13.3 Death in custody

Policy summary

A death in custody must be initially responded to as a medical emergency. The place of discovery must be preserved in the same manner as a crime scene.

A death in custody must be reported to the NSW Police Force and the NSW State Coroner by the Governor who has custody of the inmate, regardless of whether the inmate is in the correctional centre or temporarily absent. There are also requirements to notify certain government authorities of an inmate's death.

Police conduct a coronial investigation for the State Coroner and investigate the manner and cause of death. CSNSW Investigations conduct an internal investigation into the incident response and custodial management of the inmate. In rare cases, SafeWork NSW may conduct an investigation where death resulted from a workplace incident. Staff must cooperate with police and investigators.

Following a death in custody, staff must be provided with critical incident support. Affected inmates must be offered professional support services. An after action review must be conducted by the Governor.

A *Death in custody checklist* is provided for Governors and OICs which contains consolidated response, reporting and notification procedures for a death in custody.

Management of Public Correctional Centres Service Specifications

Service specification	Decency and respect Professionalism and accountability Safety and security

Scope

This section applies to all correctional centres and other facilities administered by or on behalf of Corrective Services NSW (CSNSW).

It also applies to all CSNSW employees, and where relevant to other personnel such as, Justice Health & Forensic Mental Health Network (JH&FMHN), contractors, subcontractors, and visitors.

Requirements to upload data to evidence.com or share evidence from evidence.com may not apply to privately managed correctional centres who may have their own evidence management system and processes in place.

While it is not mandated that privately managed correctional centres use evidence.com, other aspects of this policy document must be complied with. If there is any conflict with process related matters described in this document, and where there is reference to specific CSNSW business units, privately managed correctional centres should seek further advice from the relevant contract management team.

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1 Legislation

1.1 Coroners Act 2009

Section 23 of the *Coroners Act 2009* provides that a senior coroner has jurisdiction to hold an inquest into the death of a person where the person died, or there was reasonable cause to suspect the person died, while:

- in lawful custody
- in a correctional centre
- temporarily absent from a correctional centre
- escaping or attempting to escape from custody
- proceeding to a correctional centre for the purpose of being admitted as an inmate while in the custody of a correctional officer.

Section 40 of the *Coroners Act 2009* provides that a coroner may issue a coronial investigation scene order which allows a police officer or other person to exercise coronial investigation scene powers at a specified place.

Section 43 of the *Coroners Act 2009* lists those powers which include the power to investigate, search, open, inspect and or seize anything at the scene to obtain evidence.

1.2 Crimes (Administration of Sentences) Act 1999

Section 74 of the *Crimes (Administration of Sentences) Act 1999* requires the Governor of a correctional centre to provide written notice to a coroner immediately after becoming aware of the death of an inmate in the Governor's custody.

1.3 Crimes (Administration of Sentences) Regulation 2014

Clause 315 of the *Crimes (Administration of Sentences) Regulation 2014* requires the Governor to keep a record at the correctional centre of the death of any inmate that occurs while the inmate is in the Governor's custody.

2 Discovery and incident response

2.1 Initiating an urgent response

Where a correctional officer discovers an inmate who appears deceased, the officer must immediately call for an urgent response.

2.2 Safety precautions when entering cells

Staff must comply with the minimum safe staffing numbers required to enter accommodation areas/cells for their centre which is outlined in Local Operating Procedure (LOP): *Safe staff numbers when entering accommodation area/cells* and LOP: *Responding to cell call alarms.*

2.3 First aid and medical assistance

The discovery of an inmate who appears deceased must be treated as a medical emergency. For medical emergency response procedures refer to **COPP section *13.2 Medical emergencies***.

2.4 Crime scene preservation

Crime scene preservation procedures must also be initiated for coronial investigation scenes. However, the safety of persons and emergency medical assistance to the injured take precedence. **Cellmates or suspected assailants must be separated and secured** for forensic processing by police. For crime scene preservation procedures refer to **COPP section *13.8 Crime scene preservation***.

