Ashford and St. Peter's Hospitals
NHS Foundation Trust

GUIDANCE FOR DEALING WITH THE POLICE AND OTHER PUBLIC BODIES

Compiled by: Claims Paralegal/Patient Safety Manager

Reviewed by: Jacqui Rees, Associate Director of Quality

Status: Approval date: June 2021

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Review date: June 2024

Patients first • Personal responsibility • Passion for excellence • Pride in our team

History

Issue	Date Issued	Brief Summary of Change	Approved by
1	May 2005	New policy	TEC
2	May 2007	Updated References & Bibliographies Amended reference to Site Co-ordinator / General Manager	
3	Jun 2010	General update & review by Trust Solicitors	
4	May 2021	General update Added reference to the security and health and safety policies. Removed referral to the mouth as part of an intimate search. Updated HM Customs and Excise to HM Revenue and Customs Removed reference to SHA's and PCT's which were abolished and have now been replaced by the CCG and NHS England. Added legal definition of a child in England. Added reference to the Trust policies regarding safeguarding children and the surrey safeguarding children partnership procedures manual. Updated the reference to the Working Together to Safeguard Children from 2006 to 2018. Added advice on out of hours support from the surrey children's services. Added reference to capacity to consent for 16+ as they are subject to the Mental Capacity Act (2005)	Safety & Quality Committee

For more information on the status of this document, please contact:	Buzandi Chibawe, Claims Paralegal
Department/Directorate	Quality Department
Date of issue	May 2021
Review due	May 2024
Ratified by	Safety & Quality Committee
Audience	All Staff

INDEX

GUIDANCE FOR DEALING WITH THE POLICE AND OTHER PUBLIC BODIES

See Also

Surrey Safeguarding Children Partnership Procedures Manual
Medicines Management Policy
CD SOP W003: Ward CD – Administration & Wastage
Missing patient Policy.
Safeguarding Adults at Risk Policy
Guidance for Doctors on Post Mortem Examinations.
Incident Reporting Policy
Handling the Media Policy
Mental Capacity Policy
Surrey Multi-Agency Information Sharing Protocol (MAISP)
Confidentiality and Data Protection Policy
Information Security Policy
Patients Property Policy
Policy for the Management of Violence and Aggression
Security Policy
Health & Safety Policy

1 INTRODUCTION AND BACKGROUND

The guidance provided in this document is to assist Trust staff when dealing with enquiries from the Police, the Coroner, Social Services, the Health and Safety Executive and other external agencies.

Where appropriate, this document refers to other Trust Policies, which may provide more detailed and comprehensive guidance. Further guidance may also be available from the Trust's Data Protection Officer and Information Governance Manager (Jane Townsend), Caldicott Guardian (Dr David Fluck), and Senior Information Risk Officer (Laura Ellis-Philip).

In certain circumstances, it will be necessary to consider this policy in conjunction with guidance published by The Department of Health; the General Medical Council; the Nursing and Midwifery Council and other legislative changes. Useful contact and website details are listed at the back of this document.

The guidance contained within this policy must not be considered to be exhaustive. It is not possible to account for every possible scenario or eventuality. In certain circumstances, it will be necessary to seek advice from more senior colleagues as necessary. This is defined as follows:

During office hours this could include the Head of Patient Experience & Involvement, Associate Director of Qualitiy, Matrons, General Managers or Executive Directors.

Out of hours, it will be as follows:

Weekdays

17.00 – 19.30 - Duty Matron – based at St Peter's Hospital (or SSM)
19.30 – 08.00 - Clinical Site Nurse Practitioner

Weekends & Public Holidays

08.00 – 19.45 - Site Co-ordinator / Clinical Site Nurse Practitioner
19.45 – 08.00 - Clinical Site Nurse Practitioner.

2 THE DUTY OF CONFIDENTIALITY

The Trust has a legal and ethical duty to ensure that information held by the Trust is confidential and should only be used for the care or treatment of the patient. Information may be disclosed to a third party with the patient's consent or other legislative provision. Wherever possible, written consent should be obtained. In the majority of cases, information held by the Trust must not be disclosed to a third party in the absence of the patient's consent.

The duty of confidentiality arises from the principle that an individual has the right to expect that information relating to their health and well being will be held in confidence and will be used for their own benefit. This principle has been reinforced by the common law and Statute, in particular Article 8 of the European Convention on Human Rights: "respect for private and family life" which is embodied in The Human Rights Act 1998.

2.1 THE DUTY OF CONFIDENTIALITY MAY BE OVERRIDDEN

The duty of confidentiality is fundamental to the special relationship that exists between a patient and his medical advisers. However, in certain situations, disclosure of confidential patient information in the absence of the patient's consent, and /or contrary to his/her express wishes, can be justified. Careful consideration must be given to every request for information to determine whether disclosure can be justified on one or more of the following grounds:

a) it is required by Statute
b) it has been ordered by a Court of Law
c) it has been requested by the Coroner
d) it is in the public interest [when the duty to society is deemed to be greater than the Trust's duty of confidentiality to an individual]
e) it is in the patient's best Interests

These are covered in greater detail below at paragraph 3.1

2.2 SAFEGUARDS

The Trust is required to take reasonable steps to ensure that any information disclosed to a third party will not be used for any other purpose than that for which disclosure was deemed justified. It is accepted that staff will have little or no control over how information is processed once it has been disclosed. However, it may be necessary at a later date to justify the extent and nature of the disclosure. This may be in response to a complaint made by the patient, or by the Police if a failure to disclose information hindered or prejudiced a criminal investigation.

