5 Initial Actions

7.5.1 The list below provides guidance on the actions that must be considered at each death. Depending on the individual circumstances it may be appropriate to conduct some or all of the actions below in order to establish the category of death. Consideration should be given to the use of appropriate resources, including CID officers, CSM, Search Advisors or other specialists to perform specific tasks:

7.5.2 The Deceased

• Examine the body - Officers must conduct a visual examination of the body looking for:
  o Injuries, blood and bruising,
  o Weapons,
  o signs of drugs misuse,
  o other signs of violence, damage to clothing, etc.
  o marks, scars or tattoos which may aid identification.
• System checks - Conduct background checks looking for previous sources of threat, risk and harm to the individual that may have a bearing on the death and record the outcome (positive and negative) on the police incident:
  o Intelligence – are there risks associated with the deceased’s lifestyle?
  o Vulnerabilities – was the deceased a victim of domestic violence, previously self-harmed, etc?
  o Incidents – did the deceased require recent police assistance?
  o Crimes – previous victim or accused,
  o Firearms certificate holder.

Note: Officers should be aware that when attending a death of specific religion, religious rituals may have been carried out prior to police arrival which would not necessarily amount to suspicion. The following are some examples and not an exhaustive list.

• Members of the Hindu faith may move their deceased so that the head faces east and a lamp is lit next to their head.

• In Judaism the deceased person’s eyes are closed and the body is laid on the floor and covered. Candles are then lit next to the body and the body is never left alone.
Note: Officers should seek advice via line management from diversity units or Lay - Community Advisers. Further guidance can be found in The Diversity Booklet – A Practical Guide. If an interpreter or translator is required refer to the Interpreting and Translating Services SOP for further information.

7.5.3 The Locus

- Search the premises – Officers must consider a visual examination of the locus, looking for:
  - other persons within – casualties, children, deceased or witnesses / suspects,
  - signs of drug misuse,
  - signs of forced entry - damage to locks or windows,
  - signs of a struggle or violence - blood, weapons, damaged furniture or broken glass,
  - the keys for the property,
  - other personal items – wallet / purse, mobile phone or car keys,
  - suicide note,
  - personal papers – to aid identification, NOK or healthcare details,
  - medication.

- Conduct door to door enquiries – to establish recent history, identification, NOK, medical history or other witnesses,

- Identify witnesses and obtain statements where relevant,

- Systems checks – previous incidents at address.

7.5.4 If at any stage it is suspected that the circumstances could indicate a Police Reportable Death, no further assessment should be undertaken by initial responders. There should be no further interference with the body or the scene at this time and officers should move to Stage 3 (see Section 8 – Stage 3 - Response).

7.5.5 Following a thorough assessment, in the absence of suspicion or concern it is reasonable to conclude at this time that the circumstances amount to a medical death and officers should move to stage 3 (see Section 8 – Stage 3 - Response).
8. **Stage 3 – Response**

8.1 In December 2015 agreement was reached between the Chief Medical Officer for Scotland (CMO), COPFS and Police Scotland in relation to the roles and responsibilities of agencies in response to incidents of death in the community, refer to CMO Guidance on the Certification of Death. It is acknowledged that there is a disproportionate reliance on policing resources to resolve such incidents, particularly where there is no foundation for believing there has been any wrongdoing or criminality contributing to the death. The following guidance has been agreed with partners and sets the expectations and limitations for police and partner agencies involvement in such incidents. In all incidents regardless of category we will remain available to assist families and partners.

8.2 **Medical Death and Unexplained Medical Death**

8.2.1 The priority is to support and guide the NOK, relatives and friends in the next steps. In Scotland a MCCD is required before a death can be registered and a funeral take place. For medical deaths this means notifying the deceased’s GP of the death and allowing them to manage any ongoing needs of the bereaved and the certification or reporting to COPFS process.

8.2.2 It is the statutory duty of the doctor who has “attended” the deceased during the last illness and is familiar with their medical history, investigations and treatment, to issue the MCCD if they are able to identify a cause of death to the best of their knowledge and belief. Certainty is not a requirement. Generally this means their own GP, or another doctor from that practice with knowledge of the deceased and / or access to their clinical records. A doctor will generally review their clinical notes and the circumstances in order to determine a cause of death. Certifying doctors are not required to attend the locus or physically examine the deceased, some may choose to do so in certain circumstances, however, it is not a requirement in every case. The manner and extent to which a GP investigates the death is a matter for their own practice, however, it is important police communicate with the GP and are aware of GP’s intentions in relation to the incident in question.

8.2.3 It should be noted that the general principle to be applied is that the continuing role of the Police in non-suspicious deaths is very limited and often inappropriate. The relevant GP should take over the responsibility for the management of the death as soon as possible.
8.3 Incident Occurs During Surgery Hours

8.3.1 As this is a medical death, officers should advise the NOK to notify the deceased's GP's Surgery. It is best practice for the NOK to contact and notify the surgery themselves, they will be better placed to answer questions regarding recent history and make appropriate arrangements with the GP. However, where this is not possible for any reason, i.e. distress, frailty or where no responsible person is available, the attending officers should contact and notify the relevant surgery. Police must also take the opportunity to inform the relevant GP's surgery the matter is not considered a Police Reportable Death at this time and whether the deceased has been PLE.

8.3.2 In the majority of cases the deceased's GP will be available to assess the medical history and circumstances without significant delay and assume responsibility for the management of the incident and issue a MCCD. On confirmation that a MCCD will be issued the NOK can now be allowed to make arrangements with a funeral director of their choice to have the deceased removed to a place of rest. At this time officers must update the police incident accordingly as outlined under Incident Recording (Section 22) and notify the relevant supervisors. Thereafter there is no further requirement for police involvement.

8.3.3 In circumstances where the relevant GP assesses the medical history and circumstances and is unable to issue an MCCD, due to medical uncertainty over the cause of death, however, has no concerns in relation to the circumstances, the incident remains a medical death. Police will remain at the locus until the relevant GP confirms their intentions. It is the relevant GP's responsibility to report the matter to COPFS. The NOK should be advised to make their own arrangements with a private funeral directors of their choice to have the deceased removed to a place of rest. At this time officers must update the police incident accordingly as outlined under Incident Recording (Section 22) and notify the relevant supervisors. Thereafter, there is no further requirement for police involvement.

8.3.4 In circumstances where the relevant GP has been notified, however, is unavailable to assess the medical history and circumstances without a significant delay, the incident remains a medical death. It must be expected that GP's may be busy and genuinely unable to make an assessment within a reasonable time, however, this remains a medical death, and the priority in their response is a matter for their own practice. However, the GP or their surgery must be advised that this is not a Police Reportable Death at this time and that the police will not be progressing enquiries. The details of the time and person notified and confirmation that the matter is in hand in accordance with the CMO agreement must be recorded on the police incident.
8.3.5 The NOK should be allowed to make their own arrangements with a private funeral directors to have the deceased removed to a place of rest, until a MCCD is issued. Officers must update the police incident accordingly as outlined under Incident Recording below and notify the relevant supervisors. Thereafter, there is no further requirement for police involvement, unless further instructed by COPFS. It is the responsibility of the relevant GP to assess the medical history and circumstances and either issue an MCCD or report the death to COPFS direct.

8.4 Incident Occurs Out With Surgery Hours

8.4.1 Where the death occurs out of surgery hours, generally between 1800 hours and 0800 hours Monday to Friday and all day at weekends, then NHS 24 should be contacted and notified of the death, in the same manner as above. The incident remains a medical death. Depending on the nature of the incident and needs of the bereaved, NHS 24 will decide on their appropriate response, however, are unlikely to be in a position to issue a MCCD. All relevant details must be passed to NHS 24 who will record the incident and notify the relevant GP or surgery of the details of the death electronically. The NOK should be advised to contact the deceased’s GPs surgery when it next opens, in order to notify them of the death. They should then be allowed to make their own arrangements with a private funeral directors of their choice to have the deceased removed to a place of rest. At this time officers must update the police incident accordingly as outlined under Incident Recording below and notify the relevant supervisors. **Officers must ensure that an action is raised locally for early shift officers to contact the relevant surgery when next open to ensure the relevant GP has been made aware of the death and their responsibility to conclude the matter.**

8.4.2 Confirmation must be sought from the surgery that the matter is in hand and will be dealt with in accordance with the CMO agreement. It is the responsibility of the relevant GP to assess the medical history and circumstances and either issue an MCCD or report the death to COPFS direct.