2.5 Liaison duties

For deaths other than expected deaths from natural causes, a senior officer must be appointed as 'Liaison Officer' to liaise directly with police, emergency services, CSNSW investigators, JH&FMHN and any other relevant services.

Where possible the Liaison Officer must not have been directly involved in the incident.

The Liaison Officer will report directly to the Governor or OIC.

2.6 Cooperation with police and investigators

Correctional officers (responding officers and witnesses) must remain on duty and be available to assist investigating police and CSNSW investigators unless permitted to cease duty by the Governor.

Staff must cooperate with CSNSW investigators and attend an interview if requested. Staff may have a support person present at an interview. Notwithstanding the need for staff to assist police and investigators, an officer must be excused from duty if the officer requires immediate medical treatment or immediate counselling.

2.7 Death in custody checklist – Governor/OIC procedures

The ***Death in custody checklist*** provides Governors and OICs with a consolidated list of procedures that must be completed for a death in custody. The checklist may be completed electronically. It contains telephone numbers and email hyperlinks to relevant authorities.

Procedures from these COPP policies are contained in the *Death in custody checklist*:

- ***13.1 Serious incident reporting***
- ***13.2 Medical emergencies***
- ***13.8 Crime scene preservation***
- ***13.9 Video evidence***

2.8 Release of deceased inmate from Correctional Centre or Medical Facility

After an inmate has been pronounced deceased in a correctional centre or medical facility (e.g. hospital), the police OIC will inform CSNSW when custody of the body is being transferred to the police and coroner for the purpose of transporting the body to the morgue and provide the relevant paperwork.

Until this advice and relevant paperwork has been received from police, CSNSW officers must retain charge of the body, remain on duty, and continue supervision until such time as the body has been removed to be transported to the morgue.

3 Notifications

3.1 NSW Ambulance Service

The Governor or OIC must ensure that an ambulance has been called and that access is facilitated in accordance with **COPP section *13.2 Medical emergencies***.

3.2 NSW Police Force

A death in custody must be immediately reported to the nearest police station by telephone. The following details must be provided to police:

- full name and date of birth of inmate
- time, date and place where inmate was discovered deceased
- brief facts and circumstances of death
- whether the inmate is Aboriginal.

Police must be informed at the first instance if the death is suspicious and if any inmates are suspected of involvement. This can assist police with deploying sufficient resources at the earliest opportunity to forensically process inmates.

The date and time of the telephone call along with the name and station of the police officer must be recorded by the notifying officer in the appropriate journal (e.g. *Manager of Security Journal* or *B Watch OIC's Journal*).

The police are responsible for notifying the inmate's next of kin (NOK) and emergency contact person (ECP). The deceased inmate's NOK/ECP details must be provided to the police OIC as soon as possible after police arrive at the correctional centre.

Local police will advise the Commander, Corrective Services Investigation Unit (CSIU) of the death in custody. Local police will inform the CSIU when the NOK/ECP has been notified.

The Commander CSIU will advise the Governor or OIC and Chaplaincy Coordinator if police have any difficulties contacting the NOK/ECP.

3.3 Serious incident reporting

Refer to **COPP section *13.1 Serious incident reporting*** for procedures. **Key stakeholders will be notified by the Duty Officer** (e.g. CSNSW Investigations, Chaplaincy Coordinator, Principal Manager, Aboriginal Strategy and Policy Unit).