When considering a request for third party disclosure, the following information must be recorded in the patient's medical records:

a) The name, position and contact details of the person / organisation making the request.

b) The reason why the patient's consent was not obtained, e.g.

- consent was withheld
- the patient was unconscious or otherwise incapacitated
- the patient is a minor and parental consent could not be obtained.

c) The name and position of the member of staff who made the decision.

d) The basis on which the decision was made, e.g.

- the patient lacks mental capacity and disclosure was deemed to be in

the patient's best interests
- disclosure was in compliance with a Court order, a copy of which should be filed in the patient's medical records
- disclosure was deemed to be in the public interest.

e) The extent of the disclosure, e.g. name only; address; medical details etc.

f) The name, position and contact details of the third party to whom the information was disclosed, by whom; when; and by what means.

3 DISCLOSURE OF CONFIDENTIAL INFORMATION

If it has been established that the patient will not or cannot consent to disclosure of confidential information, staff should consider whether disclosure might be justified on one or more of the following grounds:

3.1 PURSUANT TO STATUTE

Below are four of the more common examples of when disclosure of patient information may be required by statute. The list must not be considered to be exhaustive.

3.1.1 Road Traffic Act 1988

Section 171 Where the driver of a vehicle is alleged to be guilty of an offence under this Act (i.e. such as driving whilst under the influence of alcohol or drugs, causing a road traffic accident, failing to stop at the scene of an accident), the Trust is required to provide the Police, if so requested, any information which may lead to the identification of the driver. It is likely that disclosure will be limited to the patient's name and address.

The duty to disclose information to the Police is limited to information, which may assist in the identification of the driver. It does not extend to disclosing details about the patient's injuries, for example, if the injuries are consistent with a seatbelt being worn at the time of impact. Further information should only be disclosed with the patient's consent or pursuant to a Court order.

3.1.2 The Crime and Disorder Act 1998

Section 115 makes it lawful for NHS bodies to exchange relevant information as part of a strategy to reduce crime and disorder. The extent of the disclosure will be limited to information, which may assist with the detection or prevention of a crime. The requesting party may be the Police, the Probation Service, the Youth Justice Team, Customs and Excise and /or other associated public bodies. The request should be made in writing and should be considered by a senior member of staff. The terms of this statutory provision are vague and potentially wide ranging. If there is any doubt as to whether disclosure can be justified under this provision, advice should be sought from a senior colleague (please see Section 1).

See Section 4 for more information about the rights and powers of the Police.

3.1.3 The Children Act 1989 & 2004

Section 27 of the 1989 Act places an obligation on NHS bodies to co-operate with the provision of information to other NHS bodies, Education Authorities, Local Health Board, appropraite national bodies and other relevant bodies to disclose information in connection with a Section 47 investigation into the well being of a child.

Please refer to the Surrey Safeguarding Children Partnership Procedures Manual and the Trust's Safeguarding Team for more information about the statutory provisions and child protection matters.

3.1.4 Disclosure to statutory regulatory bodies pursuant to statute

Patient records or other patient information may be needed by a statutory regulatory body, for instance, to investigate a health professional's fitness to practice. Wherever practicable, the patient's consent must be obtained. If the patient withholds consent or cannot be contacted, you should seek further advice. Disclosure may be justified in the public interest or for the protection of other patients.

Section 35 of the Medical Act 1983 gives the GMC power to require doctors to supply any document or information which appears relevant to the discharge of the GMC's functions provided that, disclosure is not prohibited by other legislation. It may not be clear which piece of legislation takes precedence and further advice should be sought if you are unsure.

3.2 PURSUANT TO A COURT ORDER

If you are unsure that disclosure in the absence of patient consent can be justified, the requesting party should be informed that the Trust will not disclose information unless ordered to do so by a Court of Law. This may arise if the requesting party has provided inadequate or incomplete information, such that, Trust staff are unable properly to consider the request.

If the request for disclosure is pursuant to a Court Order you must:

- file a copy of the Court order in the patient's medical records
- disclose only the information specified in the order

3.2.1 Information relating to sexual health

Special statutory provisions apply to information relating to a patient's sexual health. Information must not be disclosed without the patient's consent unless disclosure is pursuant to a Court Order.

3.3 AT THE REQUEST OF THE CORONER

The duty of confidentiality continues after a patient's death. However, if the circumstances of the death require it to be reported to be the Coroner, the Trust has a duty to co-operate with the Coroner's investigation and must disclose information relating to the deceased's medical history and treatment.

The Coroner has wide ranging powers to gather information and evidence to assist with the inquest process and may require staff involved with the patient's care to provide written statements about their involvement with the patient and, to attend the inquest to give evidence under oath.