8.4.3 Officers will remain at the locus until the arrival of any attending funeral directors or, if appropriate, a relevant GP. However, a relevant Police Inspector with oversight of the incident may withdraw police officers earlier if they are satisfied that the NOK are capable of managing the situation and have been consulted and are content for the police to withdraw.

8.4.4 Officers must offer the NOK, HCP and funeral directors details of the incident number for future reference.
8.5 Preparatory Work

8.5.1 In the case of medical deaths / unexplained medical deaths only, where further investigation is ongoing by the relevant GP and no MCCD has been issued, Funeral Director's (FDs) will follow their current best practice in relation to soiled bodies, specifically that clothing will be removed and the remains washed to remove sick and faeces. This is not only more dignified but may also prevent further deterioration of the skin.

8.5.2 FDs should be instructed not to carry out any further work, including embalming and invasive procedures until a MCCD is issued.

8.5.3 As per current guidance, no preparatory work should be undertaken for Police Reportable deaths.

8.6 Review

8.6.1 It is reasonable to expect that throughout the incident new information will come to light or a healthcare professional may express genuine concern. We should encourage and welcome open dialog with those who hold information or specialist knowledge regarding the death and accept that in some instances discussion will be required before settling on any informed decision. We should anticipate challenge and be prepared to defend or amend our decisions. If at any stage a relevant healthcare professional, funeral director or anyone involved in the death becomes concerned or suspicious in relation to the circumstances of the death beyond medical uncertainty as to the cause, then the original assessment must be reviewed and the new information considered. The review should be conducted without delay, preferably by the Police Inspector who oversaw the original incident, however, due to the passage of time this may be the on duty Police Inspector with responsibility for the area in question. The result may be that having considered the new information we are satisfied with the original decision or indeed we are satisfied that the circumstances now meet the threshold for a Police Reportable Death.

8.6.2 In circumstances where the deceased is identified but no NOK can be identified or contacted within a reasonable time, regardless of whether a MCCD will be issued, the death should be treated as a Police Reportable Death. However, the scale and extent of any associated investigation, if any, will be determined by the circumstances. The police will remove the deceased to a public mortuary using a police contracted undertaker and thereafter notify the Ultimus Haeres Unit at COPFS (see section 31).

8.6.3 In circumstances where the deceased is identified and the NOK have been traced, however, are unwilling to take responsibility for the deceased or do not have the means to engage a Funeral Directors, regardless of whether a MCCD will be issued, the death should be treated as a Police Reportable Death. However, the scale and extent of any associated investigation, if any, will be determined by the circumstances.
The police will remove the deceased to a public mortuary using a police contracted Funeral Director and thereafter as soon as reasonably practicable or the next working day contact should be made with the Relevant Local Authority Bereavement Service. Under the National Assistance Act 1948 “It shall be the duty of every authority to cause to be buried or cremated the body of any person who has died or been found dead in their area, in any case where it appears to the authority that no suitable arrangements for the disposal of the body have been or are being made otherwise than by the authority”. In such circumstances the Local Authority will endeavor to trace a NOK to make funeral arrangements and if unsuccessful will thereafter register the death and make the necessary funeral arrangements themselves.

In circumstances where a dispute arises between police and healthcare professional as to the category of death and the healthcare professional refuses to fulfil their obligations, the death should be treated as a Police Reportable Death. However, the scale and extent of any associated investigation, if any, will be determined by the circumstances. The details of the dispute, including the names of those involved, must be recorded in the officer’s notebook and on the police incident. The reporting officer must include in the remarks section of the Deaths Report the details of the dispute and the fact of refusal by the healthcare professional.

As a contingency and only in specific justifiable occasions in any medical death where SAS have not been requested to provide emergency medical care and death is not indisputable a relevant GP or out of hours GP should be requested to PLE. The background, rational and justification for this course of action must be fully recorded on the incident.

In circumstances where a Medical Death occurs in a public place, SAS should not be expected to transfer the deceased to a mortuary. However close liaison with SAS should be undertaken in order to preserve the dignity of the deceased and limit the distress to families.

**Police Reportable Deaths**

Having thoroughly assessed the circumstances of the death and concluded that it is a Police Reportable Death the policing priority must now be to protect the scene, secure available evidence and conduct an appropriate investigation. Officers should secure the scene and implement a scene entry log and enforce counter contamination measures. Officers must notify the relevant supervisors and the on duty CID resource.

In all Police Reportable Deaths early consideration must be given to the appointment of an appropriate senior police investigator of at least the rank of Inspector to manage the ongoing police investigation. In all suspicious, child deaths and drugs deaths a Detective Inspector will be appointed as SIO.

All further actions and investigation in relation to the death will be carried out in accordance with the senior investigators instruction and policy.
8.7.4 Police Reportable Deaths will vary in the manner in which they are managed and reported, however, all shall be conducted in accordance with the principles within the ACPO Murder Investigation Manual and the Crime Investigation SOP.

8.7.5 As a contingency and only in specific justifiable occasions in any Police Reportable Death where SAS have not been requested to provide emergency medical care and death is not indisputable, a Forensic Physician should be requested to PLE. The background, rational and justification for this course of action must be fully recorded on the incident.

8.8 Reporting

8.8.1 The investigation of deaths is directed by the Scottish Fatalities Investigation Units at COPFS. They are based in Glasgow and Edinburgh and contact details can be found in Appendix ‘E’

8.8.2 It is essential that COPFS receives a death report from the Police the day after the death or, at the latest, the day after that (if, for example, medical information is not immediately to hand). The PF would rather the Police held off reporting the death for essential medical history (that is pertinent to the death). However, death reports should be submitted within 24 hours after death (excluding weekends) or 24 hours after the PF instructs the police to investigate the circumstances surrounding the death.

8.8.3 Any hard copy correspondence which is requested by the Scottish Fatalities Investigation Unit should not be sent to local Procurator Fiscal Offices but must be sent under receipt to the Scottish Fatalities Investigation Unit directly.

8.9 General Investigation Considerations

- Appoint a Crime Scene Manager.
- Consider Forensic Services attendance for photography and any scene work.
- COPFS must be advised and instruction taken.
- Early consideration should be given by the SIO and on-call DSU with strategic oversight to contact the on-call SIO for the relevant Major Investigation Team (MIT),
- The on duty CID Officer will advise the area Detective Inspector on-call or otherwise.
- Only following COPFS direction will a request be made to initiate the attendance of a Pathologist.
- The role of the initial attending officers is critical in all deaths. The information and circumstances which officers will be presented with at the outset of the enquiry are essential for allowing early decisions to be made.
• It is therefore of critical importance that the initial officers in attendance record all relevant details in their official police notebooks / PDAs and ensure that such information is passed to the appointed SIO without delay.

• It is the responsibility of the Supervisor attending the scene of any suspicious death to ensure that from the outset it is adequately protected to achieve optimum forensic capture and evidence gathering. The attending Supervisors will also ensure a Scene Entry Log is commenced to record entry to the locus. All entry from this time should be directed by the appointed SIO or CSM.

• Supervisor to ensure that all statements are collated for the death report or Major Incident Team

9. Child Deaths

9.1 Sudden Unexpected Death in Infancy (SUDI) was formerly referred to as ‘cot death’ or SIDS (Sudden Infant Death Syndrome) and its causes are still largely unexplained.

9.2 Whilst maintaining a professional approach to such an investigation, officers must display understanding and compassion during what will be an extremely difficult period for any family. They should also consider evidence recovery protocols and use tact and diplomacy to maintain scene preservation.

9.3 On receiving notification of all SUDI and unexplained child deaths during normal ‘office hours’, an SIO of at least Detective Inspector rank will be appointed. Out with these times, the on-call Detective Inspector must be contacted. Thereafter, they will lead the investigation as the SIO.

9.4 Officers should be aware that the welfare of families and all involved is of paramount importance and that all necessary support should be provided, which also includes the Trauma Risk Management (TRiM) process for all officers and police staff.

9.5 The attendance and investigation of such deaths will be carried out in line with the ACPOS Scottish Investigators’ Guide to Sudden Unexpected Deaths in Infancy (SUDI). Further professional advice and information can be found at: www.sudiscotland.co.uk.
10. **Drugs Deaths**

10.1 The Police Inspector with oversight of the death will liaise with the appropriate on duty or on-call Detective Supervisor (Detective Inspector or Detective Sergeant depending on geographical area). A supervising Detective Officer must review the incident and if necessary arrange a CSM to assess the scene and review forensic opportunities. Officers should consider the criminal offences committed in these circumstances and ensure the police response is commensurate to the death.