3.4 NSW State Coroner

A coroner must be notified immediately in writing as soon as the Governor becomes aware of the inmate's death. For this purpose a copy of the IRM *Incident Details* report can be emailed to:

NSW State Coroner's Court
1A Main Ave
Lidcombe NSW 2141
Telephone: **(02) 8584 7777**
Fax: **(02) 8584 7788**
Email: lidcombe.coroners@dcj.nsw.gov.au

Department of Communities & Justice Legal (DCJ Legal) must also be sent a copy of the notification. This can be done by sending a copy of the above email to:

General Counsel
Department of Communities & Justice Legal

Telephone: **(02) 8346 1388**
Email: enquiries_generalcounsel@dcj.nsw.gov.au

A Governor is not obliged to notify the Coroner of the death of an inmate who has been transferred from a correctional centre to a mental health facility pursuant to an order under s. 55 of the *Mental Health (Forensic Provisions) Act 1990*.

3.5 Scheduled visitors

The visits schedule for a deceased inmate must be checked. Visitors who have a scheduled visit must be notified that the visit is cancelled. Notification of cancellation must not occur until it is confirmed by police that they have notified the NOK of the inmate's death. This does not apply where police cannot locate the NOK within a reasonable time.

3.6 48 Hour incident/injury notification e-form for non-employees

A notification form must be completed for the CSNSW insurer in the event of a death in custody. **(Refer to COPP section *13.2 Medical emergencies*)**.

3.7 SafeWork NSW

SafeWork NSW must be immediately notified of the death of an inmate by telephone on **13 10 50**. This applies to deaths from unknown causes and deaths suspected of being caused by accident, electrocution, fire or ingestion of poisons. **This does not apply to suicides, homicides, or expected deaths from a terminal illness**. If in doubt, notify SafeWork NSW. **(Refer to COPP section *13.2 Medical emergencies)***.

3.8 Sentence Management Operations

Sentence Management Operations (SMO) **are responsible for notifying the relevant courts** which have active warrants, detainers or orders for the inmate. The respective Cluster Manager, SMO must be notified of the inmate's death as soon as possible.

3.9 Foreign nationals

The NSW Police Force, Coroner or other authority registering the death is responsible for notifying the inmate's embassy or consulate. **CSNSW is not required to make this notification**.

3.10 Australian Border Force

If the deceased inmate is an immigration detainee then the Australian Border Force must be notified as soon as possible by telephone and email at:

Command Centre
Regional Command NSW
Australian Border Force

24 hours: **(02) 8339 6693**
Email: nationaldetentionplacements@border.gov.au
RCNSWCC@border.gov.au

A copy of the death in custody IRM *Incident Details* report must be attached to the email.

3.11 Federal Offenders Unit

If the deceased inmate is a federal offender then the Australian Attorney-General's Department must be notified by telephone and email at:

Principal Legal Officer
Federal Offenders Unit
Attorney-General's Department
4 National Circuit
Barton ACT 2600

Call: **(02) 6141 2867**
Email: Federal.Offenders@ag.gov.au

A copy of the death in custody IRM *Incident Details* report must be attached to the email.

4 Reports and records

4.1 Incident/witness reports

An *Incident/witness report* must be submitted to the Governor or OIC by all staff who:

- responded to the incident;

- last saw the inmate alive;
- witnessed an incident or event possibly related to the death (e.g. inmate complained of feeling unwell the previous day); or
- were significantly involved in the management of the incident.

An *Incident/witness report* must contain a detailed account of the officer's involvement including any actions taken, decisions made or directions given. The report must be submitted as soon as possible and before ceasing duty.

Officers must write their reports from their own recollection of events and independently from each other. Reporting officers should have adequate facilities to meet this requirement (e.g. access to computers in separate areas).

An officer must not view video footage including CCTV, handheld video (HHV) or body worn video (BWV) if a person has sustained life-threatening or fatal injuries. For more information about viewing footage to assist to write a report refer to **COPP section *13.9 Video evidence***.

4.2 Staff reports

The Governor or OIC must obtain reports from the following staff as soon as possible after the death in custody:

- Manager of Security
- Manager Offender Services & Programs
- Intelligence Officer
- Night Senior
- Senior Psychologist or Psychologist
- Services and Programs Officer
- Education Services Coordinator
- Senior Case Management Officer
- Case Officer
- Wing/Pod Officer
- Chaplain
- Community Corrections Officer (where applicable)
- any other staff member the Governor considers relevant to the inmate's management (e.g. Regional Aboriginal Pathways Officer).