The role and powers of the Coroner and the provision of witness statements are dealt with in greater detail at Sections 5 and 6.

3.4 IN THE PUBLIC INTEREST

Disclosure of confidential information may be justified without the patient's consent if the benefits to society or an individual outweigh the patient's interests in keeping the information confidential. This may arise if the failure to disclose information may expose the patient or others to a serious risk of harm, or will assist in the prevention or detection of a crime, the nature of which, the public interest prevails over a patient's right to confidentiality. This is a matter of judgment and the balance, must be carefully considered.

The requesting party should confirm that without the information requested, the detection or prevention of a serious crime or harm will be adversely delayed or prejudiced, and that the information is not available from another source.

The patient should be told that information is to be, or has been disclosed, except where to do so will undermine the purpose of disclosure. This may arise if the patient is suspected of involvement in, or the commission of, a serious crime and to alert them may prejudice the police investigation.

Disclosure must be limited to information which is relevant to the facts justifying disclosure, for example it might be appropriate to disclose only the patient's identity.

3.4.1 Firearms / Knife Crime

The Police should be informed whenever a person arrives at hospital with a wound resulting from a gunshot or suspected attack with a knife, blade or other sharp instrucment.

This includes situations where:

- the patient does not wish to report the matter to the Police
- the patient's condition is such that he is unable to consent
- the patient is temporarily incapacitated e.g. if sedated/anaesthetised

Disclosure can be justified on the basis that it is likely that the patient has been the victim of and/or involved in a serious crime and it is probable that the public interest test will be satisfied. It is unlikely that the wounds were inflicted lawfully.

The Police do not need to be informed where a knife or blade injury to a patient is accidental or the result of self-harm.

The patient's details should not be disclosed until the Police have assessed the potential risk to the public and or/other individuals and it is apparent that disclosure is in the public interest. The extent of the disclosure must be restricted to information required to prevent a further crime or to detect the commission of a crime. This may be limited to the patient's identity or information about the location of alleged assault / incident. A request for more detailed information or for copies of the patient's medical records must be carefully considered.

If there does not appear to be an immediate public interest reason for disclosure, the request should be declined until:

- the Police obtain an order for disclosure and/or
- the circumstances change or more information is provided which supports public interest disclosure.

It is the responsibility of the Police to assess the risk:

- of further attacks on the patient
- to staff, patients and visitors
- of a further incident near or at the site of the original incident
  and
- to make any firearms safe

Staff must cooperate with the Police to minimise any risk to staff, patients and visitors.

For further information, see Confidentiality: reporting gunshot and knife wounds (2018) www.gmc-uk.org.

3.5 IN THE PATIENT'S BEST INTERESTS

This includes, but is not limited to, the following situations:

3.5.1 Patients with care and support needs

See the Safeguarding Adults at Risk Policy and Procedure.

If there is a suspicion that a patient with care or support needs is the victim of physical, sexual, emotional or signifcant financial abuse, and the patient cannot or will not consent to disclosure of information pertaining to the abuse, staff are required to provide relevant information promptly to an appropriate responsible person or agency, if it is believed that disclosure is in the patient's best interests. This may be the duty social worker, the Safeguarding Team and the Police.

The patient should be informed that there is concern for their wellbeing and/or safety and that is the reason why their consent to disclosure has been requested. If it is suspected that the patient will not consent due to fears about possible repercussions (e.g. from a carer), steps must be taken to ensure the patient's immediate safety and consideration given to notifying the appropriate person(s) and or body.

A decision not to disclose information in these circumstances may need to be justified in Court or to a professional body in the event that the patient suffers further harm as a result of the failure to disclose.

3.5.2 Minors

Under the law, a child is defined as anyone who has not yet reached their 18th birthday. If a patient is under 16 years of age, consent for disclosure of information can be given by a person with parental responsibility as defined by **Section 3 of The Children Act 1989**:

"all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property ".

Rights and responsibilities include:

- safeguarding and promoting a child's health, development and welfare
- financially supporting the child
- providing direction and guidance to the child
- maintaining direct and regular contact with the child
- acting as a legal representative until the child is 16, if required
- ensuring that the child is suitably educated

Who has parental responsibility?

Married parents The law presumes that married parents each have parental responsibility for their child. They share parental responsibility jointly but can exercise it independently.

Unmarried mothers When parents are not married, the mother will automatically have parental responsibility, whether or not she is living with the child's father.

Unmarried fathers When parents are not married, the father does not automatically have parental responsibility even if he is living with the child's mother. He can acquire equal parental responsibility if:

- he has a parental responsibility agreement with the mother;

OR

- he has acquired it through a Parental Responsibility Order from the Court
- he is appointed as guardian
- he and the child's mother marry
- the child was born after 1st December 2003 and he is named on the child's birth certificate

Difficulties may arise if the person or persons with parental responsibility are suspected of abuse and they will not consent to disclosure of information, or where alerting those persons to concerns about the child's well being may hinder a subsequent child protection investigation. Please refer to Trust policies regarding safeguarding children or the Surrey Safeguarding Children Partnership Procedures Manual for guidance on child protection matters (these can be found under the safeguarding children resources on Trustnet). Please also see Working Together to Safeguard Children (2018). Cases may be discussed with the children's safeguarding team or, out of normal office hours support may be acquired via the emergency duty team at Surrey Children's Services.