10.2 The senior Detective Supervisor, in consultation with the Crime Scene Manager will make an assessment regarding what further resources need to be deployed. The minimum actions to be taken at a suspected drug death must include witness statements, scene photography supported by a systematic search for drug paraphernalia.

10.3 An Officer of at least Detective Inspector rank will ultimately have overall responsibility for the subsequent investigation and reporting of same to the Procurator Fiscal. The SIO will investigate any suspected drugs death as they would with any other suspicious death.

10.4 Detective Officers will attend post mortem examinations in relation to drug related deaths to provide continuity when toxicology and other samples are taken.

10.5 The investigation into the death must be conducted without undue delay and the necessary management of the investigation recorded. It is not acceptable to delay the investigation until the results of the toxicology are known.

10.6 Toxicology examinations for suspected drug deaths must be prioritised and in each occasion the SIO should consult with the forensic gateway to ensure that samples are prioritised. It is important both for the families of the deceased and the reputation of the service that the cause of the person’s death be identified as soon as reasonably practical.

10.7 A drugs death is one where there is prima facie evidence of a fatal overdose of controlled drugs. Such evidence would be recent drug misuse, for example, controlled drugs and / or a hypodermic syringe found in close proximity to the body and / or the person is known to the police as a drug user, although not necessarily a notified user.

10.8 The absence of ‘prima facie evidence’ does not preclude a death from being possibly drug related, for example, the deceased may have consumed the drugs away from the locus of the death, the scene may have been interfered with by others prior to police arrival, etc.

10.9 It is critically important during the assessment stage that officers conduct all appropriate checks of intelligence, crime and criminal history systems to establish any potential information that may indicate the death to be drug related.
10.10 This definition includes all drugs controlled under the Misuse of Drugs Act 1971. In addition, it will also include instances of deaths that may arise from the use of illicit uncontrolled drugs (e.g. New Psychoactive Substances (NPS)) or prescribed and ‘over the counter’ drugs that have not been legitimately obtained, or where a criminal act may still have been committed that caused or contributed to death.

10.11 An SIO may consider the use of a Police Search Adviser (POLSA) to provide advice on best practice in relation to any subsequent searches.

10.12 The Service Substance Misuse Co-ordinator (SSMC) or equivalent should be advised of all cases of suspected drug related deaths in order that any public health concerns can be addressed.

10.13 Release of the Body

10.13.1 Historically, this is an area which often causes issues with the NOK due to the length of time it takes to obtain toxicology results and complete enquiries in relation to the supply of controlled drugs. To mitigate this, regular consultation should be had with the PF and NOK to ensure no undue delays are experienced in the release of the body and that the family are kept fully apprised.

10.13.2 Where there is a possibility of criminal proceedings for Culpable Homicide and a specific suspect has been identified, the death shall continue to be treated as a suspicious death.

11. Work Related Deaths

11.1 ‘Work related death’ is not a legal term and can have a wide meaning, therefore a wide interpretation should be applied at the earliest stages of an investigation to allow for the fullest possible exploration of possibilities. Just because someone dies at their place of work does not necessarily make it a work related death and all the circumstances should be taken into consideration when deciding if the circumstances relate to a work related death.

11.2 The Corporate Manslaughter and Corporate Homicide Act 2007, ACPOS Manual of Guidance for Senior Investigating Officers should form the basis of any police investigation into work related deaths.

11.3 Associated Memoranda of Understanding and other useful documents can be accessed via Appendix ‘B’.

11.4 Initial Response

11.4.1 A significant number of reports of death in the workplace reported to the police are done so by telephone call. It is essential that Call Handlers ensure the information they record is accurate, adequate and relevant.
11.4.2 It is important that any information known or subsequently uncovered relating to risks and hazards associated with the incident are relayed to any person who may be affected (e.g. area control room to initial attending officers, partner agencies etc.) and in order to allow the PIO to make informed decisions.

11.5 Attendance

11.5.1 The safety of officers and others present at the scene of a “work related death” is paramount. Therefore, on initial attendance, a dynamic risk assessment must be undertaken and the advice and assistance sought from persons responsible for the management of the premises or accident site to establish all known or foreseeable risks and hazards present. Depending on the circumstances, nature, scale of the incident and known hazards, consideration should be given to a PIO being appointed to attend the scene and ensure an appropriate response and if necessary, seek advice from Police Scotland Health & Safety Advisers.

11.5.2 Officers attending initially will establish the nature and circumstances of the incident and liaise with the person in charge. The locus will be treated as a Crime Scene and the necessary steps taken to identify, control, secure and preserve the scene and record all activity.

11.5.3 The appropriate on duty or on-call Detective Inspector should be notified at the earliest opportunity.

11.5.4 The necessity and the appointment of a SIO should be considered at an early stage and in consultation with the on duty or on-call CID Command Officer.

11.5.5 Consideration should be given by the SIO to appointing a CSM at the earliest opportunity. The CSM will attend immediately at the locus after being fully briefed by the SIO.

11.5.6 The Duty PF should be notified of the circumstances at the instruction of the SIO.

11.5.7 Consideration should be given by the SIO to the appointment of a Family Liaison Officer (FLO) for bereaved relatives via the Family Liaison Coordinator. Further guidance can be found in the Family Liaison SOP.

11.5.8 Contact should also be made with the Health and Safety Executive (HSE) or other relevant enforcing agency, on the instruction of the SIO, and this should be done at an early stage to allow any such agency to attend the scene.

11.6 Investigation

11.6.1 There will thereafter be liaison with the PF and other relevant bodies as to the progression and primacy of the enquiry as per the HSE Work-Related Deaths, A Protocol for Liaison.
11.6.2 Where there is an indication of criminality, the police will assume primacy for the investigation throughout and will work jointly with the HSE and or any other relevant enforcing agency.

11.7 Offshore Deaths

11.7.1 Police Scotland has direct responsibility for all installations, fixed or floating within the area of the United Kingdom Sector of the Continental Shelf North of Latitude 55° (Scottish Waters) and West of the Median Line within the Norwegian Sector. That responsibility encompasses all exploration and production operations ongoing in the Central and Northern North Sea and also includes fields under development in the waters west of the Shetland Islands. The ‘A’ Division Administration Support Unit must be contacted following all offshore related deaths. Their contact details can be found in appendix ‘E’. They will manage all deployments and equipment required to conclude the incident.

11.7.2 The Energy and Protective Security Unit provide support and services in relation to Offshore Emergency Response, Protective Security Advice and Counter Terrorism Contingency Planning. This department regularly delivers inputs to Offshore Installation Managers (OIMs) in relation to a variety of offshore scenarios, including a death offshore. The importance of protecting the locus and preserving evidence is highlighted during these inputs and OIMs are also provided with A Guide to Police Procedures for Offshore Installation Managers, which is an industry publication and details these issues.

11.7.3 All operational policing matters relating to deaths within the offshore environment will be overseen by the appropriate Local Policing Commander. Where there is an indication of criminality in the death, the appropriate response will be provided as per the guidelines for a suspicious death.

11.7.4 Following the death of any person on an offshore installation or a vessel engaged in offshore duties, recognised procedures as per the Guide to Police Procedures for Offshore Installation Managers will be adhered to by the relevant agency.

11.7.5 All Police Scotland staff required to go offshore must have successfully completed the Basic Offshore Safety Induction and Emergency Training. Supervisors must make themselves aware of the latest risk assessment in relation to such incidents and ensure the appropriate safety measures are deployed. Refer to the Officer Travelling Offshore Generic Risk Assessment.

12. Suicides

12.1 The Police Inspector with oversight of the death and the on duty CID supervisor will, where possible, attend the scene of any suicide and assess the scene and thereafter take whatever action is deemed necessary to ensure a full and thorough investigation is carried out.
12.2 If a CID Supervisor is unable to attend the reason must be fully updated on Command and Control.

12.3 Consideration should be given to the appointment of a CSM, Family Liaison Officer, Scene Examiner and other specialist services, however, in these circumstances, an SIO would be appointed of at least Detective Inspector rank and they would direct any such specialist resources.

12.4 Where the circumstances are deemed not to be suspicious, the investigation should be conducted as per the Local Command Area tasking process.

12.5 Following a suicide, it should be established whether a Criminal Justice DNA sample has previously been taken from the deceased. Following criminal acts, it has been known for people to take their own lives because of the resultant feelings of remorse or fears of possible exposure, therefore where it is established that no such sample has been taken or where the deceased has had a sample taken, but not confirmed, consideration should be given to taking DNA samples from deceased.