A report should include the following details in summary (where relevant):

- **historical synopsis** of the inmate from the staff member's perspective;
- **overall involvement** with the inmate;
- **significant and most recent contacts** between the staff member and inmate;
- **unusual behaviours or comments** by the inmate;
- **professional summary** or comment; and
- any other relevant information.

4.3 CSNSW Investigations

CSNSW Investigations conduct an internal investigation into the death in custody for the Commissioner. This includes a review of the inmate's management while in custody and the incident response.

The annexure ***Death in custody reports and records checklist*** contains the records and reports required by investigators. Investigators may request additional reports or copies of records including CCTV and video footage. These must be provided by the correctional centre as soon as practicable.

4.4 Digital Warrant File and Case Management File

The inmate's Case Management File must be scanned and uploaded to EDRMS. The original documents must be given to the investigating police, along with a print-out of the Digital Warrant File. **It is not necessary to produce photocopies of the files unless requested.**

4.5 Uploading reports and records to EDRMS

All reports and records relating to a death in custody must be scanned and uploaded to the **EDRMS *Death in Custody – Initial Notifications (holding file)* 12/7372**.

Follow this link for instructions in how to upload files to EDRMS for a death in custody.

The holding file will contain the reports and records for seven days before being transferred to a death in custody case file. Stakeholders (*Death in Custody - Case File Access Group*) can access both file directories.

4.6 Evidence.com

All reports and documents including video footage relating to a death in custody that may be required to be shared with internal or external stakeholders must be uploaded and shared via evidence.com

4.7 Accessing reports and records in EDRMS

Once the records are transferred to a death in custody case file, *Death in Custody - Case File Access Group* members may find the file in EDRMS by performing a **Title Word** search and typing "0000" followed by the deceased inmate's MIN.

5 Post incident support

5.1 EAP critical incident support

For policy and procedures refer to **COPP section *13.2 Medical emergencies***.

5.2 After action review

An after action review (formerly known as an operational debriefing) must be convened and chaired by the Governor or OIC for all staff involved in the incident. A review must not occur until after officers have submitted their reports and are no longer required by police or CSNSW investigators to assist with enquiries.

A review must follow the order in which events occurred and remain specific to operational matters. A review should be conducted with as little formality as possible so all ranks feel free to participate.

An after action review provides all employees who were directly or indirectly involved in the incident with the opportunity to:

- discuss and evaluate the incident response (e.g. timeliness, effectiveness)
- identify good practices and responses
- identify deficiencies and lessons learned
- make recommendations to improve the response and management of any future incidents.

A review provides the Governor or OIC with an opportunity to identify the root causes of any failures so that LOPs and correctional centre practices can be improved. The Governor may refer any systemic issues identified to the respective Custodial Director.

5.3 Support service provision for inmates

Where an inmate was exposed to or affected by a death in custody, arrangements must be made for the inmate to be offered support service provision by a psychologist, another appropriate OS&P staff member, or JH&FMHN. The case manager must also be notified. The referral of an inmate must be recorded in a case note unless the referral is made through opening the appropriate OIMS referral line.

Inmates exposed to or potentially affected by a death in custody include any inmate who:

- was housed in the same cell or dormitory at the relevant time
- discovered or observed the inmate when deceased
- was a relative of the deceased inmate, whether or not housed in the same correctional centre
- was known to be a friend of the deceased inmate
- worked with the deceased inmate at the correctional centre.

6 Family, religious and cultural matters

6.1 Aboriginal Strategy and Policy Unit

In the case of an Aboriginal death in custody, the Principal Manager, ASPU will notify the Aboriginal Legal Service (ALS) and Aboriginal Affairs NSW in accordance with ASPU reporting procedures.