Patients between the ages of 16 and 18 may consent to disclosure of information, or consent may be given by a person with parental responsibility. Ideally, the consent of both should be obtained, unless the child expresses a wish that his or her parent/guardian should not be informed. Patients aged 16 or over are entitled to consent to their own treament. Under the Mental Capacity Act (2005) young people aged 16 and over are presumed to have capacity and can therefore consent to, or refuse treatment in their own right including hospital admission. They can refuse access to their records and not give consent for clinicians to disclose information to parents. THE MCA does not apply to under 16's.

4 THE RIGHTS AND POWERS OF THE POLICE

When requesting information about a patient and /or access to a patient, the Police must produce identification. If possible, a record of the officer's name and/or badge number should be made in the patient's medical records. You must not disclose information if the officer is unable to produce identification. Those listed in Section 1 (in or out of hours) should be informed. If there is suspicion that the person making the request is not a Police Officer, the senior person will notify the Police.

The Police may be entitled to confidential patient information and patient property in circumstances where it is not possible to obtain the patient's consent, or the patient withholds consent to disclosure. However, it must not be assumed that the Police have an automatic right to information, and you must be satisfied that you have authority to agree to the request.

4.1 ACCESS TO HEALTH RECORDS

In normal circumstances, health records must not be shown or given to the Police without the written consent of the patient unless one of the exceptions detailed in Section 3 is satisfied. However, **sections 19-21 of the Police and Criminal Evidence Act 1984**, permits a police officer to seize anything which he has reasonable grounds to believe is stolen or is evidence relating to an offence and it is necessary to take it in order to prevent it from being concealed, lost, damaged, altered or destroyed. This includes the original medical records. The request should be made in writing and the police officer should be requested to sign to confirm the details of the items seized. A copy of the records should be taken if the Police seize the original records.

If the Police wish to take possession of medical records, the Health Records Manager and the senior person involved must be informed (see list Section 1).

4.2 ACCESS TO PATIENTS

The Police should not be allowed access to a patient if it would delay or hamper the patient's treatment or compromise his recovery. If the patient's condition allows him to speak to the Police,

he should be asked if he is willing to do so. If the patient refuses, subject to certain statutory provisions (detailed below), the Police must abide by that decision.

4.2.1 Patients in custody

The Police have right of access to a patient who is in their custody.

4.2.2 Patients involved in Road Traffic Accidents

Section 9 of the Road Traffic Act 1988, and **The Police Reform Act 2002**, allows the Police rights of access to a patient who is suspected to have been involved in a road traffic accident, in order to interview, breathalyse and take specimens of breath or to request a specimen of blood for laboratory analysis (see 5 below). The attending doctor must be notified before access is given. The doctor can object to access or to the patient being informed that the Police have requested access, if, in his/her clinical judgment, it would be prejudicial to the patient's care or treatment.

4.3 BLOOD SAMPLES

With the consent of the patient and the agreement of the doctor in charge of his care, a blood sample may be taken by a Police surgeon/medical practitioner. The doctor in charge of the patient's care may object to a sample being taken if he considers that the provision of a specimen would be prejudicial to the proper care and treatment of the patient, e.g. it would delay their transfer to the operating theatre. The Police must obtain a Court Order for a blood specimen to be taken without the consent of the patient.

The sample must not be taken by a doctor or nurse who has any responsibility for the clinical care of the patient. For these purposes, an 'Authorised Medical Practitioner' is a doctor or healthcare professional who is engaged under an agreement to practice medical services to the police.

The release of a sample that has been taken for diagnostic purposes is permitted with the written consent of the patient and authorisation from the consultant in charge of the patient's care. The patient should be aware of the reason for the request, which may include drug screening and DNA analysis. Details of the sample must be recorded in the patient's medical records along with a copy of the written consent.

4.4 NON-INTIMATE SAMPLES

Non-intimate samples include:

- hair (other than pubic hair)
- sample from a nail or under a nail
- swab other than from a body orifice – including the mouth
- footprint or other body impression other than from a part of the hand.

Non intimate samples may be taken with the consent of the patient.

It the patient refuses consent or lacks capacity to consent, a Court Order must be obtained **unless** the patient is in Police custody, in which case, a Police Inspector can authorise the taking of a non-intimate sample. This authority should be confirmed in writing and is given pursuant to Section 63 of **The Police and Criminal Evidence Act 1984.**

It is usual for the Police to be responsible for taking a non-intimate sample.

4.5 INTIMATE SAMPLES

Intimate samples include:

- blood
- semen
- urine
- saliva
- pubic hair
- swab from an orifice – including the nose

An intimate sample may be taken from a patient in Police detention with the patient's consent. The sample must not be taken by a doctor or nurse with any responsibility for the clinical care of the patient (see section 4.3 above).