12.6 Consideration to obtaining a DNA sample should be made when the deceased has previous convictions for crimes of a sexual or violent nature or where intelligence links them to such crimes.

12.7 A scene examiner should be requested to record the scene prior to removal of the deceased.

12.8 Where a suicide note is believed to be stored electronically it is important to seize for examination any associated devices, this will not only provide the details of the note but also when and potentially by whom it was created.

12.9 Any original hardcopy suicide note must be seized as a production.

13. **Chemical Suicides**

13.1 Chemical or detergent suicide is a way of committing suicide that is becoming increasingly prevalent and information can easily be sourced from the internet.

13.2 One method that is becoming increasingly prevalent is the mixing of household chemicals to form a poisonous gas. The most common gas is formed by the mixing of a household source of sulphur with an acid to produce Hydrogen Sulphide gas.

13.3 Hydrogen Sulphide gas is colourless and extremely toxic (at 700 parts per million just two or three breaths can cause immediate death).
13.4 Warning Signs
- Subject appears unconscious and unresponsive;
- Tape over vents and / or windows;
- Bucket or other container containing chemicals;
- Empty containers of chemicals around the subject;
- Smell of rotten eggs;
- Suicide note and possibly a note left for the Emergency Services.

13.5 Response to Chemical Suicide in a Vehicle
- Officers and their Supervisors must make themselves aware of the latest risk assessment in relation to such incidents and ensure the appropriate safety measures are deployed. Refer to Chemical Suicide Risk Assessment.
- Extreme caution must be taken when dealing with incidents involving potentially dangerous and harmful chemicals. Officers must not open vehicle doors.
- A survey of both the general area and visually, through the windows, the inside of the vehicle to determine the consciousness and responsiveness of the subject.
- If the subject is conscious, the subject should be asked to open a door and exit the vehicle. They should then be requested to walk or crawl away from the vehicle into fresh air. Caution must be exercised when dealing with the subject due to gas being released from their clothing and exhaled breath.
- If the subject is unresponsive, windows must not be broken or doors opened, officers should keep away from the vehicle, initiate a cordon and make sure the Fire and Ambulance Services are aware of the hazard.

13.6 Response to Chemical Suicide in a Building
- On approach to the premises checks must be made for outward visual signs including any warning notices placed by the subject or the smell of rotten eggs or sewer gas;
- It should be confirmed if anyone who has been in the building has or is complaining of breathing difficulties;
- Do not enter any confined space where there is the least suspicion of toxic gas;
- Be prepared to evacuate other areas of the locus.

13.7 Public Health Response
- Inform other Emergency Services of potential contamination threat via the Area Control Room;
• Consideration should be given to the use of the Chemical, Biological, Radiological and Nuclear (CBRN) body bag which is available along with additional CBRN equipment via stores;

• Undertakers and mortuary staff must be made aware of the Hazardous Chemical (HAZCHEM) threat.

13.7.1 Further information and advice regarding these incidents are contained within the Health Protection Agency publication entitled Chemical Fatality Guidance and the Chemical Fatality and Self Harm Incidents Response Guidance Document.

14. Drowning

14.1 It is important to remember, when dealing with deaths involving drowning, that a sample of the water must be obtained upstream from where the deceased was found for further analysis. If the circumstances allow and it is safe to do so, the temperature of the water in which deceased drowned should also be obtained.

15. Deaths at Sea

15.1 The death or a significant event leading to the death must occur within the territorial boundaries of Scotland, both actual and extended. However, the PF must make some initial enquiry into all deaths brought to their attention. That enquiry may go no further than to establish jurisdiction, but where the body is in Scotland, may involve steps to determine a cause of death and to eliminate suspicion of a criminal act. Thereafter, a decision will require to be made as to whether further investigation is justified.

15.2 In the case of deaths and fatal accidents of a type which must be brought to the notice of the Procurator Fiscal occurring on board a ship, the duty of investigating is laid upon the Procurator Fiscal within whose area or district the circumstances of the death appear to be most closely connected.

15.3 The ship must be subject to the jurisdiction of the appropriate Court district and the death must have occurred within Scotland. The following are the general principles which apply:

• If the ship is in a Scottish harbour, port or anchorage, or in a river or estuary, or in waters intra fauces terrae (territorial waters), the PF within whose district the harbour or port is, or those opposite whose district the anchorage is, have jurisdiction. In the case of a river or estuary or other waters intra fauces terrae, the jurisdiction will be that of the district nearest to which the accident occurred;

• If the death or accident occurs on a British ship within the territorial waters (within the 3 mile limit), the appropriate district is that where the body was disembarked;
• If the death or accident occurred on a ship, British or foreign, engaged in oil related work, the appropriate district is the port from which the ship operates;

• If a death occurs at sea and it is impossible to accurately establish whether the death occurred within or out with territorial waters, the appropriate district is that where the body was disembarked;

• If a death occurs at sea out with territorial waters, but no cause of death has been ascertained by a competent medically qualified person and the death is brought to the attention of the PF of the district in which the ship berths;

• The PF should arrange for the body to be disembarked and initial enquiry carried out to determine the cause of death and to eliminate suspicion of a criminal act;

• If a death occurs at sea out with the territorial boundaries of Scotland, both actual and extended and the cause of death has been ascertained by a competent medically qualified person and there are no grounds of suspicion, the PF has no jurisdiction.

15.4 Police Scotland have jurisdiction when dealing with deaths on board oil related vessels which are ‘in operation’. The appropriate Local Area Commander should be consulted in any case where there is any doubt as to primacy and where appropriate liaise with COPFS.

15.5 Consideration should always be given to notifying both the Marine Accident Investigation Branch (MAIB) and the Maritime Coastguard Agency (MCA) for any death at sea in order for each agency to assess their requirement to be involved in any investigation.

15.6 The Memorandum of Understanding between the AAIB, MAIB, ACPOS and COPFS is relevant within Scotland and officers involved in enquiries with the MAIB should familiarise themselves with this document. Contact should be made with Information Assurance for assistance.

16. Diving Related Deaths

16.1 In cases of deaths arising from diving, either commercial or recreational, the following actions are important to assist the Pathologist in correctly ascertaining the cause of death:

• The body is to be removed to the mortuary as expeditiously as possible. This is to ensure that results of any time sensitive diagnostic tests, such as a Computerised Tomography (CT) scan (which will be organised and directed by the Pathologist) are not rendered inaccurate by a delay in transferring the body to the mortuary.
• The diving equipment should be examined by an appropriately qualified person at the earliest opportunity and ideally before the Post Mortem so as to provide the Pathologist with as much relevant information as possible. Examination should be made of the dive suit, all valves and regulators, the tank and gas supply and the dive computer. A printout from the dive computer should be forwarded to the Pathologist;

• It is also important for the Reporting Officer to seize any Dive Logs the deceased may have had, either with them or elsewhere and make enquiries concerning recent dives and whether any problems were encountered. Furthermore, the Death Report must include details of the deceased’s diving experience, with particular reference to the type of equipment and the type of diving suit they were using.

16.2 Where the death of a diver engaged in employment occurs, the police must notify both the Health and Safety Executive and Crown Office and Procurator Fiscal service and treat the investigation as per the work related deaths protocol.

17. Deaths Associated with Medical Care

17.1 Medical and dental professionals are required to report certain categories of deaths to the Procurator Fiscal, prior to considering the issue of a Death Certificate. In addition to categories of sudden death, these include:

• Any death caused by an industrial disease or industrial poisoning;
• Any death due to a disease, infectious disease or syndrome which poses an acute, serious public health risk;
• Any death where the circumstances seem to indicate fault or neglect on the part of another person;
• Any death, if not already reported, where a complaint is received by a Health Board or NHS Trust and the complaint is about medical treatment given to the deceased with a suggestion that the medical treatment may have contributed to the death of the patient;
• Any death occurring in health premises in the community, including a GPs surgery, health centre, dental surgery or similar facility;
• Any death which was unexpected having regard to the clinical condition of the deceased prior to their receiving medical care;
• Any death which is clinically unexplained;
• Any death which appears to be attributable to a therapeutic or diagnostic hazard;
• Any death apparently associated with lack of medical care;
• Any death which occurs during the administration of a general or local anaesthetic;
• Any death occurring as a result directly or indirectly of an infection acquired while under medical or dental care while on NHS premises, including hospitals, GPs surgeries, health centres and dental surgeries;
• Any death caused by the withdrawing of life sustaining treatment to a patient in a persistent vegetative state;
• Any death following the withdrawing of life support facilities (whether with or without the authority of the Court of Session);
• Any death not falling into any of the foregoing categories where the cause remains uncertified or where the circumstances of the death may cause public anxiety.