The Principal Manager, ASPU or Regional Aboriginal Pathways Officer (RAPO) will liaise with the Governor or OIC to obtain details about the death and police notification of the NOK; and assist the Governor with any family or cultural issues.

Principal Manager
Aboriginal Strategy and Policy Unit
Corrective Services NSW
Telephone: [redacted]

For more information about ASPU's death in custody policy and procedures, refer to *Corrections Strategy and Executive Services - Aboriginal Strategy and Policy Unit: Aboriginal Death in Custody Policy*.

6.2 Chaplaincy services

Chaplaincy services will be coordinated by the Chaplaincy Coordinator ChaplaincyCSNSW@dcj.nsw.gov.au in accordance with death in custody procedures in the CSNSW Chaplaincy Manual.

Following notification from the Duty Officer, the Chaplaincy Coordinator will liaise with the Governor or OIC to obtain the NOK/ECP contact details. The Chaplain must be provided all relevant details including the time, place and circumstance of the death.

Subject to the approval of the police OIC and the deceased's NOK, chaplains may be given access to the deceased inmate at the centre to perform religious ministrations.

In the event that an inmate's property cannot be collected by the NOK, the Chaplain may liaise with the local centre to arrange distribution of property to the inmates NOK.

6.3 Funeral subsidy to family of deceased inmate

The Chaplaincy Coordinator is responsible for informing that a funeral subsidy may be applied for following an inmate's death in custody. **(Refer to COPP section *9.2 Application for financial assistance for families of inmates)***.

6.4 Information requests from family

Following a death in custody, the Police will provide the deceased's NOK with the contact number for the Police OIC so that they can communicate directly with the investigating police.

The Police OIC will also provide their contact details to CSNSW Investigations who will enter this information into an OIMS case note.

In cases where an individual contacts CSNSW for information relating to a death in custody, CSNSW staff must refer the individual to the Police OIC and provide their contact details as noted in the OIMS case note.

Note: CSNSW staff must be sensitive to the needs and requests of the deceased inmate's family. All efforts should be made to provide frank and helpful advice in a polite and considerate manner.

6.5 Period of time a cell is to remain sealed

A cell where a death occurred must remain sealed until the coroner or police OIC advise that it is no longer required as a coronial investigation scene or crime scene.

6.6 Inspection of the scene by family and their representatives

The Coroner or police OIC may grant a family's request to inspect the coronial investigation scene. If a request is granted, the Governor may give approval to the following persons to inspect the scene under supervision of police or an officer from the Office of the NSW State Coroner:

- family of the deceased or their legal representatives
- Aboriginal Legal Service (if the deceased is Aboriginal)
- an independent forensic expert retained by the family

6.7 Religious and cultural ceremonies on site

The Governor may permit the deceased's family to conduct a religious or cultural ceremony at the place of death. As far as is practicable, the place of death must remain secure until arrangements can be made for the ceremony to take place.

If the deceased inmate was Aboriginal, the family may be permitted to undertake a smoking ceremony and bring flora into the centre for that purpose. If there are any operational issues with facilitating a ceremony, then the Governor must liaise with the Principal Manager, ASPU.

6.8 Protocol for family attendance at scene

A suitable time must be negotiated with the family to allow them access to the incident scene giving consideration to the operations of the correctional centre.

During this inspection, there must be no communication between any of the correctional centre's inmates and members of the family or their legal representatives. The family and their legal representatives must be informed of this prior to the inspection or ceremony.

7 Deceased inmate's property

7.1 Property seized by police as coronial exhibits

Investigating police may seize some CSNSW property (e.g. bedsheets) or an inmate's property as exhibits. This is usually done with the implied consent of the Governor; however police may seize property pursuant to a coronial investigation scene order.

In cases of suspected suicide, police usually seize exhibits such as recent correspondence, medications, ligatures and any similar articles. Such property is of little monetary value so a property receipt is not required.