4.6 INTIMATE SEARCHES

An intimate search consists of the physical examination of a person's body orifices which include the ear, nose, rectum or vagina. The Police do not have any powers to conduct intimate searches without consent or to authorise anyone else to perform such a search unless they have reason to believe that the patient has hidden on his person an item, which could be used to injure himself or others. This may include razor blades, knives, explosives and Class A drugs if it is believed that the drugs are intended for supply.

4.7 TO ARREST A PATIENT

The Trust is required to co-operate if the Police request access to arrest a patient. An assessment must be made of the potential risk of harm, distress and alarm to other patients, staff and visitors. Efforts must be made to minimise the risk by co-operating with the Police and, if possible, moving the patient to a side room/office so that the arrest can be effected in private.

In circumstances where a patient has been arrested but is not yet fit for discharge, it is the responsibility of the Police to ensure the patient's detention. Staff should liaise with the Police to minimise any disruption and/or risk to staff, patients and visitors.

If the decision is made not to arrest the patient whilst he is receiving in-patient care, but the Police make a request to be notified of when the patient is to be discharged, the senior person (as outlined in Section 1) should request details of the seriousness of the alleged offence(s) in order to assess the risk to staff, patients and visitors whilst the patient remains an inpatient and to assess if the patient's confidentiality can be breached in this way. It is not for the Trust to act as `unofficial gaolers'.

4.8 ACCESS TO PATIENT PROPERTY

The Police have wide ranging statutory powers to search and seize property and they should confirm the basis of their authority to search Trust premises and/ or seize patient property. The senior person (as outlined in Section 1) must be informed of the request, and will if necessary, seek further advice.

The Police and HM Revenue and Customs have extensive powers to seize anything (except that which is subject to legal privilege) regardless of whether they had authority to search for it. Where Police or Revenue and Customs Officers have seized or retained patient's property, they should be asked to provide a record of what is being retained, a copy of which should be filed in the patient's health records.

4.9 DECEASED PATIENTS

The Police may request property and/or other items from a deceased patient. This may include blood stained clothing, blood samples, bullets and other items recovered from a body.

The Coroner's office should be notified of the request and guidance obtained. The Police may be acting on the instructions from the Coroner. The deceased's property must be held securely until the Coroner's office confirms that it should be released to the police. The Coroner does not need a Court Order to take possession of property or blood samples from the Trust.

The details of property, blood sample etc, taken by the Police must be recorded in the patient's medical records and the deceased's next of kin should be notified. The next of kin cannot object to removal of property and any objections or concerns should be directed to the Coroner's office.

See Section 5 for more information about the role and powers of the Coroner.

4.10 ILLEGAL DRUGS

If a patient is found to be carrying an unidentified substance, which is suspected to be an illegal/illicit drug and not required for medical purposes, consideration should be given to the quantity of the substance, and in particular, if it appears to be for the patient's personal use, or if the quantity indicates that it is intended for supply. This will not always be easy to assess and if in doubt, advice may be sought from the Trust's Chief or Deputy Chief Pharmacist.

4.10.1 Personal Use Suspected

If the quantity is small and believed to be for personal use only, the patient must be informed that the Trust does not allow illegal drugs to be used, or held on its premises. The patient should be asked to agree that either the substance be disposed of (in accordance with the Trust's Medicines Management Policy) or removed i.e.:

- the substance may be removed from the site by an adult nominated by the patient
  or
- the substance must be locked in the controlled drug cupboard for the minimum amount of time until it can be disposed of by the pharmacist in the pharmacy department following the procedure for the destruction of controlled drugs in a clinical area. Any substance placed in the ward's controlled drug cupboard must be witnessed by two members of staff and be documented in the patient's medical records and the controlled drug registrar.

If the patient will not consent for disposal or removal, or lacks capacity to consent, the substance should be removed from the patient (if this can be done without risk to staff, patients or visitors) and locked in the controlled drug cupboard and further advice sought. If it is not possible to remove the substance from the patient, e.g. due to fear of violence, further advice should be sought and consideration given to notifying the Police.

4.10.2 Drugs intended for supply

The senior person (as identified in Section 1) must be informed if a patient is suspected of carrying, or has in their possession, an unknown substance and/or illegal drugs, the quantity of which leads to a suspicion that it is intended for supply (this includes patients who are suspected of having illegal drugs concealed in their body – 'body packers'). The senior person (as identified in Section 1) will notify the Police or seek advice from a senior colleague as to whether the Police should be informed.

Whilst the Trust is not under a statutory duty to inform the Police, it is likely that, in these circumstances, the Trust's duty to society is greater than the Trust's duty of confidentiality to the patient (see Section 2 of this Policy).

The patient should not be informed that the Police are to be/ have been contacted until consideration has been given to the facts of the individual case, and in particular, of the risk to patients staff and visitors if the patient is informed of the Police's involvement prior to their arrival.

The patient's care must not be delayed pending the arrival of the Police if such delay would put the patient at risk of harm.

If a patient has drugs concealed on their person, the Police (or Customs and Excise) may request to be present during medical procedures and/or examinations in order to ensure a 'chain of evidence'. This may arise if the patient requires surgery to remove drugs from his stomach. At all times, the patient's clinical needs are paramount and such a request may be refused, if in the opinion of the attending doctor, the Police's presence will be prejudicial, or delay the proper care and treatment of the patient.