17.2 At the request of the Procurator Fiscal, the Police will conduct an enquiry and submit a full Death Report. Witness statements will be taken from medical / dental staff in the usual way.

17.3 An F.89 (Death under Medical Care Form) may be mentioned. This form is completed by the Doctor in charge of the case and submitted direct to the Procurator Fiscal. It provides the Fiscal with medical evidence, including treatment provided to the deceased.

17.4 Deaths occurring in care homes, independent hospitals, hospices etc., may attract an independent investigation by the Care Inspectorate.

18. Deaths within Railway Property

18.1 British Transport Police (BTP) will investigate all deaths in Scotland, where the locus of consequence is on the railway, with the exception of Homicides, Drugs Deaths, and Road Accidents (this excludes any accident where a technical issue is a contributory factor, consultation in this instance would be undertaken with Police Scotland, BTP and the Procurator Fiscal to determine who will have responsibility as the investigating and reporting agency).

Officer should consider early liaison with BTP in order to ensure that there are no significant delays and an appropriate operational response.

18.2 Further guidance on the investigation of deaths within railway property is included within the Safety and Policing of the Railways SOP.
19. **Deaths on Aircraft / Air Accidents**

19.1 The Crown Office and Procurator Fiscal's Office (COPFS) has jurisdiction in the case of a death on an aircraft, if the death occurred in Scottish airspace. In the event of an air crash the accident site must be within the territorial boundaries of Scotland, both actual and extended, or the event leading to the crash must have occurred within such boundaries. However, in all cases of a death on an aircraft a full sudden death report will be submitted to the Procurator Fiscal (SFIU).

19.2 The Air Accidents Investigation Branch (AAIB) investigates aircraft accidents and serious incidents that occur in the UK or involve UK registered or manufactured aircraft overseas. (This includes micro-lights, gliders, hang gliders and para-gliders but does not include incidents involving parachutes or powered parachutes).

19.3 It also participates in accident investigations worldwide where there is a specific UK interest. The AAIB also provides technical assistance to the Ministry of Defence in support of Boards of Inquiry investigating military aircraft accidents.

19.4 AAIB Inspectors have powers to investigate all civil aviation accidents and incidents within the UK. Each Inspector has power to have free access to the accident site; the aircraft, its contents or its wreckage; witnesses; the contents of flight recorders; the results of examination of bodies; the results of examinations or tests made on samples from persons involved in the aircraft's operation and relevant information or records. They also have the power to control the removal of debris or components; examine all persons as they think fit; take statements; enter any place, building or aircraft; remove and test components as necessary and take measures for the preservation of evidence.

19.5 All parties will make every effort to establish and maintain good liaison, communication and cooperation with one another throughout their respective investigations, and to work together as appropriate to achieve the best outcome for all. The responsibility for achieving this lies with the senior representative of each party at the scene of the accident or incident.

19.6 Where it is not clear initially whether another party has an interest in carrying out an investigation, the potential involvement of the other parties should be borne in mind in the conduct of any investigation.

19.7 The AAIB (Military) is a joint service organisation, based at Farnborough, who investigate incidents involving military aircraft. Their remit includes not only incidents involving British military aircraft worldwide, but military aircraft of foreign nations where the incident occurs within the United Kingdom or its airspace.
19.8 After the fire fighting and rescue phase of any civilian aircraft incident the AAIB will assume control of the site and undertake the investigation and recovery work. When there are clearly fatalities within the wreckage they should not be removed before liaising with the AAIB Duty Co-ordinator, and the duty Consultant Pathologist. If it is decided to remove remains they should be first photographed / videoed in situ and minimal disturbance should be caused to the wreckage. Such sites have numerous potential health and safety threats and this activity must be subject to a risk assessment prior to the commencement of recovery operations.

19.9 A Memorandum of Understanding is in place between AAIB, MAIB, ACPOS and COPFS which sets out the principles for effective liaison, communication and cooperation between these parties so that air accidents, and related criminal incidents and deaths, can be independently investigated, as necessary, by each party, in parallel with each other, whilst also ensuring that legitimate public expectations are met. Contact should be made with Information Assurance for assistance.

19.10 Contact details for the AAIB are available through control rooms.

19.11 When a death occurs on an aircraft and there is a suspicion that the primary or secondary cause of death may be an infectious or communicable disease, it is the responsibility of the captain of the aircraft to inform the airport authorities. However, if suspicions are raised after arrival, the appropriate Port Health Authority or the Area Environmental Health should be contacted via the appropriate Area Control Room. Should any such infectious or communicable disease be suspected, the passengers and crew are to be held on the aircraft until clearance is given by the appropriate Port Health Authority. In any event consideration should be given to obtaining contact details from all persons aboard the aircraft.

19.12 In the case of military aircraft the situation is further complicated by the possibility of armed ejector seats and a variety of ordnance. Aircrew who are obviously dead will be left in situ. It should also be noted that deaths of members of the Armed Forces, on duty, are not within the scope of section 1(1) (a) (i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, although joint enquiries may be conducted.

19.13 There are a number of British Parachute Association (BPA) affiliated drop zones within Scotland, and additionally there may be occasions when parachute displays are organised out with these areas. The BPA are the governing body for both military and civilian parachuting; and in the event of a parachuting fatality will provide technical help in the investigation.

20. **Fatal Road Collisions**

20.1 Refer to the Road Traffic Collisions SOP.
21. **Deaths in Police Custody**

21.1 Refer to the Death or Serious Injury in Police Custody SOP.

22. **Incident Recording**

22.1 It is extremely important that incidents are fully updated and reflect not only decisions but the information and rational on which they were based. The following areas should be considered where applicable:

- Deceased's full details;
- Attendance of SAS and details of personnel;
- Time of PLE and by whom;
- Contact details for point of contact in relation to death, i.e. NOK, carer, relative or friend;
- Brief summary of circumstances;
- Known medical history;
- Positive and negative result of system checks;
- Positive and negative outcome of body inspection;
- Positive and negative outcome of initial checks at scene;
- Details of enquiries conducted so far and result;
- Details of requests for specialist assistance and outcome i.e. scene examination, POLSA;
- Known hazards and risks associated with scene;
- Any decisions regarding the category of death and by whom;
- Details of healthcare professional contacted and outcome;
- Details of attending HCP;
- Conclusions of HCP and intentioned action;
- Known concerns / suspicions and details of who raised them;
- Details of attending funeral directors;
- Location deceased has been removed to;
- Intended further actions.

23. **Removal of Body by Police**

23.1 In all Police Reportable Deaths the deceased will be conveyed to the appropriate Police Mortuary by a relevant Police contracted undertaker.
23.2 In the event of a deceased being found alone and where no arrangements can be made to place the house in the care of a relative, it should be securely locked and the security of the property checked and assessed.

24. Personal Property

24.1 Police officers should search the remains of a deceased and recover any personal property, either at the scene or once taken to the Mortuary or body recovery area. In certain circumstances SPA staff assisting in the forensic examination can carry out this task providing it is corroborated by a Police Officer.

24.2 In most circumstances this search should be carried out at scene but this may be delayed due to forensic recovery or examination procedures. This task will thereafter be conducted at the Mortuary / body recovery area either separately or as part of the post mortem examination. This task should never be left to the undertaker or mortuary staff.

24.3 Care should be taken over the return of property to the NOK and family and it should be done in a manner that bestows respect. It can be very distressing for NOK and families to have items returned to them that are damaged or soiled, particularly when they are not expecting them. If an item has been damaged or soiled then prior consultation with the recipient must take place advising and warning them of the condition of the item before it is returned.

24.4 Any items taken from a deceased must be lodged and receipted through the appropriate Production system prior to the return to the NOK. All items handed over to NOK must be properly receipted and documented in the Officer’s notebook at the time the handover occurs. This should be supported by means of a statement from the person taking possession of the items.

24.5 A cursory search of a premises should be undertaken under the direction of a Supervising Officer to identify, gather and safe keep any cash or valuables.

24.6 Any items taken from the deceased or their premises must be lodged and receipted through the appropriate production system prior to the return to the NOK.