A property receipt is required if police request to take a valuable item without a warrant. A copy of the inmate's OIMS property record endorsed by police is sufficient.

7.2 Property seized by police as crime exhibits

Where an inmate has died as a result of a suspected serious offence, police may seize property under a crime scene warrant or search warrant. Police will provide the Governor or OIC with a copy of the occupier's notice for the respective warrant and a NSWPF *Property Seizure/Exhibit Form* listing all items seized.

Enquiries relating to property seized by police must be referred to the police OIC.

7.3 Release of property and monies

Section 61 of the *Probate and Administration Act 1898* provides that a deceased person's property is vested in the NSW Trustee & Guardian until probate, or administration, or an order to collect is granted in respect of the person's estate. This is regardless of whether the person is testate or intestate.

Most property held by CSNSW on behalf of a deceased inmate has little monetary value and the possibility of competing claims would be unlikely. In such cases, CSNSW will permit the deceased inmate's NOK/ECP to take possession of the property and to be paid any money banked on behalf of the inmate. Refer to subsection ***6.2 Chaplaincy services*** regarding chaplaincy assistance in some circumstances.

CSNSW will release a deceased inmate's money and property to the NOK/ECP providing they sign an ***Indemnity for property of deceased inmate*** form to protect CSNSW from any competing claims for the deceased inmate's property.

Unclaimed property may be disposed of six months after the date of death in accordance with **COPP section *4.7 Confiscated, unclaimed and disposing of property***.

8 Miscellaneous matters

8.1 Media enquiries

All media enquiries about a death in custody must be referred to the police OIC or CSNSW Media and Communication Unit. Staff must not disclose any information about a death in custody without the approval of the CSNSW Media and Communication Unit. Refer to the *CSNSW Communications Policy and Procedures* for more information.

The CSNSW Media and Communication Unit will only release information about a death in custody after the inmate's NOK and/or ECP and registered victim (if any) has been notified.

9 Coronial inquests

9.1 Staff attendance at inquests

For information about staff attendance at inquests refer to **COPP section *20.11 CSNSW staff at coronial inquests*.** The Coronial Information and Support Program (CISP) provide support services to persons who are called as a witness in a coronial inquest or inquiry. The CISP can provide witnesses with practical information about attending court, court protocols and procedures, and the process of giving evidence.

Coronial Information Support Program
Office of the NSW State Coroner
Call: **(02) 8584 7777**

9.2 Informing staff of the Coroner's findings and recommendations

The Assistant Commissioner, Custodial Corrections must ensure that the relevant Director, Custodial Operations and Governor are advised of the Coroner's findings and recommendations.

The Governor must inform all personnel who provided reports, statements, and/or evidence relating to the case of the Coroner's findings and recommendations.

9.3 Report to Minister on Coroner's findings and recommendations

The Assistant Commissioner, Custodial Corrections must, within three calendar months of publication of the Coroner's findings, provide the Minister with a report about any action taken or proposed to be taken as a result of the Coroner's findings and recommendations. This report must include any action taken with respect to any person.

10 Quick links

- *Related COPP*
- *Forms and annexures*
- *Related documents*

11 Definitions

Aboriginal inmate	For the purpose of this policy, a reference to an Aboriginal inmate is also a reference to a Torres Strait Islander inmate
ASPU	Aboriginal Strategy and Policy Unit, CSNSW
COPP	Custodial Operations Policy and Procedures
Correctional centre	Any place of detention including a correctional centre, correctional complex, police or court cell complex or residential facility where inmates are in Corrective Service NSW custody
Critical incident	An incident that has the potential to provoke a strong emotional response, at the time, or soon after the incident
CSIU	Corrective Services Investigation Unit, NSW Police Force
CSNSW	Corrective Services NSW
DCJ Legal	NSW Department of Communities & Justice Legal (formerly known as Office of the General Counsel (OGC))
ECP	An inmate's nominated contact person in case of a medical emergency, such as, but not limited to spouse, de facto partner, a parent, adult child, sibling, or trusted person. ECP can be the same person as the nominated NOK. The ECP is contacted if an inmate is taken to hospital with life threatening injuries and it is obvious he or she will be admitted. For non-life threatening injuries, the inmate's ECP is contacted on the day admission to hospital is confirmed.