4.11 PHOTOGRAPHS AND FINGERPRINTING

Pursuant to the **Police and Criminal Evidence Act 1984 (also section 61 Counter- Terrorism Act 2008)**, the Police cannot take a person's fingerprints without his consent except where the person is detained at a Police station. The Police may not take a patient's fingerprints on Trust premises without the patient's consent. Recent case law has confirmed that the Police may retain a person's fingerprints on the Police database, even in circumstances where the person has not been convicted of an offence.

The Police may request permission to take fingerprints from an unconscious patient whose identity is unknown. This may be in an attempt to identify the patient in the event that their details are held on the database. Even in these circumstances, the Police have a right to retain the fingerprint details. There are potential implications for the patient, and therefore, save in exceptional circumstances as detailed below, any such request must be refused. The senior person (as identifed in Section 1) must be informed and, if necessary, legal advice obtained.

In exceptional circumstances, it may be appropriate to allow the Police to take a patient's photograph or fingerprints without consent. This may arise if, for example:

A

- the patient cannot be identified; **and**
- the patient is unconscious; **and**
- the patient's prognosis is such that he or she is unlikely to regain consciousness; **and**
- the patient's next of kin cannot be located; **and**
- the Police require the patient's fingerprints for the sole purpose of identifying the patient;

OR

B

- the patient is unconscious; **and**
- was the victim of a serious crime; **and**
- the next of kin have no objections to photographs and/or fingerprints being taken to identify an assailant or to appeal for witnesses.

The senior person (as identified in Section 1) and the patient's consultant must be informed of the request and the patient's family / next of kin consulted. The outcome of this should be documented in the patient's medical records.

4.12 OFFENSIVE WEAPONS (INCLUDING FIREARMS AND KNIVES)

Offensive weapons should be removed from patients and taken into the Trust's possession under the normal procedure for patient's property. If a patient refuses to part with an offensive weapon,

the senior person (as identified in Section 1) must be informed and the Police notified. The safety of staff, patients and visitors is paramount.

If there is a suspicion that an offensive weapon has been used in criminal activity, it may be appropriate to notify the Police subject to the criteria as set out in section 2 of this policy.

4.13 CCTV FILM

The Trust has security cameras positioned throughout the hospital sites. CCTV film may be disclosed to the Police where:

- Section 3.1.2 of this Policy applies
- Sections 19-21 of the **Police and Criminal Evidence Act 1984** have been invoked (see section 4.11 above)
- Subject to a Court Order

All requests for the release of CCTV footage/films should be directed to the CCTV Controller, within normal working hours, and to the senior person (as identified in Section 1) out of hours.

4.14 MISSING/UNIDENTIFIED PATIENTS AND CONTACTING NEXT OF KIN

The Trust may wish to gain assistance from the Police in tracing a patient's relatives; identifying a patient's next of kin; or searching for a missing patient. Under these circumstances, brief details may be given, but unless absolutely necessary for the purposes of locating/identifying the person, no clinical information should be disclosed in the absence of patient consent. Please also refer to the Trust's Missing Patient Policy.

4.15 WITNESS STATEMENTS

Save for the exceptions referred to in Section 3 above, the patient's written consent is required if the Police request witness statements which is likely to include confidential / clinical information. Exceptions may apply. Refer to Section 6, which deals with witness statements.

5 THE CORONER

It is the principal duty of the Coroner to investigate deaths which appear to be due to violence, or are unnatural, or are sudden and of unknown cause, and those which occur in legal custody. The Coroner's remit is limited to establishing:

- the identity of the deceased
- where the death occurred
- how the deceased came about their death.

The question of how the person came about their death includes, "and in what circumstances". The Coroner is not concerned with 'liability'. However, the Coroner can record a verdict which states that neglect caused or contributed to the death or in extreme cases , that the person was unlawfully killed. The Coroner is also entitled to make recommendations to the Trust, CCG or any appropriate national body or in an effort to prevent another death occurring in similar circumstances. The Coroner can also refer the matter to the Police for investigation.

5.1 REPORTING A DEATH TO THE CORONER

All deaths must be reported to the Coroner if there is a belief that any of the following apply:

a) the cause of death appears to be unknown;

b) death appears to have been unnatural or caused by violence or neglect; or to have been in suspicious circumstances;

c) any death which occurs during an operation or before recovery from the effects of an anaesthetic (there is no legal definition of this time period); or

d) any death, which appears from the contents of any medical certificate to have been due to industrial disease or industrial poisoning.

This list is not exhaustive. Further advice can be obtained from the Coroner's office. See also Guidance for Doctors on Post Mortem Examinations.

5.2 POST-MORTEM EXAMINATIONS

The Coroner will consider the facts available and decide whether to order a post-mortem examination. The post-mortem examination will assist the Coroner when deciding if an inquest is required. If the Coroner does not direct or request a post-mortem examination, it may only take place with the authority of the person lawfully in possession of the body. This will usually be the deceased's next of kin. If the Coroner directs or requests a post-mortem examination, this will override the wishes of the family of the deceased.