25. Case Reporting Process

25.1 All Police Reportable Deaths will be reported and transmitted to the Scottish Fatalities Investigation Unit (SFIU) through local divisional reporting methods. All death reports will be submitted without delay and will be proof read by line management prior to submission to SFIU.

25.2 In all police reportable deaths and suicides officers must ensure they complete an operational statement for the SIO prior to the completion of their tour of duty.
Note: In North East Division a copy of the report should be printed off, scanned and emailed to the Pathologist at the Mortuary and the relevant Reports Office (Reports Central, Reports Moray or Reports Peterhead). Any relevant additional information, particularly additional witness details and the cause of death, should be submitted to the Procurator Fiscal by Subject Report via the secure COPFS email address for the area.

Note: In Fife Division any relevant additional information, particularly additional witness details and the cause of death, should be submitted to the Procurator Fiscal by PF Memo, by submitting it electronically to the Case Management Unit who will send the Memo on via the secure COPFS email address. Officers should copy and paste the content of all PF Memos onto the 'Admin' section of the CrimeFile Death Record.

25.3 The following guidance has been supplied by COPFS and must be considered and included in all death reports.

25.4 Deceased Details
- **Full name** – The first name and surname must be in the correct order and if the deceased was married it must be stated which surname they are known by, as these details are used to complete the death certificate. The name on the death report must correspond with that on the body tag;
- **Full address (including postcode)**;
- **Contact telephone numbers** - both landline and mobile number (if applicable);

25.5 Next of Kin
- **Take all possible measures to identify NOK**;
- **How many NOK are required?** Only one member of the family is required to be NOK, however, if the family refuse to have only one point of contact, there can be a maximum of two NOK. The term NOK is not legally binding but identifies the person/people who are the main point of contact for PF and Police. Other individuals can be included in the Remarks section of the Police Report if necessary.
- **Identify the NOK’s preferred first language**;
- **State if the NOK are vulnerable and whether they have the capacity to make decisions** – specify if the NOK require an appropriate adult/another family member or friend etc. to be present if/when they are spoken to?
- **Specify the NOK’s relationship to the deceased**;
25.6 Family Situation:

- **Are there any family issues** – was the deceased estranged from family / any family fallouts or splits? Are these likely to affect the investigation into the deceased’s death? Are there going to be feuding family members contacting the PF / Police rather than just the NOK? If yes to any of these questions, the PF **must** be advised in the report. The family must also be told that if possible, only the NOK contacts the PF and Police to stop any repetition.

25.7 Medical History (obtained from GP)

- Full name of GP;
- Full address of GP Practice;
- Telephone number;
- If the deceased has recently changed GPs, include their details and obtain medical information from the new practice;
- Police do **not** need to see the GP in person. Information provided by the Duty Doctor at the practice over the phone as a matter of **urgency** is sufficient unless instructed to seize medical records;
- Who is the deceased’s registered GP?
- The date the deceased registered with the practice;
- The date that the deceased was last seen at the practice including the member of staff, details of the reason for the deceased’s attendance, any treatment received, new course of action etc.
- Significant and **relevant** medical history (potentially pertinent to the death) – list this information in the report from newest illness to oldest. State if the deceased misused drugs (including smoking) / alcohol, had any mental health problems, anything else which caused concern;
- Include opinion of the GP with regards to what may have contributed to the death;

25.8 Medication

- **Full list of medication that deceased person was on at the time of their death** - dosage and how many times to be taken (each day or week etc.);
- **Is there evidence of deliberate or accidental overdose at the locus** – if there was, how much of the medication was left when compared to the prescription details on any containers?
- **Is it consistent?** (i.e. does the name on the medication match the deceased?).

25.9 Circumstances of Death:

- **State the condition and demeanour of the deceased in the days leading up to their death** – were they complaining of feeling unwell / did they look unwell?
What circumstances led to the deceased being found – were they found by a family member / were they found as a result of someone calling Police due to a concern for them etc.

Where was the deceased found – exact place where they were found (in bed of front bedroom within 123 Main Street, Edinburgh etc.);

Who found the deceased – including what time they were found by this person;

Movement of the deceased prior to Police arrival – moved for CPR to be carried out by person who found them / NOK etc.

State if there was anything unusual / suspicious about the circumstances / locus – was the locus secure when Police arrived / was entry forced / have the keys been located / any signs of a disturbance etc. State if there are no unusual circumstances;

Who the body was checked by – Police officers must check the body of the deceased for any marks or injuries. The death cannot be fully confirmed as a medical death until this has been done.

State the method of identification and who this has been provided by - identified by informant / photo identification (bus pass / driving licence / passport). The deceased must be identified by some means – one source is sufficient unless it is a potential drugs or suspicious death where two sources are required. This does not need to take the form of formal identification (unless instructed) and does not necessarily need to take place within a hospital setting. When it comes to drugs or suspicious deaths, the body can be identified to two Police Officers by two NOK, who knew the deceased in life and then those two officers must make themselves available to identify the body prior to the Post Mortem PM. This should be thought of from the outset.

25.10 Suicide Notes

Must be photographed in situ - by Scene Examiner.

If suicide note is on a computer – seize the computer and try to obtain passwords;

Seize original suicide note as production;

Explain the procedure - explain that the family cannot have the original, as the PF needs to have the original in their possession whilst carrying out their investigation. The family will eventually get the original suicide note but it could be some time before the PF releases it;

Suicide note content – type the content of the suicide note into the ‘Remarks’ section of the death report for the attention of the PF.

25.11 Family Issues

Personal Possessions – Only seize what is necessary in a case. Jewellery and wallets etc. can be returned to families immediately unless it relates to the death;
**Keys to the house** – Only retain keys to the property for as long as is absolutely necessary. The PF has no “policy” on this and it is very much left up to the discretion of local supervisors. If the death is not a Police Reportable Death, the keys and house should be returned to the custody of the family immediately without asking the PF for “permission”. Car keys should not be retained as a matter of course. If Productions are retained, ensure they are retained for a purpose and articulate why in the death report to the PF (as well as including them on a Production Release Notes (PRN) within the Death Report with a clear production number). If the reason for retaining the items is not included in your report, then the PF cannot make an informed decision about release;

**Toxicology results** – Family should be made aware of the time results may take. By the time toxicology (drugs screen) results are received and then passed to the pathologist for a final cause of death, this often takes 10-12 weeks from Post mortem. Provide NOK a realistic timescale so they know when to expect to hear from the PF;

**Fatal Accident Inquiry (FAI)** – This decision as to whether an FAI is held is made by the PF irrespective of the family’s wishes, although their views are should be articulated within the body of the Police Death Report. The families views with regards to the death and / or the care preceding the death will be taken into account by the PF. Police must state within the report if the family have any issues;

**Nursing home / Hospital deaths** – Detail clearly in main body of report if the deceased’s family have raised concerns regarding the care of the deceased, if the deceased suffered falls or if they have issues with GP / hospital care. If the fall has caused / contributed to the ultimate death, Police must address the following eight questions within the Police Death Report:

- Was the patient prone to falls?
- Had the resident / patient been the subject of a risk assessment?
- If so, what were these measures?
- Were the measures identified and a risk assessment implemented?
- Was the risk assessment regularly reviewed and updated?
- State the dates and outcomes of the reviews;
- Has the fall resulted from the condition of the floor, or some other environmental factor such as poor housekeeping?
- Was there a failure in a piece of equipment such as a hoist etc.?

**25.12 Outstanding Criminal Cases**

- Identify clearly as part of the death report if the deceased has any pending criminal cases on the Police system.

**25.13 Report Writing**

- Keep the story of the report brief and to the point;
• Ensure that everything that is being written in the report is relevant to the death;

26. Identification

26.1 It is entirely preferable and considered best practice that identification of a person is made to officers at the locus for all sudden deaths.

26.2 It is routinely accepted that all investigated deaths require a minimum of one person to confirm a person’s identity to a police officer, though in suspicious or criminal deaths it is necessary that this identification be by two persons.

26.3 Identification can also be assisted by medical and forensic means.

26.4 Where identification has not been possible prior to removal of the body, arrangements must be made to have the required person(s) attend the Mortuary for identification purposes.

27. Dealing with Next of Kin

27.1 The investigation of a death whilst routine to police, will have a tremendous impact upon the family of the deceased.

27.2 In addition to police attendance at the locus of a death, often officers are involved in the initial notification of a death which was not expected. It is important that the NOK are informed of the death by the police as soon as possible. Consideration should be given to ensuring that all persons who could be considered as NOK are informed with the necessary auditing of this action recorded.