	An inmate's consent to contact the ECP will be obtained unless the inmate is incapable of giving consent. The ECP will also be contacted if an inmate is an inpatient and: - Their medical condition deteriorates and becomes life threatening; or - Their hospital stay is extended beyond the expected hospital discharge date. The ECP is not contacted in the case of death, unless they are also the nominated NOK.
EDRMS	Electronic Document and Records Management System
First responding officer	A correctional officer who discovers a serious incident. There may be more than one first responding officer at any given incident and a first responding officer's duties may be shared
IRM	Incident Reporting Module
Immigration detainee	A person detained in CSNSW custody pursuant to an order issued under the *Migration Act 1958* (Cth)
JH&FMHN	Justice Health & Forensic Mental Health Network
LOP	Local Operating Procedure
NOK	An inmate's nominated contact person in the case of death, or deemed life threatening by Health staff, such as, but not limited to spouse, de facto partner, a parent, adult child, sibling, or trusted person. The NOK is contacted in the case of death and this is done by Police. The NOK will not be contacted upon admission to Hospital for a non-life threatening situation.
NSWPF	NSW Police Force
OIC	Officer in charge: the on-duty ranking correctional officer who is in charge of the correctional centre in the absence of the Governor, e.g. manager of security or night senior
OIMS	Offender Integrated Management System
OS&P	Offender Services and Programs
Police OIC	The senior police officer in charge of the initial police response and then the detective who takes charge of the coronial investigation.
SMO	Sentence Management Operations

12 Document information

Business Centre:		Statewide Operations
Approver:		Craig Smith (A/Deputy Commissioner Security and Custody)
Date of Effect:		16 December 2017
EDRMS container:		18/7551
Version	**Date**	**Reason for amendment**
1.0	16/12/17	Initial publication *(Replaces section 13.2 of the superseded Operations Procedures Manual)*.
1.1	14/03/19	Included a link to ASPU's new policy and procedures
1.2	12/06/19	Inclusion of subsection [6.4] regarding Police OIC contact details.
1.3	02/07/19	Inclusion at [4.1] about the ability of officers to view CCTV, HHV and BWV to assist them to complete a report if a person has not sustained a life-threatening or fatal injury.
1.4	15/10/19	Inclusion to [6.2] regarding Chaplain assistance for distribution of property to inmates NOK.
1.5	05/12/19	Update made to subsection [6.3] regarding discretionary provision of funeral subsidy.
1.6	12/03/20	General formatting update and improvements
1.7	20/01/21	Inserted sentence at [8.1] that says the CSNSW Media and Communication Unit will only release information about a death in custody after the inmate's NOK and/or ECP and registered victim (if any) has been notified.
1.8	08/07/22	Expanded NOK and ECP definitions.
1.9	23/03/23	Addition of subsection 4.6 – inclusion of all reports and documents including video footage on evidence.com
1.10	22/08/23	Addition of subsection 2.8 – inclusion of information relating to the release of a deceased inmate from a Correctional Centre or Medical Facility to the Police and Coroner. Updates in line with CSNSW restructure: deletion of reference to Security and Intelligence (S&I); renaming of Director of Custodial Operations to Custodial Director; and renaming of State Sentence Administration (SSA) to Sentence Management Operations (SMO).
1.11	13/05/24	Update of subsection 2.2 *Safety precautions when entering cells* to require staff to require staff to comply with relevant LOPs. See DC Memorandum 2024/11 *Safe staffing number when entering accommodation areas/cells.*