5.3 THE CORONER'S RIGHTS AND POWERS

The Coroner does not need a Court Order to obtain property, blood samples, or confidential clinical information from the Trust. The Coroner's powers are wide ranging and generally speaking, the Coroner is entitled to any information which assists the inquest process.

The Coroner is entitled to request access to the deceased's medical records. If a patient has died in what appear to be suspicious circumstances, the Coroner may take possession of the deceased's medical records to ensure that they are not altered, lost or destroyed. The Health Records Manager and the Associate Director of Quality must be advised of any such request and a copy of the medical records must be taken before being given to the Coroner and will be held by the Associate Director of Quality.

5.4 PROVIDING A STATEMENT/REPORT TO THE CORONER

The Coroner may require evidence of a medical nature (usually in the form of written statements) from three different categories of doctor:

a) the deceased's medical attendant, i.e. general practitioner and/or a hospital doctor;

b) the pathologist who conducted the post-mortem;

c) an acknowledged expert in the field of medicine directly related to the case.

The reports will assist the Coroner to decide if the doctor/healthcare professional will be required to attend the inquest and give oral evidence under oath. This may be if the medical facts are particularly complex or if there are concerns about the care provided.

The Coroner may also request a Statement from staff. All staff asked to provide a Statement and/or attend a Coroner's Inquest should advise the Patient Safety Manager (Claims & Coroners) who will provide advice and guidance on preparing for, and attending inquests.

Refer to Section 6 for more information about providing witness statements

5.5 WHEN MIGHT THE POLICE BE INVOLVED?

On occasions, the Coroner may have sufficient concern about the circumstances of a death that he asks the Police to investigate. The Police may wish to interview and obtain witness statements from staff and any such request should be directed to the Associate Director of Quality (or senior person out of hours, as identified in Section 1). Guidance and support will be provided to members of staff involved. With the agreement of the Police, a senior Trust representative or the Trust's legal advisers will accompany the members of staff at the Police interviews in order to offer support and take notes.

The Health & Safety Executive may also decide to investigate and they too may wish to interview and obtain witness statements from staff. As with the Police, the Associate Director of Quality should be immediately notified and advice and support will be provided.

5.6 THE INQUEST

The inquest will be held in public and anyone may attend. Evidence is given under oath and the Coroner has the right to issue a Summons to order a witness to attend. Whilst the Coroner is not concerned with apportioning blame, he may inquire into whether the death was contributed to by sub optimal care. The family of the deceased, or their representative, will have an opportunity to question witnesses. The questions must relate only to who the deceased was, how, when, and where he/she died. At the conclusion of the evidence the Coroner will sum up the facts and deliver a verdict. If there is a jury, the Coroner will direct them on the law and to appropriate verdicts.

5.7 THE VERDICT

There is no requirement for the verdict to be in any particular form of words, save that it must be in plain language and must not identify an individual as having criminal or civil liability. Some of the more often used verdicts are set out below.

5.7.1 Natural Causes

If the post mortem examination confirms that the patient died of natural causes, and not by an external factor which hastened the death, it is unlikely that an inquest will be required.

5.7.2 Accidental Death

Death was found to have occurred as a result of something over which there was no human control i.e. an accident.

5.7.3 Misadventure

Death was as a result of a lawful human act, which takes an unexpected turn and leads to death. This may arise if a patient undergoes treatment for a non life threatening condition, and dies as a result of a complication of the treatment.

5.7.4 Neglect

‘Neglect’ has a much narrower meaning at an inquest than in the civil courts and must be distinguished from 'negligence.' For the purposes of an inquest, ‘neglect’ means

“a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position”.

The neglect must be directly connected with the death and must be at least a contributory cause. In the medical context, neglect is capable of including a gross failure to provide basic medical or nursing attention. However, the mere fact that clinical judgement had been exercised incorrectly will not justify a neglect verdict. The failure must be gross and it must relate to more than a single,

transitory error. A finding of 'neglect' will usually be applied as an adjunct to another verdict, so that the verdict is expressed as, for example, 'suicide contributed to by neglect.'

5.7.5 Open Verdict

An open verdict will be recorded if the cause of death is unascertainable or if there is insufficient evidence to determine the cause of death.

5.7.6 Narrative

The Coroner can give a short factual statement of how the person died, for example, "Mr X died as a result of complications following necessary surgery to repair a hiatus hernia."

6 WITNESS STATEMENTS

External agencies may ask staff to provide witness statements and/or reports, which will include confidential patient information. The amount of detail will vary depending on the proceedings for which it is to be used, e.g.

- to confirm a patient's injuries if they have been the victim of a crime
- to confirm a patient's injuries and/or details if they are suspected of committing a crime
- or have witnessed a crime
- at the request of the Coroner
- at the request of any other Court, e.g. in relation to Family Proceedings
- to confirm a chain of evidence i.e. drugs removed from "body packer"

The above list is not exhaustive and the amount of detail in the statement will vary depending on who is making the statement and the purpose for which it has been requested. On most occasions, the patient's written consent is required if the statement is to include clinical and/or confidential patient information. Written consent may not be required if one of the exceptions detailed in Section 3 apply. Further advice must be sought from the Associate Director of Quality if there is uncertainty.