27.3 All attempts taken to inform family members of a death should be recorded on the command and control system and in police issue notebooks.

27.4 The initial contact with the family will undoubtedly lay the foundations for the relationship during the enquiry.

27.5 Officers must act professionally and responsibly at all times and remain approachable. When death occurs in specific religions and cultures, family members and friends may seek a quick resolution to enquiries and the release of the body. Reference should be made to the Police Scotland Diversity Booklet – A Practical Guide to ensure a professional approach is adopted in these circumstances.

27.6 It is an important task during police investigations that officers advise the NOK as soon as a Certificate of Death has been issued and the COPFS has authorised the release of the body. No communication should be passed to any other person regarding certification until the NOK are aware.
27.7 In circumstances where the locus of a death has been contaminated with blood or other substance, consideration must be given to the cleaning of the property before it is returned to the NOK. Possible options to consider for this are the assistance of the local housing department, the home insurance agents for the property or indeed an approach should be made to the NOK to discuss suitable arrangements. It would not normally fall to the police to pay for this service.

28. **Dealing with Relatives Abroad**

28.1 Where a person visiting the UK from abroad dies or is seriously injured, Interpol may assist in delivering messages abroad but only after all avenues have been exhausted.

28.2 In the first instance all possible steps must have been taken by Police or relatives in the United Kingdom to contact the relative abroad themselves. This can be done by telephoning them direct, through travel companies, holiday tour representatives or the local British Consul, etc. These channels should be fully explored before using Interpol. Should the services of Interpol be required, officers should liaise with their local intelligence office in the first instance.

29. **Found Bones**

29.1 Dundee University offer a service to identify any recovered or found bones where there is doubt around their origin.

29.2 This service is available 24 hours a day, although out with office hours, 0900 – 1700 hours Monday to Friday, this function will be undertaken by on-call staff and it may take several hours to provide a result. These potential delays out with office hours should be taken into account when considering this course of action.

29.3 In circumstances where bones of an unknown origin are either handed into a Police Station or the police are directed to them, an image and short narrative around the circumstances of the bone can be emailed to the service via the contact details found in Appendix ‘E’. During office hours, a phone call prior to emailing the image should be made to in order to discuss the circumstances.

29.4 This service is simply another option for staff to consider in identifying bones in quick time, when often getting the assistance of the regional Pathologist may take considerably longer.

29.5 This service should only be used once first discussed with a Duty Supervisor / CID to confirm the appropriateness of doing so.
29.6 This process does not affect the option of taking bones to the Regional Pathologist, but merely allows officers with another option to get a quick time decision regarding where the bones may have originated from and allow for decisions around locus protection etc.

30. **Foreign Nationals**

30.1 In the event of a suspicious death where the victim is a foreign national, the relevant consulate should be contacted and advised of the fact of death and that a police investigation into those circumstances is ongoing.

30.2 High Commissions of Commonwealth member countries do not require to be informed of the death if the deceased is also a United Kingdom citizen through dual nationality.

30.3 When submitting a Death Report, the nationality of deceased, where known, should be clearly identified to the PF.

31. **Ultimus Haeres**

31.1 Where a person who resides in Scotland dies without leaving a Will this is referred to as 'dies intestate'.

31.2 If the deceased also has no known and traceable blood relatives, spouse or civil partner who would be entitled by law to succeed to his / her property, or co-habitee who would be entitled to make a claim under Section 29 of the Family Law (Scotland) Act 2006, then that property, both heritable (anything fixed like a house, outhouse) and moveable, falls to the Crown as ‘**ultimus haeres**’ (meaning Ultimate Heir).

31.3 It is the responsibility of the COPFS National Ultimus Haeres Unit (NUHU) to investigate all potential Ultimus Haeres (UH) cases within Scotland. If it is established that a case is a UH case and there is an estate to administer, then the National Ultimus Haeres Unit will report the case to the Queen's and Lord Treasurer's Remembrancer (QLTR).

31.4 The QLTR is the Crown's representative in Scotland for all ownerless property, including such an estate, and will ingather, administer and dispose of the items of the estate. Details of these estates are placed on the QLTR's website and if no claims from relatives are subsequently made, those proceeds are paid into the Scottish Consolidated Fund for the use of the Scottish Government.

31.5 If the Police are investigating a death of a person who is intestate and has no NOK then they should notify the National Ultimus Haeres Unit without delay. They are based in Glasgow and can be contacted via the details in appendix ‘E’. If difficulty is experienced contacting the NUHU, contact should be made with the local COPFS office dealing with the death.
31.6 The National Ultimus Haeres Unit will make further investigation to attempt to find NOK. If this search is not fruitful they will search the deceased's property. They will ingather anything of value and continue to search for details of the NOK. The Police are not normally involved in this search although the Unit may ask for assistance if required.
Appendix ‘A’

List of Associated Legislation

- Corporate Manslaughter and Corporate Homicide Act 2007;
- Equality Act 2010;
- Family Law (Scotland) Act 2006;
- Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976;
- Health and Safety at Work etc. Act 1974;
- Human Rights Act 1998;
- National Assistance Act 1948;
- Police and Fire Reform (Scotland) Act 2012.
Appendix ‘B’

List of Associated Reference Documents

Standard Operating Procedures

- Crime Investigation SOP
- Death or Serious Injury in Police Custody SOP
- Family Liaison SOP
- Interpreting and Translating Services SOP
- Road Traffic Collisions SOP
- Safety and Policing of the Railways SOP
- Trauma Risk Management (Police Officers and Authority / Police Staff) SOP

Guidance

- A Guide to Police Procedures for Offshore Installation Managers
- ACPO Murder Investigation Manual
- BTP Fatality Guidance Manual
- CMO Guidance on the Certification of Death.
- COPFS Guidance on Reportable Deaths,
- COPFS The Role of the PF
- HPA Guidance on the Management of Chemical Fatality and Self-Harm Incidents
- HSE Work-Related Deaths A Protocol For Liaison
- PNB Circular 02/9 (See Section D Bonus Payments)
- Police Scotland Chemical Fatality and Self Harm Incidents Response Guidance Document
- Police Scotland Diversity Booklet - A Practical Guide
- Scottish Investigator's Guide to Sudden Unexpected Deaths in Infancy (SUDI)
Appendix ‘C’

Glossary of Terms

AAIB – Air Accidents Investigation Branch
BPA – British Parachute Association
BTP – British Transport Police
CBRN – Chemical, Biological, Radiological and Nuclear
CID – Criminal Investigation Department
CMO – Chief Medical Officer
COPFS – Crown Office Procurator Fiscal Service
CSM – Crime Scene Manager
CT – Computerised Tomography
DNACPR – Do No Attempt Cardiopulmonary Resuscitation
DSU – Dedicated Source Unit
FAI – Fatal Accident Inquiry
FLO – Family Liaison Officer
HAZCHEM – Hazardous Chemicals
HSE – Health and Safety Executive
MAIB – Marine Accident Investigation Branch
MCA – Maritime Coastguard Agency
MCCD – Medical Certificate of Cause of Death
MIT – Major Investigation Team
NOK – Next of Kin
NUHU – National Ultimus Haeres Unit
OIC – Officer in Charge
OIM – Offshore Installation Manager
ORR – Office of Rail Regulation
PDA – Personal Data Assistant
PIO – Police Incident Officer
PLE – Pronounced Life Extinct
POLSA – Police Search Advisor
PRN – Production Release Notes
PM – Post Mortem
QLTR – Queen’s and Lord Treasurer’s Remembrance
SAS – Scottish Ambulance Service
SFIU – Scottish Fatalities Investigation Unit
SIO – Senior Investigating Officer
SPA – Scottish Police Authority
SSMC – Service Substance Misuse Co-ordinator
SUDI – Sudden Unexpected Death in Infancy
TRiM – Trauma Risk Management
UH – Ultimus Haeres
Appendix ‘D’

Mortuary and Post Mortem Procedures

1. Removal of Remains to Mortuary

1.1 All remains recovered in the course of a Police Reportable Death will be removed by the Contracted Undertaker (CU), who can be contacted via the Control Room.

**Note:** Prior to a transportation to a mortuary contact must be made by telephone to allow time for preparation for the arrival of the deceased.

**Note:** Police contracted undertakers should arrive at the scene with an Uplift and Transportation of Deceased Persons (Form 134-001). They should populate this at the locus and the officer at scene is responsible for checking and signing before handing back to the contracted undertaker.