6.1 WRITING A WITNESS STATEMENT

As a general rule, all witness statements and reports should:

- Include the name, address and date of birth of the patient if known
- state how long the patient has been known to the writer and/or been under the care of the Trust
- include the writer's name, post held, qualifications, number of years experience in the relevant field
- have a chronological account of the writer's involvement with the patient.
- detail any relevant medical history
- explain medical terminology in lay terms where appropriate
- be dated and signed
- be restricted to fact. Avoid opinion and/or speculation
- should **not** be written without access to the deceased's medical records, and ideally, the post mortem report if the statement is for the purposes of an inquest.

6.1.1. At the request of the Police

If the statement is required to confirm a patient's medical details, and or their identity, the statement may be prepared with reference to the patient's medical records and there will be little if any, need for direct contact with the Police following receipt of the request. It is likely that the

Police will rely on the written statement in any Court proceedings, and therefore, there will not be a need to interview the person making the statement.

The Police may wish to interview staff if for example, it is alleged that a crime has been committed on Trust premises and may have been witnessed by staff. It is likely that the interview will be ‘informal’ and it should take place at the Trust at a convenient time for the staff member concerned. With the agreement of the Police, a senior Trust representative or the Trust's legal advisers may accompany staff at the interviews to offer support and if appropriate, to take notes.

A Police officer may draft the statement as the interview progresses. It is important that he statement is carefully checked before it is signed. A copy of the statement should be requested. However, the Police do not routinely supply copies of witness statements until investigations are complete, or just prior to trial if criminal proceedings are pursued.

6.1.2 Interview under Police caution

If there is suspicion that a patient's death may have been caused by or contributed to, by a Trust employee, and the circumstances of the death are suspicious, the Police (possibly at the request of the Coroner) may wish to interview staff whilst under police caution. The interview will take place at a police station and will be tape-recorded. The Police must tell the interviewee that they are not under arrest, they are free to leave and they are entitled to free and independent legal advice however and depending on the circumstances, the Chief Executive may agree that legal advice may be provided via the Trust's solicitors.

If the member of staff has been been arrested they will not be allowed to leave police custody unless on bail or after charge even then they may be remanded in custody if certain circumstances apply. However, nothing changes the right to free and independent legal advice.

6.1.3 Internal Investigation

The Trust has a duty to investigate serious clinical and non clinical incidents and to produce a report at the conclusion of the investigation. In normal circumstances, the internal investigation will not interfere with external matters such as an inquest, and the sharing of information may assist all parties. However, in the event that a member of staff has been arrested and /or charged in connection with an incident/death, and there is a risk that the criminal investigation may be compromised by the internal process, it may be necessary to delay the internal investigation. Each case will be considered on its facts and, in the event of a Police investigation, the way forward agreed with the Police.

7 MONITORING

The application of this policy will be monitored locally by General Managers and Matrons with exception reporting via the Trust Incident Reporting procedure.

8 ARCHIVING ARRANGEMENTS

This is a Trust wide document and archiving arrangements will be arranged by the Quality Department.

9 USEFUL CONTACT DETAILS

Department of Health & Social Care	www.dh.gov.uk
General Medical council	www.gmc-uk.org 0161 923 6602
Medical Defence Union	www.the-mdu.com 020 7202 1500
BMA	www.bma.org.uk
Royal College of Nursing	www.rcn.org.uk
Royal College of Midwives	www.rcm.org.uk

10 REFERENCES AND BIBLIOGRAPHY

ACTS OF PARLIAMENT / LEGISLATION

www.legislation.hmso.gov.uk

Human Rights Act 1998
Article 8

Road Traffic Act 1988
Section 171
Section 9

Police and Criminal Evidence Act 1984
Section 19 – 21
Section 63

The Crime and Disorder Act 1998
Section 115

The Children Act 1989 & 2004
Section 27
Section 3

The Medical Act 1983
Section 35

The Coroner's Rules, Statutory Instrument 1984 No 552

Mental Capacity Act 2005

EXTERNAL GUIDELINES

GMC Guidance For Reporting Gun Shot Wounds 2008
www.gmc-uk.org.

11 EQUALITY IMPACT ASSESSMENT SUMMARY

Name: Guidance for Dealing with the Police and Other Public Bodies

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
The guidance provided in this policy is to assist Trust Managers when dealing with enquiries from the Police, the Coroner, Social Services and other external agencies. The overarching aim of the policy is to ensure appropriate patient confidentiality is maintained at all times.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
This policy equally effects all patients in circumstances where the Trust is dealing with enquiries / requests for information from the Police, Coroner, Social Services and other agencies. This policy was originally drafted by Trust Solicitors and has most recently been reviewed by them in consultation with Trust Senior Managers.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
No adverse or potentially adverse impacts have been assessed for any equalities groups. The policy equally effects all from any equalities group.
Conclusion • Provide a summary of the overall conclusions
The policy reflects statutory legislation and national guidance on dealing with the Police and other Public Bodies.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
No changes recommended.

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues,	**Sexual orientation including lesbian, gay**

access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)