1.2 Police officers, or Area Control Room staff will provide a brief outline of the known circumstances of the death and ensure the deceased will be accepted on arrival. Confirmation of contact made with the mortuary will be recorded on the appropriate Contact, Command and Control system for the division.

1.3 In any circumstance of a Police Reportable Death two police officers will follow the CU from the locus to the mortuary to ensure the chain of evidence is maintained to the mortuary.

2. Post Mortem Examination

2.1 The COPFS retain the services of the Forensic Pathologist and only under their explicit direction will a request will be made for a Pathologist to attend any locus.

2.2 The Procurator Fiscal will issue instruction on what is required from the Police in relation to Post Mortem attendance, and what should be taken to it. For example productions, photographs or medical notes.

**Note:** Any information obtained at a post mortem examination must be treated as strictly confidential.

2.3 All samples and specimens taken by Pathologists are to be labelled immediately by the Police Officers present, who are to ensure that both they and the Pathologists sign each label. The Police are to retain custody of the samples and specimens pending the Procurator Fiscal instructions as whether or not a forensic examination will take place. Refer to the Body Handling and Recover Generic Risk Assessment for further guidance.
3. **Mortuary Procedures**

3.1 On arrival at the mortuary, police officers will remain with the deceased while they are processed by mortuary attendants. Officers must complete the local mortuary form to ensure all details and record of all property is appropriately recorded. Forms may vary depending on local arrangements or agreements with mortuaries.

*Note:* In all Police Reportable Deaths removal of clothing and personal belongings will be undertaken according to the instructions of the SIO / PIO. They will consider the circumstances and critical nature of the death. Homicides, child deaths and drugs deaths are obvious examples of where clothing would only be removed during the Post Mortem process, however, if there is any doubt senior investigators should consider consulting the relevant Forensic Pathologist.

3.2 If the SIO requests property to be removed, these should be logged and recorded in the officer’s notebook alongside information on the authorising SIO whom has made the instruction and justification of same.

3.3 For safety purposes, Police Officers should enquire if the body they are dealing with is known to carry or potentially carries a risk of infection and if so, they should ensure that the body bag is clearly labelled as such. This knowledge should also be communicated verbally to the mortuary / hospital staff on arrival.

4. **Procedure for Notifying Relatives of Release of the Deceased**

4.1 In suspicious cases, relatives should be made aware that significant delay may occur before the remains are released for cremation or burial. Furthermore, on no account should Police Officers suggest a time of release to any interested party in respect of a sudden death.

4.2 If under any circumstance, any deceased person seized by police in the investigation of a Police Reportable Death has a death certificate issued, or is released by the Procurator Fiscal, the local Divisional Co-ordination Unit (DCU) or Deaths Unit will be informed. Contact will be made by the mortuary or directly by COPFS. Suitable arrangements can then be made with family or selected funeral director to collect the remains.

5. **Mortuary Locations and Access**

5.1 **Police Scotland East**

*Note:* All child deaths occurring in Fife and Central Scotland will be conveyed to the Western General Hospital. Child deaths in Edinburgh, and the Lothian’s and Borders will be taken to Edinburgh Royal Infirmary. Any exceptions requested must be in consultation with local COPFS.
### Division | Police Reportable Deaths | Access / Mortuary Information
--- | --- | ---
Edinburgh | Edinburgh City Mortuary | **Contact Number:**
 | | 0131 556 8211
 | | **Address:**
 | | 297 Cowgate,
Edinburgh,
EH1 1NA
 | | **Access Information:**
 | | Out of Hours access can be given through St Leonards Police Station.
Fife | Edinburgh City Mortuary | See ‘Edinburgh’
Forth Valley | Edinburgh City Mortuary | See ‘Edinburgh’

#### 5.2 Police Scotland North

**Note:** In the Highlands and Islands, all child deaths will be taken to and dealt with at Raigmore. In Lerwick, Moray and Grampian all child deaths will be conveyed to Aberdeen Queen Street. No child PM’s will be performed in Dundee, these will be conveyed to Glasgow.

| Division | Police Reportable Deaths | Access / Mortuary Information
--- | --- | ---
Highlands and Islands | Raigmore Hospital Mortuary, Inverness | **Contact Number:**
 | | 01463 704000
 | | **Address:**
 | | Old Perth Road,
Inverness,
Inverness-shire,
IV2 3UJ. Telephone:
 | | **Access Information:**
 | | 1 Hour notice to be given where possible during working hours. Out with working hours 30 minutes notice will suffice.
<table>
<thead>
<tr>
<th>Region</th>
<th>Address Description</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tayside</td>
<td>Police Mortuary, 9 Dudhope Crescent Road, Dundee</td>
<td>Info removed. Exempt under FOI (Scotland) Act 2002, 30(c), Prejudice to the Effective Conduct of Public Affairs</td>
</tr>
<tr>
<td></td>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Police Mortuary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 Dudhope Crescent Road, Dundee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Located within the East annexe building of the Former Tayside Divisional Headquarters)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Access Information:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During office hours please make contact and provide an estimated time of arrival.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out of hours access will be given by Custody Sergeant, Public Enquiry Office, West Bell Street.</td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td>Mortuary, Queen Street, Aberdeen</td>
<td>Info removed. Exempt under FOI (Scotland) Act 2002, 30(c), Prejudice to the Effective Conduct of Public Affairs</td>
</tr>
<tr>
<td></td>
<td><strong>Address:</strong></td>
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<tr>
<td></td>
<td>Mortuary</td>
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<td>Queen Street</td>
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<tr>
<td></td>
<td>Aberdeen</td>
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<tr>
<td></td>
<td><strong>Access Information:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Police Access to mortuary is restricted to Monday to Friday - 9 am to 4.30 pm unless to lodge a body. In some extreme circumstances access could be permitted to assist in identification of a deceased person. Key held by Public Office at Queen Street Aberdeen.</td>
<td></td>
</tr>
</tbody>
</table>
5.3 Police Scotland West

**Note:** All child deaths occurring in the West of Scotland will be taken to the Royal Hospital for Sick Children co-located with Queen Elizabeth University Hospital, Glasgow.

<table>
<thead>
<tr>
<th>Division</th>
<th>Police Reportable Deaths</th>
<th>Access / Mortuary Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow</td>
<td>Queen Elizabeth University Hospital, Glasgow</td>
<td>Contact Number: Info removed. Exempt under FOI (Scotland) Act 2002, 30(c), Prejudice to the Effective Conduct of Public Affairs</td>
</tr>
<tr>
<td>Renfrewshire and Inverclyde</td>
<td>Queen Elizabeth University Hospital, Glasgow</td>
<td>Address: 1345 Govan Road, Glasgow, Lanarkshire G51 4TF</td>
</tr>
<tr>
<td>Argyll &amp; West Dunbartonshire</td>
<td>Queen Elizabeth University Hospital, Glasgow</td>
<td>Access Information: To rear of Laboratory Buildings. Use intercom at gate to communicate that mortuary is aware of your arrival. Second Intercom located at garage door to communicate with Technicians within.</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>Queen Elizabeth University Hospital, Glasgow</td>
<td>See ‘Greater Glasgow’.</td>
</tr>
<tr>
<td>Ayrshire Division</td>
<td>Queen Elizabeth University Hospital, Glasgow</td>
<td>See ‘Greater Glasgow’.</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>Queen Elizabeth University Hospital, Glasgow</td>
<td>See ‘Greater Glasgow’.</td>
</tr>
</tbody>
</table>

6. Business Management Units

6.1 Contractors should send invoices with supporting force form 134-001 (Uplift and Transportation of Deceased Persons Form) to their local Business Management Unit (BMU). Each form will contain information to assist with recording different types of removals. Each category of removal has a separate cost code which should be applied and sent onwards to finance.
Useful Contact Details

‘A’ Division Administration Support Unit

Information removed. Exempt under Freedom of Information (Scotland) Act 2002, 30(c), Prejudice to the Effective Conduct of Public Affairs

Dundee University Bones Service
Email: bones@dundee.ac.uk.
Telephone: 01382 388825

Scottish Fatalities Investigations Units (COPFS)
West - sfiuwest@copfs.gsi.gov.uk
East - sfiueast@copfs.gsi.gov.uk
North - sfiunorth@copfs.gsi.gov.uk

Ultimus Haeres Unit

Information removed. Exempt under Freedom of Information (Scotland) Act 2002, 30(c), Prejudice to the Effective Conduct of Public Affairs